# Section 3: Data definitions

Victorian Perinatal Data Collection (VPDC) manual

Version 7.0

VICTORIA State Government | Health and Human Services

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# Contents

# Introduction

This section provides the specifications for each Victorian Perinatal Data Collection (VPDC) data element collected and reported to the department.

The format for the transmission of VPDC data is specified in Section 5: Compilation and submission.

Software vendors should read Section 3: Data definitions and Section 5: Compilation and submission together (along with other sections of this manual) to understand the VPDC and transmission requirements.

Additional items are derived from the items reported in the VPDC. These are referenced in Section 2: Concept and derived item definitions, for information only.

# Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the mother is admitted into a high dependency unit (HDU) / intensive care unit (ICU) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 94 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Admitted to high dependency unit / intensive care unit |
| 2 | Not admitted to high dependency unit / intensive care unit |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Depending on the facilities, and policies of the hospital, this high dependency care may take place in the labour ward, high dependency unit, intensive care unit, coronary care unit, or any other specialist unit. The mother may spend time in this unit for days either before and/or after the birth. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | High dependency unit (HDU), intensive care unit (ICU) |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) | | |
| Definition source | DHHS | Version | 1. January 1999 |
| Codeset source | DHHS | Collection start date | 1999 |

# Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the neonate is admitted into a special care nursery (SCN) or neonatal intensive care unit (NICU) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 113 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Admitted to SCN |
| 2 | Admitted to NICU |
| 3 | Not admitted to SCN or NICU |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | The criteria for admissions to SCN may vary depending on the facilities available and level of care provided within a particular hospital. This data element is a flag for neonatal morbidity and/or congenital anomalies.<br>If code 1, Admitted to SCN or code 2, Admitted to NICU is selected, then morbidity and/or anomalies must be documented. If the neonate is admitted to both SCN and NICU, report code 2 Admitted to NICU. Do not report a value for stillbirth episodes, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | Intensive care unit (ICU) |
| Related data items (this Section): | Congenital anomalies – free text, Hospital code (agency identifier), Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code |
| Related business rules (Section 4): | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2007 |
| Codeset source | DHHS | Collection start date | 1999 |

# Admitted patient election status – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the mother is admitted as a public or private patient | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 17 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Public |
| 2 | Private |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Homebirths under the care of an independent midwife or medical practitioner should be reported as code 2 Private. Homebirths under the public homebirth program must be reported as code 1 Public. Transport Accidet Commission (TAC), Department of Veterans' Affairs (DVA) and WorkCover patients must be reported as code 1 Public. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (section 4): | Mandatory to report data items, Setting of birth – actual and Admitted patient election status – mother valid combinations |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1998 |
| Codeset source | DHHS | Collection start date | 1998 |

# Anaesthesia for operative delivery – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether anaesthesia is administered to the mother for, or associated with, the operative delivery of the baby (forceps, vacuum/ventouse or caesarean section) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 79 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Anaesthesia administered |
| 2 | Anaesthesia not administered |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Operative delivery includes caesarean section, hysterotomy, forceps and vacuum/ventouse extraction. Do not report a value for birth episodes with no operative delivery, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes with an operative delivery |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009 |
| Codeset source | DHHS | Collection start date | 1999 |

# Anaesthesia for operative delivery – type

**Specification**

| | | | |
|---|---|---|---|
| Definition | The type of anaesthesia administered to a woman during a birth event | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x4) |
| Location | Episode record | Position | 80 |

Permissible values

| Code | Descriptor |
|---|---|
| 2 | Local anaesthetic to perineum |
| 3 | Pudendal block |
| 4 | Epidural or caudal block |
| 5 | Spinal block |
| 6 | General anaesthetic |
| 7 | Combined spinal-epidural block |
| 8 | Other anaesthesia |
| 9 | Not stated / inadequately described |

Reporting guide

This item should be recorded for operative or instrumental delivery of the baby only. It does not include the removal of the placenta.

Combined spinal-epidural block:

The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

Other anaesthesia:
May include parenteral opioids, nitrous oxide.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes with an operative delivery |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Anaesthesia for operative delivery – indicator |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999<br>2. July 2015 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1999 |

# Analgesia for labour – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether analgesia is administered to the woman to relieve pain during labour | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 77 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Analgesia administered |
| 2 | Analgesia not administered |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Analgesia will usually be administered by injection or inhalation. This item is to be recorded for first and second stage labour, but not third stage labour (for example, removal of placenta), and not when it is used primarily to enable operative birth. Inhalation analgesia such as nitrous oxide ($N_2O$ and $O_2$) can be used for manual removal of placenta on occasion. Do not report a value for birth episodes where the woman does not have labour, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where there is a labour |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999 |
| Codeset source | DHHS | Collection start date | 1999 |

# Analgesia for labour – type

**Specification**

| | | | |
|---|---|---|---|
| Definition | The type of analgesia administered to the woman during a birth event. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x4) |
| Location | Episode record | Position | 78 |

Permissible values

| Code | Descriptor |
|---|---|
| 2 | Nitrous oxide |
| 3 | Systemic opioids |
| 4 | Epidural or caudal block |
| 5 | Spinal block |
| 7 | Combined spinal / epidural block |
| 8 | Other analgesia |
| 9 | Not stated / inadequately described |

Reporting guide

This item is to be recorded for first and second stage labour, but not for third stage labour, e.g. removal of placenta.

Systemic opioids.
Includes intramuscular and intravenous opioids.

Combined spinal / epidural block.
The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

Other analgesia.
Includes all non-narcotic oral analgesia. Includes non-pharmacological methods such as hypnosis, acupuncture, massage, relaxation techniques, temperature regulation, aroma therapy and other.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where there is a labour |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Analgesia for labour – indicator |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999<br>2. July 2015 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1999 |

# Antenatal corticosteroid exposure

## Specification

| | | | |
|---|---|---|---|
| Definition | Administration of any antenatal dose of steroids for the purpose of fetal lung maturation | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 139 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | None |
| 2 | One dose |
| 3 | Two doses (one course) |
| 4 | More than two doses |
| 9 | Not stated/adequately described |

| | |
|---|---|
| Reporting guide | Report the number of steroid doses given during the pregnancy episode |
| Reported by | All Victorian hospitals where a live birth has occurred and homebirth practitioners |
| Reported for | All live birth episosodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | The number of steroid doses |
| Related business rules (Section 4): | Birth status. Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Apgar score at one minute

## Specification

| | | | |
|---|---|---|---|
| Definition | Numerical score used to indicate the baby's condition at one minute after birth | | |
| Representation class | Total | Data type | Number |
| Format | N[N] | Field size | 2 |
| Location | Episode record | Position | 102 |
| Permissible values | Range: zero to 10 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | The score is used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, reflexes and colour. The maximum or best score is 10. If the Apgar score is unknown, for example, for babies born before arrival, report as 99. For stillbirth episodes, report the Apgar score as 00. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Birth status ‘Stillborn’ and associated data items valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1998 |
| Codeset source | NHDD | Collection start date | 1998 |

# Apgar score at five minutes

## Specification

| | | | |
|---|---|---|---|
| Definition | Numerical score used to indicate the baby's condition at five minutes after birth | | |
| Representation class | Total | Data type | Number |
| Format | N[N] | Field size | 2 |
| Location | Episode record | Position | 103 |
| Permissible values | Range: zero to 10 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | The score is used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, reflexes and colour. The maximum or best score being 10. If the Apgar score is unknown, for example, for babies born before arrival, report as 99. For stillbirth episodes, report the Apgar score as 00. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Apgar score at one minute | | |
| Related business rules (Section 4): | Birth status ‘Stillborn’ and associated data items valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | NHDD | Collection start date | 1982 |

# Artificial reproductive technology – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether artificial reproductive technology (ART) was used to assist the current pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 60 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Artificial reproductive technology was used to assist this pregnancy |
| 2 | Artificial reproductive technology was not used to assist this pregnancy |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | If reporting code 1 Artificial reproductive technology was used to assist this pregnancy, also report the type of ART in Procedure – free text and/or Procedure – ACHI code, for example, IVF, Clomid, GIFT or ICSI. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Artificial reproductive technology – indicator conditionally mandatory data items, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Birth order

## Specification

| | | | |
|---|---|---|---|
| Definition | The sequential birth order of the baby, including that in a multiple birth for the current pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 99 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Singleton or first of a multiple birth |
| 2 | Second of a multiple birth |
| 3 | Third of a multiple birth |
| 4 | Fourth of a multiple birth |
| 5 | Fifth of a multiple birth |
| 6 | Sixth of a multiple birth |
| 8 | Other |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be reported as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth). |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Birth plurality and Birth order valid combinations, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | NHDD | Collection start date | 1982 |

# Birth plurality

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of babies resulting from a single pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 98 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Singleton |
| 2 | Twins |
| 3 | Triplets |
| 4 | Quadruplets |
| 5 | Quintuplets |
| 6 | Sextuplets |
| 8 | Other |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus is likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included they should be recognisable as a fetus and have been expelled or extracted with other products of conception when pregnancy ended at 20 or more weeks gestation. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Birth order |
| Related business rules (Section 4): | Birth plurality and Birth order valid combinations, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. July 2015 |
| Codeset source | NHDD | Collection start date | 1982 |

# Birth presentation

**Specification**

| | | | |
|---|---|---|---|
| Definition | Presenting part of the fetus (at the cervix) at birth | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 73 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Vertex |
| 2 | Breech |
| 3 | Face |
| 4 | Brow |
| 5 | Compound |
| 6 | Cord |
| 7 | Shoulder |
| 8 | Other |
| 9 | Not stated / inadequately described |

Reporting guide

For a multiple pregnancy with differing presentations, report the presentation of the fetus for each birth.

- Code 2 Breech: includes breech with extended legs, breech with flexed legs, footling and knee presentations.
- Code 5 Compound: refers to more than one presenting part. It is the situation where there is an associated prolapse of hand and/or foot in a cephalic presentation or hand(s) in a breech presentation.
- Code 8 Other – specify: when Other – specify is reported, further information about the details must be reported in Events of labour and birth – free text or Events of labour and birth – ICD-10-AM code.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Birth presentation conditionally mandatory data items, Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999<br>3. January 2009 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

# Birth status

## Specification

| | | | |
|---|---|---|---|
| Definition | Status of the baby at birth | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 100 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Live born |
| 2 | Stillborn (occurring before labour) |
| 3 | Stillborn (occurring during labour) |
| 4 | Stillborn (timing of occurrence unknown) |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Code 1 Liveborn: CCOPMM defines liveborn as the birth of an infant, regardless of maturity or birth weight, who breathes or shows any other signs of life after being born.<br>Code 2 Stillborn (occurring before labour) , code 3 Stillborn (occurring during labour) and code 4 Stillborn (timing of occurance unknown): CCOPMM defines a stillbirth as the birth of an infant of at least 20 weeks' gestation or if gestation is unknown, weighing at least 400 grams, which shows no signs of life after birth. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | Live birth, Stillbirth (fetal death) |
| Related data items (this section): | Apgar score at one minute, Apgar score at five minutes |
| Related business rules (Section 4): | Birth status 'Live born' and associated conditionally mandatory data items, Birth status 'Stillborn' and associated data items valid combinations, Mandatory to report data items, Scope 'Stillborn' |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. July 2015<br>3. January 2017 |
| Codeset source | NHDD | Collection start date | 1982 |

# Birth weight

## Specification

| | | | |
|---|---|---|---|
| Definition | The first weight, in grams, of the live born or stillborn baby, obtained after birth r the weight of the neonate or infant on the date admitted if this is different from the date of birth. | | |
| Representation class | Total | Data type | Number |
| Format | NN[NN] | Field size | 4 |
| Location | Episode record | Position | 101 |
| Permissible values | Range: 10 to 9998 (inclusive)<br><br>**Code** **Descriptor**<br>9999 Not stated / inadequately described | | |
| Reporting guide | Unit of measure is in grams.<br><br>For live births, birth weight should preferably be measured within the first few hours after birth before significant postnatal weight loss has occurred. While statistical tabulations include 500g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.<br><br>In the case of babies born before arrival at the hospital, the birth weight should be taken shortly after the baby has been admitted to hospital. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | Birth weight | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items, Scope ‘Stillborn’ | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (DHHS modified) | Version | 1. January 1982 |
| Codeset source | NHDD | Collection start date | 1982 |

# Blood product transfusion – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the mother was given a transfusion of whole blood, or any blood product (excluding anti-D), during her postpartum stay | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 90 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Transfusion of blood products received |
| 2 | Transfusion of blood products not received |
| 9 | Not stated / inadequately described |

Reporting guide

Blood products may include:

- whole blood
- packed cells
- platelets
- fresh frozen plasma (FFP).

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Estimated blood loss (ml) |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | NHDD | Collection start date | 2009 |

# Breastfeeding attempted

**Specification**

| | | | |
|---|---|---|---|
| Definition | Whether the mother attempted to breastfeed the baby or express breast milk at least once | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 115 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Attempted to breastfeed / express breast milk |
| 2 | Did not attempt to breastfeed / express breast milk |
| 9 | Not stated / inadequately described |

Reporting guide

For this data item, expressed breast milk is considered breastfeeding initiation.

- Code 1 Attempted to breastfeed/express breast milk: includes if the baby was put to the breast at all, regardless of the success of the attempt, or if there was any attempt to express milk for the baby.
- Code 2 Did not attempt to breastfeed/express breast milk: includes if the baby was never put to the breast and there was no attempt to express milk for the baby. Also includes if the mother was transferred or died before she could attempt to breastfeed/express breast milk. If the baby was transferred or died, still indicate if the mother attempted to express milk at least once. Do not report a value for stillbirth episodes, leave blank.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Chorionicity of multiples

## Specification

| | | | |
|---|---|---|---|
| Definition | The number of chorionic membranes that surround the index fetus in a multiple pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 140 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Monochorionic |
| 2 | Dichorionic |
| 3 | Trichorionic |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the number of chorionic membranes surrounding index fetus in multiple pregnancy- ie monochorionic, dichorionic and trichorionic |
| Reported by | All Victorian hospitals where a multiple birth has occurred and homebirth practitioners |
| Reported for | All birth episodes with a birth plurality of two or three |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Birth plurality |
| Related business rules (Section 4): | Birth plurality - conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Collection identifier

## Specification

| | | | |
|---|---|---|---|
| Definition | A unique identifier for VPDC data collection | | |
| Representation class | Identifier | Data type | String |
| Format | AAAA | Field size | 4 |
| Location | Episode record, Header record, File name | Position | 1 |
| Permissible values | **Code** **Descriptor**<br>VPDC Victorian Perinatal Data Collection | | |
| Reporting guide | Software-system generated | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Congenital anomalies – ICD-10-AM code

## Specification

| | | | |
|---|---|---|---|
| Definition | Structural, functional, genetic, chromosomal and biochemical abnormalities that can be detected before birth, at birth or days later, in either a live born or stillborn baby. They may be multiple or isolated. | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5(x9) |
| Location | Episode record | Position | 134 |
| Permissible values | All ICD-10-AM codes<br>• For applicable codes for congenital anomalies refer to the ICD-10-AM/ACHI library file available on request, by email to hdss.helpdesk@dhhs.vic.gov.au | | |
| Reporting guide | Any congenital abnormality detected before birth, at birth or days later. This includes structural, functional, genetic, chromosomal and biochemical anomalies in either a live born or stillborn baby. These anomalies may be multiple or isolated.<br>Other anomalies that include neoplasms, metabolic and haematological conditions should also be reported.<br>The most common congenital anomalies are listed in Section 2.<br>Congenital anomalies not required to be reported are also listed in Section 2. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where a congenital anomaly is present | | |
| Related concepts (Section 2): | Congenital anomalies | | |
| Related data items (this section): | Congenital anomalies – indicator | | |
| Related business rules (Section 4): | Congenital anomalies – indicator and congenital anomalies – code<br>Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2018 |
| Codeset source | ICD-10-AM | Collection start date | 2018 |

# Congenital anomalies – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether there were any congenital anomalies identified | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 107 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Reportable congenital anomalies identified |
| 2 | Reportable congenital anomalies not identified |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Where reportable congenital abnormalities are identified, please select the most appropriate code in the Congenital anomalies – ICD-10-AM code field. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Congenital anomalies – ICD-10-AM code |
| Related business rules (Section 4): | Congenital anomalies – indicator and Congenital anomalies – ICD-10-AM code conditionally mandatory data item, Mandatory to report data items, Sex – baby and Congenital anomalies – indicator conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009 |
| Codeset source | DHHS | Collection start date | 1999 |

# Country of birth

**Specification**

| | | | |
|---|---|---|---|
| Definition | The country in which the mother was born | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 18 |
| Permissible values | Please refer to the 'Country of birth and country of residence SACC codeset' available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files | | |
| Reporting guide | Report the country in which the person was born, not the country of residence.<br><br>Select the code which best describes the patient's country of birth (COB) as precisely as possible from the information provided<br><br>• Codes representing a country do not end in 'zero' or 'nine'<br>- For example, patient response 'Australia' is coded 1101 *Australia*<br>• Codes ending in 'zero' are used for supplementary (not further defined, nfd) categories<br>- For example, patient response 'Great Britain' does not contain enough information to be coded to a country so is coded 2100 *United Kingdom, Channel Islands and Isle of Man, nfd*<br>• Codes ending in 'nine' are used for residual (not elsewhere classified, nec) categories<br>- For example, patient response 'Christmas Island' is coded 1199 *Australian External Territories, nec* | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | Migrant status | | |
| Related data items (this section): | Language other than English spoken at home, Spoken English proficiency, Refugee status, Years in Australia | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1994<br>3. January 2009 |
| Codeset source | NHDD | Collection start date | 1982 |

# Data submission identifier

**Specification**

| | | | |
|---|---|---|---|
| Definition | The date and time the VPDC electronic submission file is generated in 24-hour clock format | | |
| Representation class | Identifier | Data type | Date/time |
| Format | YYYYMMDDHHMM | Field size | 12 |
| Location | Header record, File name | Position | Not applicable |
| Permissible values | A valid calendar date and time value using a 24-hour clock (not 0000 or 2400) | | |
| Reporting guide | Software-system generated. Time must be in 24-hour clock format. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Date of admission – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The date on which the mother is admitted | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 7 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the appropriate date based on the circumstances of the birth (attending hospital or using a home practitioner). |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Date and time data item relationships, Date of admission – mother and Date of birth – baby conditionally mandatory data items, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1998 |
| Codeset source | NHDD | Collection start date | 1982 |

# Date of birth – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | The date of birth of the baby | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 95 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Century (CC) can only be reported as 20. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Date of admission – mother |
| Related business rules (Section 4): | Date and time data item relationships, Date of admission – mother and Date of birth – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1998 |
| Codeset source | NHDD | Collection start date | 1982 |

# Date of birth – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The date of birth of the mother | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 22 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Century (CC) can only be 19 or 20. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Date and time data item relationships, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity. | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1998 |
| Codeset source | NHDD | Collection start date | 1982 |

# Date of completion of last pregnancy

## Specification

| | | | |
|---|---|---|---|
| Definition | Date on which the pregnancy preceding the current pregnancy was completed | | |
| Representation class | Date | Data type | Date/time |
| Format | {DD}MMCCYY | Field size | 6 (8) |
| Location | Episode record | Position | 42 |

Permissible values

Dates provided must be either a valid complete calendar date or recognised part of a calendar date.

| Code | Descriptor |
|---|---|
| 999999 | Not stated / inadequately described |
| 99YYYY | Year known, month unknown (where YYYY = year) |
| DDMMYYYY | Date, year and month known (where DD= day, MM = month, YYYY = year) |
| MMYYYY | Date unknown, year and month known (where MM = month, YYYY = year) |

Reporting guide

Record the month and year of the pregnancy preceding the current pregnancy. Century (CC) can only be 19, 20 or 99. If the day, month and year is known, report all components of the date. If this is the first pregnancy, that is, there is no preceding pregnancy, do not report a value, leave blank.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for

Birth episodes where Gravidity is greater than 01 Primigravida

Related concepts (Section 2):

None specified

Related data items (this section):

None specified

Related business rules (Section 4):

Date and time data item relationships, Gravidity ‘Multigravida’ conditionally mandatory data items, Gravidity ‘Primigravida’ and associated data items valid combinations, Parity and associated data items valid combinations

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity. | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999 |
| Codeset source | NHDD | Collection start date | 1982 |

# Date of onset of labour

## Specification

| | | | |
|---|---|---|---|
| Definition | The date of onset of labour | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 61 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 88888888 | No labour |
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Century (CC) can only be reported as 20.<br><br>Code 88888888 No labour: this code is only reported when the mother has a planned or unplanned caesarean section with no labour. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Date of rupture of membranes, Method of birth |
| Related business rules (Section 4): | Date and time data item relationships, Labour type 'Woman in labour' and associated data items valid combinations, Labour type 'Woman not in labour' and associated data items valid combinations, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Date of onset of second stage of labour

**Specification**

| | | | |
|---|---|---|---|
| Definition | The date of the start of the second stage of labour | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 63 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 88888888 | No labour |
| 99999999 | Not stated / inadequately described |

Reporting guide

Code 88888888 No second stage of labour: this code is only reported when the mother has a planned or unplanned caesarean section and did not reach second stage of labour.

Century (CC) can only be reported as 20.

In the instance of the woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:
1. Had she had a show or rupture of membranes (ROM)?
2. Had she vomited at all within the hour prior to giving birth or thought she was going to vomit?
3. Had there been any noticeable urge to push?
4. Did she notice if she had bowel pressure prior to having the baby and how long before?
5. Had any family members noticed any change in her behaviour (restless, agitated) prior to having baby?

If none of these questions can be answered then a reasonable assumption would be that the birth occurred within one to two contractions prior to the birth and second stage may be judged to be two and five minutes prior to the birth.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Date of onset of labour, Date of rupture of membranes, Method of birth |
| Related business rules (Section 4): | Date and time data item relationships, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Date of rupture of membranes

**Specification**

| | | | |
|---|---|---|---|
| Definition | The date on which the mother's membranes ruptured (spontaneously or artificially) | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 65 |

Permissible values: A valid calendar date

| Code | Descriptor |
|---|---|
| 77777777 | No record of date of rupture of membranes |
| 88888888 | Membranes ruptured at caesarean |
| 99999999 | Not stated / inadequately described |

**Reporting guide**

Report the date on which the membranes were believed to have ruptured, whether spontaneously or artificially. If there is a verified hindwater leak, that is followed by a forewater rupture, record the earlier date.

If there is some vaginal loss that is suspected to be ruptured membranes, but in hindsight seems unlikely, record the time at which the membranes convincingly ruptured. In unusual situations, a brief text description will minimise queries.

In the case of a caul birth, report the date and time of ROM as the date and time of birth. If date of ROM is known but time of ROM is not, report unknown date and time. When an unknown code is reported for ROM, unknown codes must be reported for Date and Time of Onset of Labour and Date and Time of Onset of Second Stage of Labour.

Century (CC) can only be reported as 20.

Code 88888888 Membranes ruptured at caesarean: this code is only reported when the mother has a planned or unplanned caesarean section and membranes were ruptured during caesarean.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Method of birth |
| Related business | Date and time data item relationships, Labour type 'Woman in |

| | |
|---|---|
| rules (Section 4): | labour' and associated data items valid combinations, Labour type 'Woman not in labour' and associated data items valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009<br>2. January 2019 |
| Codeset source | DHHS | Collection start date | 2009 |

# Discipline of antenatal care provider

## Specification

| | | | |
|---|---|---|---|
| Definition | The discipline of the clinician who provided most occasions of antenatal care | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 54 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Obstetrician |
| 2 | Midwife |
| 3 | General practitioner |
| 4 | No antenatal care provider |
| 8 | Other |
| 9 | Not stated / inadequately described |

Reporting guide

- Code 1 Obstetrician: includes public and private obstetric care including care provided by medical staff in hospitals under the supervision of an obstetrician
- Code 2 Midwife: includes public and private midwifery care including care provided by midwife-led units in hospitals with limited medical input
- Code 3 General practitioner: includes public and private care by general practitioners (including those with a diploma of obstetrics) and care provided by medical staff in hospitals under the supervision of a general practitioner

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Discipline of lead intrapartum care provider

**Specification**

| | | | |
|---|---|---|---|
| Definition | The discipline of the clinician who, at the time of admission for the birth, is expected to be primarily responsible for making decisions regarding intrapartum care | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 93 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Obstetrician |
| 2 | Midwife |
| 3 | General practitioner |
| 4 | No intrapartum care provider |
| 8 | Other |
| 9 | Not stated / inadequately described |

Reporting guide

The discipline of the clinician who, at the time of admission for the birth, is expected to be primarily responsible for making decisions regarding intrapartum care. In some cases birth will take place without any direct input from this person, for example, rapid, uncomplicated labour. Please note that this responsibility may transfer during labour with transfer from midwifery to GP/obstetric care, or from GP to obstetric care.

- Code 1 Obstetrician: includes public and private obstetric care, including care provided by midwives and medical staff in hospital when the mother is admitted under the supervision of an obstetrician.
- Code 2 Midwife: includes public and private midwifery care and including care provided by midwife-led units in hospital with limited medical input.
- Code 3 General practitioner: includes public and private care by general practitioners (including those with a diploma of obstetrics) including care provided in hospitals when the mother is admitted under the supervision of a general practitioner.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Episiotomy – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether an incision of the perineum and vagina was made | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 88 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Incision of the perineum and vagina made |
| 2 | Incision of the perineum and vagina not made |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | For episiotomies extended by laceration or laceration extended by episiotomy record Perineal laceration – indicator as code 1 Laceration of the perineum following birth, Episiotomy indicator as code 1 Incision of perineum and vagina made and Perineal laceration – repair as code 1 Repair of perineum undertaken. Specify the degree of the tear in Perineal/genital laceration – degree/type. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Method of birth |
| Related business rules (Section 4): | Episiotomy – indicator and Method of birth valid combinations, Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009 |
| Codeset source | DHHS | Collection start date | 1999 |

# Episode Identifier

## Specification

| | | | |
|---|---|---|---|
| Definition | An identifier, unique to the birth episode within the submitting organisation. It will be used to manage new/updated submitted information | | |
| Representation class | Identifier | Data type | String |
| Format | A(9) | Field size | 9 |
| Location | Episode record | Position | 130 |
| Permissible values | Permissible characters:<br>a–z and A–Z<br>numeric characters | | |
| Reporting guide | System generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Patient identifier – mother<br>Patient identifier – baby | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Not applicable | | |
| Definition source | DHHS | Version | 1. January 2017<br>2. January 2019 |
| Codeset source | DHHS | Collection start date | 2017 |

# Estimated blood loss (ml)

## Specification

| | | | |
|---|---|---|---|
| Definition | An estimate of the amount of blood lost at the time of birth and in the following 24 hours in millilitres (whether the loss is from the vagina, from an abdominal incision, or retained for example, broad ligament haematoma) | | |
| Representation class | Total | Data type | Number |
| Format | N[NNNN] | Field size | 5 |
| Location | Episode record | Position | 89 |
| Permissible values | Range: zero to 12000 (inclusive)<br><br>**Code** **Descriptor**<br>99999 Not stated / inadequately described | | |
| Reporting guide | Report the best estimate of the amount of blood lost in millilitres (ml). This is usually reported to the nearest 50 ml, but may be more accurate than this if desired, for example when there is a very small amount of bleeding. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Estimated date of confinement

## Specification

| | | | |
|---|---|---|---|
| Definition | The estimated date of confinement (agreed due date) | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 47 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | The Estimated date of confinement (agreed due date) may be based on the date of the last normal menstrual period (LNMP) or on clinical or ultrasound assessments. If there is uncertainty in each of these, report the agreed due date based on the best available information in the particular case. Century (CC) can only be reported as 20. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Date and time data item relationships, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Estimated gestational age

## Specification

| | | | |
|---|---|---|---|
| Definition | The number of completed weeks of the period of gestation as measured from the first day of the last normal menstrual period to the date of birth | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 48 |
| Permissible values | Range: 16 to 45 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed weeks (for example, if a baby is 37 weeks and six days, this should be recorded as 37 weeks). | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Estimated date of confinement | | |
| Related business rules (Section 4): | Estimated gestational age and Gestational age at first antenatal visit valid combinations, Estimated gestational age conditionally mandatory data items, Mandatory to report data items, Scope ‘Stillborn’ | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | NHDD | Collection start date | 1982 |

# Events of labour and birth – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 81 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report complications arising after the onset of labour and before the completed birth of the baby and placenta. Only report conditions in this field when there is no ICD-10-AM code available for selection in your software. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Births where events occurred during the labour and/or birth | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Birth presentation, Events of labour and birth – ICD-10-AM code | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Birth presentation conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Events of labour and birth – ICD-10-AM code

## Specification

| | | | |
|---|---|---|---|
| Definition | Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x9) |
| Location | Episode record | Position | 82 |

Permissible values

| Code | Descriptor |
|---|---|
| O660 | Shoulder dystocia |
| O839 | Water birth |
| Z292 | Antibiotic therapy in labour |

For other applicable codes for indications for Events of labour and birth refer to the ICD-10-AM/ACHI (8th edition) library file available on request, by email to perinatal.data@dhhs.vic.gov.au

| | |
|---|---|
| Reporting guide | Complications arising after the onset of labour and before the completed birth of the baby and placenta. Conditions related to the neonate classifiable to code range P00–P96. Certain conditions originating in the perinatal period must be reported in data element Neonatal morbidity – ICD-10-AM code. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Births where events occurred during the labour and/or birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Birth presentation |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Birth presentation conditionally mandatory data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009<br>2. January 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 2009 |

# Fetal monitoring in labour

**Specification**

| | | | |
|---|---|---|---|
| Definition | Methods used to monitor the wellbeing of the fetus during labour | | |
| Representation class | Code | Data type | String |
| Format | NN | Field size | 2 (x7) |
| Location | Episode record | Position | 72 |

Permissible values

| Code | Descriptor |
|---|---|
| 01 | None |
| 02 | Intermittent auscultation |
| 03 | Admission cardiotocography |
| 04 | Intermittent cardiotocography |
| 05 | Continuous external cardiotocography |
| 06 | Internal cardiotocography (scalp electrode) |
| 07 | Fetal blood sampling |
| 88 | Other |
| 99 | Not stated / inadequately described |

Reporting guide

More than one method of monitoring can be recorded.

- Code 02 Intermittent auscultation: performed by Pinnards or sonicaid
- Code 03 Admission cardiotocography: a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission
- Code 04 Intermittent cardiotocography: fetal heart monitoring by CTG on a number of occasions in labour, but not continuously
- Code 05 Continuous cardiotocography: fetal heart monitoring by CTG more or less continuously from some point in labour until about the time of birth
- Code 07 Fetal blood sampling: includes scalp lactate
- If there was no labour, report 01 None or leave blank.

Reported by: All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section):
Labour Type
Fetal monitoring prior to birth – not in labour

Related business rules (Section 4):
E002 Conditionally Mandatory Element Missing
E003 Value provided when none expected
E004 Invalid Code

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Fetal monitoring prior to birth – not in labour

**Specification**

| | | | |
|---|---|---|---|
| Definition | Methods used to monitor the wellbeing of the fetus prior to birth (for example, piror to a caesarean section), but not in labour. | | |
| Representation class | Code | Data type | String |
| Format | NN | Field size | 2 (x7) |
| Location | Episode record | Position | 131 |

Permissible values

| Code | Descriptor |
|---|---|
| 01 | None |
| 02 | Intermittent auscultation |
| 03 | Admission cardiotocography |
| 04 | Intermittent cardiotocography |
| 05 | Continuous external cardiotocography |
| 06 | Internal cardiotocography (scalp electrode) |
| 07 | Fetal blood sampling |
| 88 | Other |
| 99 | Not stated / inadequately described |

Reporting guide

Report this field if Labour Type is 5 – No labour.
More than one method of monitoring can be recorded.

- Code 02 Intermittent auscultation: performed by Pinnards or sonicaid
- Code 03 Admission cardiotocography: a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission
- Code 04 Intermittent cardiotocography: fetal heart monitoring by CTG (not in labour) on a number of occasions, but not continuously.
- Code 05 Continuous cardiotocography: fetal heart monitoring by CTG more or less continuously from some point until abou the time of birth
- Code 07 Fetal blood sampling: includes scalp lactate
- If there was no labour, report 01 None or leave blank.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where there was no labour |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Labour Type<br>Fetal monitoring in labour |
| Related business rules (Section 4): | None specified |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2017 |
| Codeset source | DHHS | Collection start date | 2017 |

# First given name – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The first given name of the mother | | |
| Representation class | Text | Data type | String |
| Format | A(40) | Field size | 40 |
| Location | Episode record | Position | 9 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | The given name(s) of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Formula given in hospital

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether any infant formula was given to this baby in hospital, whether by bottle, cup, gavage or other means | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 116 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Infant formula given in hospital |
| 2 | Infant formula not given in hospital |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Do not report a value for stillbirth episodes, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Gestational age at first antenatal visit

**Specification**

| | | | |
|---|---|---|---|
| Definition | The number of completed weeks' gestation at the time of the first visit as measured from the first day of the last normal menstrual period. The visit is an intentional encounter between a pregnant woman and a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour. | | |
| Representation class | Total | Data type | Number |
| Format | N[N] | Field size | 2 |
| Location | Episode record | Position | 53 |
| Permissible values | Range: two to 45 (inclusive)<br><br>**Code** **Descriptor**<br>88 No antenatal care<br>99 Not stated / inadequately described | | |
| Reporting guide | The gestational age at first visit should be recorded in completed weeks, for example, if gestation is eight weeks and six days, this should be recorded as eight weeks. The visit may occur in the following clinical settings:<br>• Antenatal outpatients clinic<br>• Specialist outpatient clinic<br>• General practitioner surgery<br>• Obstetrician private rooms<br>• Community health centre<br>• Rural and remote health clinic<br>• Independent midwife practice setting including home of the pregnant mother. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Estimated gestational age and Gestational age at first antenatal visit valid combinations, Mandatory to report data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009<br>2. January 2018 |
| Codeset source | DHHS | Collection start date | 2009 |

# Gravidity

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of pregnancies including the current one | | |
| Representation class | Total | Data type | Number |
| Format | N[N] | Field size | 2 |
| Location | Episode record | Position | 33 |
| Permissible values | Range: one to 30 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | Report the numbers of known pregnancies regardless of the gestation, that is, count all pregnancies that result in live births, stillbirths and spontaneous or induced abortions. Include the current pregnancy. If this is the first pregnancy, report code 01 Primigravida. Pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy, even though it has two outcomes. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Date of completion of last pregnancy | | |
| Related business rules (Section 4): | Gravidity ‘Multigravida’ conditionally mandatory data items, Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and Parity valid combinations, Gravidity and related data items, Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Head circumference - baby

## Specification

| | | | |
|---|---|---|---|
| Definition | The measurement of the circumference of the head of the baby | | |
| Representation class | Total | Data type | Number |
| Format | NN.N | Field size | 4 |
| Location | Episode record | Position | 129 |
| Permissible values | Range: 01.0 to 99.8 (inclusive)<br><br>**Code** **Descriptor**<br>99.9 Not stated<br>Blank Not applicable (but can be entered if measured) | | |
| Reporting guide | Head circumference should be measured prior to discharge (or within seven days if not admitted to a hospital, i.e. homebirth). This should be at the same time as the birthweight is measured, to maximise comparability of these two measure sin percentile calculations.<br>Measurement is made in centimeteres to one decimal place, e.g. 352 millimetres is expressed as 35.2 centimetres.<br><br>In the case of babies born before arrival at the hospital, the head circumference should be taken prior to discharge. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Mandatory to report for livebirth episodes.<br>Optional to report for stillbirths (can be left blank) | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Birth Status | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | METeOR 568380 | Version | 1. January 2017 |
| Codeset source | Not applicable | Collection start date | 2017 |

# Height – self-reported – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The mother's self-reported height, measured in centimetres, at about the time of conception | | |
| Representation class | Total | Data type | Number |
| Format | NNN | Field size | 3 |
| Location | Episode record | Position | 23 |
| Permissible values | Range: 100 to 250 (inclusive)<br><br>**Code** **Descriptor**<br>999 Not stated / inadequately described | | |
| Reporting guide | Height is measured in centimetres. It is acceptable to report the measured height of the mother. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (DHHS modified) | Version | 1. January 2009 |
| Codeset source | NHDD | Collection start date | 2009 |

# Hepatitis B vaccine received

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the baby received an immunisation vaccine for hepatitis B during the birth admission | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 114 |

Permissible values

| Code | Descriptor |
|---|---|
| 2 | Hepatitis B vaccine received after seven days of age |
| 3 | Hepatitis B vaccine not received |
| 4 | Hepatitis B vaccine received less than 24 hours of age |
| 5 | Hepatitis B vaccine received between 24 hours and 7 days of age |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the administration of a dose of paediatric hepatitis B vaccine. Do not report immunoglobulin. Do not report a value for stillbirth episodes, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Birth status |
| Related business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009<br>2. January 2017 |
| Codeset source | DHHS | Collection start date | 2009 |

# Hospital code (agency identifier)

## Specification

| | | | |
|---|---|---|---|
| Definition | Numeric code for the hospital campus reporting to the VPDC | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record, Header record, File name | Position | 4 |
| Permissible values | Please refer to the 'Hospital Code Table' available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files | | |
| Reporting guide | Software-system generated. Report the campus code for your maternity hospital (includes birth centres). | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Indication for induction – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | The primary reason given for an induction of labour | | |
| Representation class | Text | Data type | String |
| Format | A(50) | Field size | 50 |
| Location | Episode record | Position | 70 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report the indication for induction in this field when there is no ICD-10-AM code available for selection in the software. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where an induction was performed | | |
| Related concepts (Section 2): | Induction | | |
| Related data items (this section): | Indication for induction – ICD-10-AM code | | |
| Related business rules (Section 4): | Labour type, Indication for induction – free text and Indication for induction – ICD-10-AM code valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999 |
| Codeset source | Not applicable | Collection start date | 1999 |

# Indication for induction – ICD-10-AM code

## Specification

| | | | |
|---|---|---|---|
| Definition | The primary reason given for an induction of labour | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (X1) |
| Location | Episode record | Position | 71 |
| Permissible values | For applicable codes for indication for induction refer to the ICD-10-AM/ACHI (8th edition) available on request, by email to perinatal.data@dhhs.vic.gov.au | | |
| Reporting guide | Report where a medical or surgical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously. For documentation of social induction, report code O480 Social induction. Note: this is a VPDC-created code. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where an induction was performed | | |
| Related concepts (Section 2): | Induction | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Labour type, Indication for induction – free text and Indication for induction – ICD-10-AM code valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009<br>3. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 1999 |

# Indications for operative delivery – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | The reason(s) given for an operative birth | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 75 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number or ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report indications for operative delivery in this field when there is no ICD-10-AM code available for selection in the software. Report up to four reasons for operative delivery in order from the most to least influential in making the decision. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Indications for operative delivery – ICD-10-AM code, Method of birth | | |
| Related business rules (Section 4): | Labour type ‘Failed induction’ conditionally mandatory data items, Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Indications for operative delivery – ICD-10-AM code

## Specification

| | | | |
|---|---|---|---|
| Definition | The reason(s) given for an operative birth | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x4) |
| Location | Episode record | Position | 76 |
| Permissible values | For applicable codes for indications for operative delivery refer to the ICD-10-AM/ACHI (8th edition) library file available on request, by email to perinatal.data@dhhs.vic.gov.au | | |
| Reporting guide | Report up to four reasons for operative delivery in order from the most to least influential in making the decision. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Method of birth | | |
| Related business rules (Section 4): | Labour type 'Failed induction' conditionally mandatory data items, Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. January 1999<br>3. January 2009<br>4. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 1982 |

# Indigenous status – baby

**Specification**

| | | | |
|---|---|---|---|
| Definition | Indigenous status is a measure of whether a person (baby) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community in which they live. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 20 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Aboriginal but not Torres Strait Islander origin |
| 2 | Torres Strait Islander but not Aboriginal origin |
| 3 | Both Aboriginal and Torres Strait Islander origin |
| 4 | Neither Aboriginal nor Torres Strait Islander origin |
| 8 | Question unable to be asked |
| 9 | Not stated / inadequately described |

Reporting guide

A person of Aboriginal descent is a person descended from the original inhabitants of Australia. The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea. In Victoria, the community of Torres Strait Island people is small and the community of Aboriginal and Torres Strait Island people is smaller again, therefore the code 2 Torres Strait Islander but not Aboriginal origin and code 3 Both Aboriginal and Torres Strait Islander origin would not be widely used.

Code 8 Question unable to be asked should only be used under the following circumstances:

- when the patient's medical condition prevents the question of Indigenous status being asked
- in the case of an unaccompanied child who is too young to be asked their Indigenous status.

This information must be collected for every admitted patient episode and updated each time the patient presents to the hospital for admission. Software must not be set up to input a default code. Rather than asking every patient about his or her indigenous status, first ask the patient, 'Were you born in Australia?' Then, proceed as follows:

- If no, the patient should be asked, 'What country were you born in?'
- If yes, the patient should be asked, 'Are you of Aboriginal or Torres Strait Islander origin?'

If the patient answers yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to correctly record the person's Indigenous status.

The parent or guardian should be asked about the indigenous status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Country of birth |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 2009 |

# Indigenous status – mother

**Specification**

| | | | |
|---|---|---|---|
| Definition | Indigenous status is a measure of whether a person (mother) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community in which she lives. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 19 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Aboriginal but not Torres Strait Islander origin |
| 2 | Torres Strait Islander but not Aboriginal origin |
| 3 | Both Aboriginal and Torres Strait Islander origin |
| 4 | Neither Aboriginal nor Torres Strait Islander origin |
| 8 | Question unable to be asked |
| 9 | Not stated / inadequately described |

Reporting guide

A person of Aboriginal descent is a person descended from the original inhabitants of Australia. The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea. In Victoria, the community of Torres Strait Island people is small and the community of Aboriginal and Torres Strait Island people is smaller again, therefore the code 2 Torres Strait Islander but not Aboriginal origin and code 3 Both Aboriginal and Torres Strait Islander origin would not be widely used.

Code 8 Question unable to be asked should only be used under the following circumstances:

- when the patient's medical condition prevents the question of Indigenous status being asked.

This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission. Software must not be set up to input a default code. Rather than asking every patient about his or her indigenous status, first ask the patient, 'Were you born in Australia?':

- If no, the patient should be asked, 'What country were you born in?'
- If yes, the patient should be asked, 'Are you of Aboriginal or Torres Strait Islander origin?'

If the patient answers yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to correctly record the person's indigenous status.

The parent or guardian should be asked about the Indigenous status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

| | |
|---|---|
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Country of birth, Indigenous status – baby |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999<br>3. January 2009 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

# Influenza vaccination status

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether or not the mother has received an influenza vaccine during this pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 125 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Influenza vaccine received at any time during this pregnancy |
| 2 | Influenza vaccine not received at any time during this pregnancy |
| 9 | Not stated / inadequately described |

Reporting guide

Report the statement that best describes the woman's understanding of her influenza vaccine status for this pregnancy.

If the vaccination was received prior to this pregnancy, report code 2 - Influenza vaccine not received at any time during this pregnancy

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. July 2015 |
| Codeset source | DHHS | Collection start date | 1 July 2015 |

# Labour induction/augmentation agent

## Specification

| | | | |
|---|---|---|---|
| Definition | Agents used to induce or assist in the progress of labour | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x4) |
| Location | Episode record | Position | 68 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Oxytocin |
| 2 | Prostaglandins |
| 3 | Artificial rupture of membranes (ARM) |
| 4 | Cervical Ripening – balloon catheter |
| 8 | Other - specify |
| 9 | Not stated/inadequately described |

Reporting guide

Code 2 Prostaglandins: includes misoprostil
Code 4 Cervical Ripening – balloon catheter: includes all catheter types
Code 8 Other – specify: if code 8 is reported, specify the agent of induction or augmentation in Labour induction/augmentation agent – other specified description

If labour is not induced or augmented do not report a value, leave blank.

Reported by: All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for: All birth episodes where labour was induced or augmented

Related concepts (Section 2): Augmentation, Labour type

Related data items (this section): Indication for Induction – free text, Indication for Induction – ICD-10-AM code

Related business rules (Section 4): None specified

## Administration

Principal data users: Consultative Council on Obstetric and Paediatric Mortality and Morbidity

| | | | |
|---|---|---|---|
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2017 |
| Codeset source | METEOR 270037 | Collection start date | 1999 |

# Labour induction/augmentation agent – other specified description

## Specification

| | | | |
|---|---|---|---|
| Definition | The agent used to induce or augment labour | | |
| Representation class | Text | Data type | String |
| Format | A(20) | Field size | 20 |
| Location | Episode record | Position | 69 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Specify the type of Labour induction/augmentation agent as free text. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | When Labour induction/augmentation agent code 8 other – specify is reported | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Labour induction/augmentation agent | | |
| Related business rules (Section 4): | Labour induction/augmentation agent and Labour induction/augmentation agent – other specified description conditionally mandatory data item | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Labour type

**Specification**

| | | | |
|---|---|---|---|
| Definition | The manner in which labour starts in a birth event | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x3) |
| Location | Episode record | Position | 67 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Spontaneous |
| 2 | Induced - medical |
| 3 | Induced – surgical |
| 4 | Augmented |
| 5 | No labour |
| 9 | Not stated / inadequately described |

Reporting guide

Labour commences at the onset of regular uterine contractions which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostoglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

A combination of up to three valid codes can be reported.

- Spontaneous: labour occurs naturally without any intervention.
- Induction of labour: a procedure performed for the purpose of initiating and establishing labour, either medically and/or surgically and/or mechanically. Medical includes prostaglandins, oxytocins, cervical ripening - balloon catheter or other hormonal derivatives ( e.g cervidal, misoprostyl). Surgical is the artificial rupture of membranes (ARM) either by hindwater or forewater rupture.
- Augmentation of labour: spontaneous onset of labour complemented with the use of drugs such as oxytocins, prostaglandins or their derivatives, and/or artificial rupture of membranes (ARM) either by hindwater or forewater rupture. If labour was augmented, select and record both spontaneous and augmented in Labour type. Code 4 Augmented cannot be reported on its own.
- No labour: indicates the total absence of labour, as in an elective caesarean or a failed induction. If a failed induction occurred, that is, the mother failed to establish labour, select both the induction type (medical, surgical or both) and no labour.

An induction, medical and/or surgical cannot be recorded with augmentation. If an induction has occurred, record the reason in Indication for induction.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

| | |
|---|---|
| Reported for | All birth episodes |
| Related concepts (Section 2): | Labour type |
| Related data items (this section): | Mandatory to report |
| Related business rules (Section 4): | Labour type ‘Failed induction’ conditionally mandatory data items, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations, Labour type and Labour induction/augmentation agent valid combinations, Labour type, Indication for induction – free text and Indication for induction – ICD-10-AM code valid combinations, Mandatory to report data items, Method of birth and Labour type valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. July 2015 |
| Codeset source | NHDD (DHHS Modified) | Collection start date | 1982 |

# Last birth – caesarean section indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | An indicator of whether a caesarean section was performed for the most recent previouspregnancy that resulted in a birth. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 44 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Last birth was caesarean section |
| 2 | Last birth was not caesarean section |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Previous birth includes live birth, stillbirth or neonatal death. Only relates to the last birth, not the last pregnancy when the outcome of last pregnancy was an abortion or ectopic pregnancy. Do not report a value for episodes where the mother has not had a previous birth. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Episodes where the mother has had a previous birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999<br>2. January 2009<br>3. July 2015 |
| Codeset source | NHDD (DHHS Modified) | Collection start date | 1999 |

# Last feed before discharge taken exclusively from the breast

**Specification**

| | | | |
|---|---|---|---|
| Definition | Whether the last feed prior to discharge was taken exclusively from the breast, with no complementary feeding of any kind | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 117 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Last feed before discharge taken exclusively from breast |
| 2 | Last feed before discharge not taken exclusively from breast |
| 9 | Not stated / inadequately described |

Reporting guide

Discharge in the context of this data element means the end of the birth episode. This encompasses discharge to home, died and transfer to another hospital. Do not report a value for stillbirth episodes, leave blank.

Code 1 Last feed before discharge taken exclusively from breast: includes when the baby took the entire last feed prior to discharge directly from the breast. Can include the use of a nipple shield.

Code 2 Last feed before discharge not taken exclusively from breast: includes any expressed breast milk or formula given at the last feed before discharge from hospital, whether by cup, spoon, gavage or by any other means.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Breastfeeding attempted |
| Related business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | NHDD | Collection start date | 2009 |

# Manual removal of placenta

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether the placenta was manually removed | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 84 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Placenta manually removed |
| 2 | Placenta not manually removed |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | This includes the placenta that is trapped behind the cervix by an oxytocic contraction and requires the placenta to be removed by inserting the hand through the cervix. If method of birth is via caesarean section, do not report a value, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes, except for those who delivered via caesarean section |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Method of birth |
| Related business rules (Section 4): | Method of birth and Manual removal of placenta conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Marital status

## Specification

| | | | |
|---|---|---|---|
| Definition | A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 21 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Never married |
| 2 | Widowed |
| 3 | Divorced |
| 4 | Separated |
| 5 | Married |
| 6 | De facto |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the current marital status of the mother |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Date of birth – mother |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | NHDD (DHHS Modified) | Collection start date | 1982 |

# Maternal alcohol use at less than 20 weeks

## Specification

| | | | |
|---|---|---|---|
| Definition | A self-reported indicator of alcohol frequency intake at any time during the first 20 weeks of her pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 135 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Never |
| 2 | Monthly or less |
| 3 | 2-4 times a month |
| 4 | 2-3 times a week |
| 5 | 4 or more times a week |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the statement that best describes maternal alcohol use behaviour during pregnancy before 20 weeks gestation |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternal alcohol volume intake at less than 20 weeks |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Maternal alcohol use at 20 or more weeks

## Specification

| | | | |
|---|---|---|---|
| Definition | A self-reported indicator of alcohol frequency at 20 or more weeks of her pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 137 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Never |
| 2 | Monthly or less |
| 3 | 2-4 times a month |
| 4 | 2-3 times a week |
| 5 | 4 or more times a week |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the statement that best describes maternal alcohol use behaviour at 20 or more weeks gestation |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternal alcohol volume intake at 20 or more weeks |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Maternal alcohol volume intake at less than 20 weeks

## Specification

| | | | |
|---|---|---|---|
| Definition | A self-reported indicator of alcohol volume intake at any time during the first 20 weeks of her pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 136 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | 1 or 2 standard drinks |
| 2 | 3 or 4 standard drinks |
| 3 | 5 or 6 standard drinks |
| 4 | 7 to 9 standard drinks |
| 5 | 10 or more standard drinks |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the average amount of standard drinks consumed per occasion when drinking |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes who report any alcohol intake in the first 20 weeks of pregnancy |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternal alcohol use at less than 20 weeks |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Maternal alcohol volume intake at 20 or more weeks

## Specification

| | | | |
|---|---|---|---|
| Definition | A self-reported indicator of alcohol volume intake at 20 or more weeks of her pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 138 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | 1 or 2 standard drinks |
| 2 | 3 or 4 standard drinks |
| 3 | 5 or 6 standard drinks |
| 4 | 7 to 9 standard drinks |
| 5 | 10 or more standard drinks |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the average amount of standard drinks consumed per occasion when drinking |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes who report any alcohol intake at 20 or more weeks' gestation |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternal alcohol use at 20 or more weeks |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 |
| Codeset source | DHHS | Collection start date | 2019 |

# Maternal medical conditions – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 49 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report conditions in this field when there is no ICD-10-AM code available for selection in the software.<br><br>Only record conditions that affected the care or surveillance of this pregnancy. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded.<br><br>Do not report past operations such as appendecectomy, knee reconstruction that do not affect or have not occurred during this pregnancy. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where a maternal medical condition is present | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Maternal medical conditions – ICD-10-AM code

**Specification**

| | | | |
|---|---|---|---|
| Definition | Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x12) |
| Location | Episode record | Position | 50 |

Permissible values

ICD-10-AM/ACHI (8th edition) available on request. Please email perinatal.data@dhhs.vic.gov.au

| Code | Descriptor |
|---|---|
| O100 | Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium |
| O142 | HELLP Syndrome |
| O240 | Pre-existing diabetes mellitus, type 1, in pregnancy |
| O2419 | Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified |
| O2681 | Renal disease, pregnancy related |
| O993 | Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium (psychosocial problems) |
| O994 | Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium |

Reporting guide

Only record conditions that affected the care or surveillance of this pregnancy.

Examples of maternal medical conditions include past history of a hydatidiform mole, rheumatoid arthritis, asthma, deafness, polycystic ovaries and multiple sclerosis. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded.

Do not report past operations such as appendectomy, knee reconstruction, which do not affect or have not occurred during this pregnancy. When pregnancy-related renal disease, psychosocial problem or disease of the circulatory system (cardiac condition) is reported, also report the specified condition in this field or in the Medical conditions – free text field.

Code O993 Psychosocial problems includes mental illness, violent relationships and alcohol or drug misuse.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where a maternal medical condition is present |
| Related concepts (Section 2): | None specified |
| Related data items | Maternal medical conditions – free text |

(this section):

| | |
|---|---|
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999<br>3. January 2009<br>4. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 1982 |

# Maternal smoking at less than 20 weeks

## Specification

| | | | |
|---|---|---|---|
| Definition | A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 31 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | No smoking at all before 20 weeks of pregnancy |
| 2 | Quit smoking during pregnancy (before 20 weeks) |
| 3 | Continued smoking before 20 weeks of pregnancy |
| 9 | Not stated / inadequately described |

Reporting guide

Report the statement that best describes maternal smoking behaviour before 20 weeks' gestation.

Code 2 Quit smoking during pregnancy (before 20 weeks): Describes the mother who ceased smoking on learning she was pregnant or gave up prior to the 20 week gestation. This does not include mothers who give up prior to falling pregnant.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternal smoking at more than or equal to 20 weeks |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (DHHS modified) | Version | 1. January 2009<br>2. July 2015 |
| Codeset source | DHHS | Collection start date | 2009 |

# Maternal smoking at more than or equal to 20 weeks

**Specification**

| | | | |
|---|---|---|---|
| Definition | The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth. | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 32 |
| Permissible values | Range: zero to 97 (inclusive)<br><br>**Code** **Descriptor**<br>98 Occasional smoking (less than one)<br>99 Not stated / inadequately described | | |
| Reporting guide | Data should be collected after the birth.<br><br>After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (>=20 weeks + 0 days).<br><br>'Usually' is defined as 'according to established or frequent usage, commonly, ordinarily, as a rule'.<br><br>If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.<br><br>If the woman smokes tobacco, but not cigarettes, estimate the number of cigarettes that would approximate the amount of tobacco used, for example, in a pipe. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (DHHS modified) | Version | 1. January 2009<br>2. July 2015 |
| Codeset source | DHHS | Collection start date | 2009 |

# Method of birth

**Specification**

| | | | |
|---|---|---|---|
| Definition | The method of complete expulsion or extraction from the woman of a product of conception in a birth event | | |
| Representation class | Code | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 74 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Forceps |
| 3 | Vaginal birth – non-instrumental |
| 4 | Planned caesarean – no labour |
| 5 | Unplanned caesarean – labour |
| 6 | Planned caesarean – labour |
| 7 | Unplanned caesarean – no labour |
| 8 | Vacuum extraction |
| 9 | Not stated / inadequately described |
| 10 | Other operative birth |

Reporting guide

In the case of multiple births, the method of birth is reported in each baby's episode record.

Where forceps/vaccuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.

Where a hysterotomy is performed to extract trhe baby, code as caesarean section.

Code 1 Forceps
Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the head during breech presentations. Includes vaginal breech with forceps to the aftercoming head

Code 3 Vaginal birth – non-instrumental
Includes manual assistance for example, a vaginal breech that has been manually rotated

Code 4 Planned caesarean – no labour
Caesarean takes place as a planned procedure before the onset of labour

Code 5 Unplanned caesarean
Caesarean is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced

Code 6 Planned caesarean – labour
Caesarean was a planned procedure, but occurs after spontaneous onset of labour

Code 7 Unplanned caesarean – no labour
Procedure is undertaken for an urgent indication before the onset of labour. If a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate

Code 10 Other operative birth
Includes D&C, D&E, hysterotomy and laparotomy.

Excludes operative methods of birth for which a specific code exists.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Anaesthesia for operative delivery – indicator, Anaesthesia for operative delivery – type, Analgesia for labour – indicator, Analgesia for labour – type |
| Related business rules (Section 4): | Anaesthesia for operative delivery – indicator and Method of birth valid combinations, Episiotomy – indicator and Method of birth valid combinations, Labour type 'Woman in labour' and associated data items valid combinations, Mandatory to report data items, Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data item, Method of birth and Labour type valid combinations, Method of birth and Manual removal of placenta conditionally mandatory data item, Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations, Perineal laceration – indicator and Method of birth valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999<br>3. January 2009<br>4. June 2015 |
| Codeset source | NHDD (DHHS Modified) | Collection start date | 1982 |

# Middle name – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The middle name of the mother | | |
| Representation class | Text | Data type | String |
| Format | A(40) | Field size | 40 |
| Location | Episode record | Position | 10 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | The middle name of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes when applicable | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | First given name – mother, Surname/family name – mother | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Name of software

## Specification

| | | | |
|---|---|---|---|
| Definition | Name of the software used by the hospital | | |
| Representation class | Identifier | Data type | String |
| Format | A(10) | Field size | 10 |
| Location | Header record | Position | Not applicable |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Software-system generated. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Neonatal morbidity – free text

**Specification**

| | | | |
|---|---|---|---|
| Definition | Illness and/or birth trauma experienced by the baby up to the time of discharge | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 111 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number or ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report conditions in this field when there is no ICD-10-AM code available for selection in the software.<br><br>Excludes congenital anomalies. Morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU.<br><br>Examples of such morbidity include jaundice that required phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections.<br><br>It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates, record all associated morbidity. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where neonatal morbidity is present | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Estimated gestational age conditionally mandatory data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Neonatal morbidity – ICD-10-AM code

**Specification**

| | | | |
|---|---|---|---|
| Definition | Illness and/or birth trauma experienced by the baby up until the time of discharge | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x10) |
| Location | Episode record | Position | 112 |
| Permissible values | ICD-10-AM/ACHI (8th edition) available on request, please email perinatal.data@dhhs.vic.gov.au | | |
| Reporting guide | Excludes congenital anomalies. Morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU.<br><br>Examples of such morbidity includes jaundice that required phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections.<br><br>It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates record all associated morbidity. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where neonatal morbidity is present | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Neonatal morbidity – free text | | |
| Related business rules (Section 4): | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Estimated gestational age conditionally mandatory data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. January 1999<br>3. January 2009<br>4. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 1982 |

# Number of antenatal care visits

**Specification**

| | | | |
|---|---|---|---|
| Definition | The total number of antenatal care visits attended by a pregnant female | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 124 |
| Permissible values | Range: zero to 30 (inclusive) | | |

| Code | Descriptor |
|---|---|
| 99 | Not stated / inadequately described |

Reporting guide

**Guide for use:**
Antenatal care visits are attributed to the pregnant woman.

In rural and remote locations where a midwife or doctor is not employed, registered Aboriginal health workers and registered nurses may perform this role within the scope of their training and skill licence.

Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record.

An antenatal care visit does not include a visit where the sole purpose of contact is to confirm the pregnancy only, or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues.

An antenatal care visit does not include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of bloods or tissue for pathology testing. Exception to this rule is made when the health professional performing the procedure or test is a doctor or midwife and the appointment directly relates to this pregnancy and the health and wellbeing of the fetus.

**Collection methods:**
Collect the total number of antenatal care visits for which there is documentation included in the health record of pregnancy and/or birth. To be collected once, after the onset of labour. Include all medical specialist appointments or medical specialist clinic appointments where the provider of the service event has documented the visit on the health record.

Multiple visits on the same day should be recorded as one visit.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |

| | |
|---|---|
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. July 2015 |
| Codeset source | NHDD | Collection start date | 1 July 2015 |

# Number of records following

## Specification

| | | | |
|---|---|---|---|
| Definition | The total numbers of records in the submission file | | |
| Representation class | Total | Data type | Number |
| Format | N[NNNN] | Field size | 5 |
| Location | Header record | Position | Not applicable |
| Permissible values | Range: one to 99,999 (inclusive) | | |
| Reporting guide | Software-system generated. This is the total number of records, excluding the header record, in a VPDC electronic submission file. The submission file will be rejected and not be processed by VPDC if the number of records following in the header record does not match the actual count of the relevant records. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Obstetric complications – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | Complications arising during the period immediately before delivery (not including the intrapartum period) that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 51 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report conditions in this field when there is no ICD-10-AM code available for selection in the software.<br><br>Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where an obstetric complication is present | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Obstetric complications – ICD-10-AM code

**Specification**

| | | | |
|---|---|---|---|
| Definition | Complications arising during the period immediately before delivery (not including the intrapartum period) that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x15) |
| Location | Episode record | Position | 52 |

Permissible values: ICD-10-AM (8th edition) available on request, please email perinatal.data@dhhs.vic.gov.au

| Code | Descriptor |
|---|---|
| O142 | HELLP Syndrome |
| O149 | Pre-eclampsia, unspecified |
| O2442 | Diabetes mellitus arising at or after 24 weeks' gestation, insulin treated |
| O2444 | Diabetes mellitus arising at or after 24 weeks' gestation, diet controlled |
| O365 | Suspected fetal growth restriction |
| O440 | Placenta praevia without haemorrhage |
| O441 | Placenta praevia with haemorrhage |
| O459 | Premature separation of placenta (abruptio placentae) |
| O468 | Other antepartum haemorrhage |
| Z223 | Carrier of streptococcus group B (GBS+) |

| | |
|---|---|
| Reporting guide | Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where an obstetric complication is present |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Obstetric complications – free text |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 1982 |

# Outcome of last pregnancy

**Specification**

| | | | |
|---|---|---|---|
| Definition | Outcome of the most recent pregnancy preceding the current pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 43 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Live birth |
| 2 | Spontaneous abortion |
| 3 | Not stated / inadequately described |
| 4 | Stillbirth |
| 5 | Induced abortion |
| 6 | Neonatal death |
| 7 | Ectopic pregnancy |

| | |
|---|---|
| Reporting guide | In the case of a multiple pregnancy with fetal loss before 20 weeks, report the outcome of the surviving fetus(es) beyond 20 weeks. In multiple pregnancies with more than one type of outcome, select the appropriate outcome based on the following hierarchy: neonatal, death, stillbirth, live birth. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where Gravidity is greater than code 01 Primigravida |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Date of completion of last pregnancy, Gravidity, Last birth – caesarean section indicator, Total number of previous abortions – induced, Total number of previous abortions – spontaneous, Total number of previous ectopic pregnancies, Total number of previous live births, Total number of previous neonatal deaths, Total number of previous stillbirths (fetal deaths), Total number of previous unknown outcomes of pregnancy |
| Related business rules (Section 4): | Gravidity ‘Multigravida’ conditionally mandatory data items, Gravidity ‘Primigravida’ and associated data items valid combinations, Outcome of last pregnancy and associated data item valid combinations, Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items, Parity and associated data items valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD METeOR identifier: 270006 | Version | 1. January 1982<br>2. January 1999 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

# Parity

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 35 |
| Permissible values | Range: zero to 20 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | To calculate parity, count all previous pregnancies that resulted in a live birth or a stillbirth of at least 20 weeks gestation or at least 400 grams birth weight. Excluded from the count are:<br>• the current pregnancy,<br>• pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and<br>• ectopic pregnancies.<br><br>A primigravida (a woman giving birth for the first time) has a parity of 00.<br><br>A pregnancy with multiple fetuses is counted as one pregnancy. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | Live birth, Neonatal death, Stillbirth (fetal death) | | |
| Related data items (this section): | Gravidity, Outcome of last pregnancy, Total number of previous live births, Total number of previous neonatal deaths, Total number of previous stillbirths (fetal deaths) | | |
| Related business rules (Section 4): | Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and Parity valid combinations, Mandatory to report data items, Parity and associated data items valid combinations, Parity and related data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD METeOR identifier: 302013 | Version | 1. January 2009<br>2. July 2015 |
| Codeset source | NHDD | Collection start date | 2009 |

# Patient identifier – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | An identifier, unique to the baby within the hospital or campus (patient's record number / unit record number) | | |
| Representation class | Identifier | Data type | String |
| Format | A(10) | Field size | 10 |
| Location | Episode record | Position | 6 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.<br><br>For planned births occurring outside the hospital system, enter the birth number or an equivalent number used to identify the mother. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where available | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Patient identifier – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | An identifier, unique to the mother within the hospital or campus (patient's record number / unit record number) | | |
| Representation class | Identifier | Data type | String |
| Format | A(10) | Field size | 10 |
| Location | Episode record | Position | 5 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system. Private homebirth practitioner only: report 9999999 for 'unknown'. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Perineal/genital laceration – degree/type

**Specification**

| | | | |
|---|---|---|---|
| Definition | The degree or type of laceration/tear to the perineum and/or genital tract following birth | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x2) |
| Location | Episode record | Position | 86 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | First degree laceration/tear |
| 2 | Second degree laceration/tear |
| 3 | Third degree laceration /tear |
| 4 | Fourth degree laceration /tear |
| 5 | Labial / clitoral laceration/tear |
| 6 | Vaginal wall laceration/tear |
| 7 | Cervical laceration/tear |
| 8 | Other laceration, rupture or tear |
| 9 | Not stated / inadequately described |

Reporting guide

First degree laceration/vaginal graze:
Graze, laceration, rupture or tear of the perineal skin during delivery that may be considered to be slight or that involves one or more of the following structures: fourchette, labia, vagina and / or vulva.

Second degree laceration :
Perineal laceration, rupture or tear as in Code 1 occurring during delivery, also involving: pelvic floor, perineal muscles, vaginal and / or muscles.

Third degree laceration:
Perineal laceration, rupture or tear as in Code 2 occurring during delivery, also involving: anal sphincter, rectovaginal septum and / sphincter not otherwise specified. Excludes laceration involving the anal or rectal mucosa.

Fourth degree laceration:
Perineal laceration, rupture or tear as in Code 3 occurring during delivery, also involving: anal mucosa and / or rectal mucosa.

Other perineal laceration, rupture or tear:
May include haematoma or unspecified perineal tear.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where the perineum is not intact following the birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Episiotomy – indicator, Method of birth, Mandatory to report data items, Perineal laceration – indicator, Perineal laceration – repair |

| | |
|---|---|
| Related business rules (Section 4): | Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (DHHS modified) | Version | 1. January 1999 |
| Codeset source | DHHS | Collection start date | 1999 |

# Perineal laceration – indicator

## Specification

| | | | |
|---|---|---|---|
| Definition | The state of the perineum following birth | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 85 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Laceration/tear of the perineum following birth |
| 2 | No laceration/tear of the perineum following birth |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | For episiotomies extended by laceration or laceration extended by episiotomy, record Perineal laceration – indicator as code 1 Laceration of the perineum following birth and Episiotomy indicator as code 1 Incision of perineum and vagina made. Specify the degree of the tear in Perineal/genital laceration – degree/type. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Episiotomy – indicator, Method of birth |
| Related business rules (Section 4): | Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations, Mandatory to report data items, Perineal laceration – indicator and Method of birth valid combinations, Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items, Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999<br>2. January 2009 |
| Codeset source | DHHS | Collection start date | 1999 |

# Perineal laceration – repair

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether a repair to a laceration/tear or incision to the perineum during birth was undertaken | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 87 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Repair of perineum undertaken |
| 2 | Repair of perineum not undertaken |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Suturing of any injury to the perineum, ncluding repair to perineal lacerations/tears and/or episiotomy. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where the perineum is not intact following the birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Episiotomy – indicator, Method of birth, Perineal laceration – indicator |
| Related business rules (Section 4): | Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations, Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Pertussis (whooping cough) vaccination status

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether or not the mother has received a pertussis containing vaccine during this pregnancy | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 126 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Pertussis containing vaccine received at any time during this pregnancy |
| 2 | Pertussis containing vaccine not received at any time during this pregnancy |
| 9 | Not stated / inadequately described |

Reporting guide

Report the statement that best describes the woman's understanding of her pertussis (whooping cough) vaccine status for this pregnancy.

If the vaccination was received prior to this pregnancy, report code 2 - Pertussis containing vaccine not received at any time during this pregnancy.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. July 2015 |
| Codeset source | DHHS | Collection start date | 1 July 2015 |

# Plan for vaginal birth after caesarean

## Specification

| | | | |
|---|---|---|---|
| Definition | Where, at the time of admission to hospital for the birth, the woman planned to have a vaginal birth after one or more previous caesarean sections. | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 46 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Vaginal birth after caesarean section was planned |
| 2 | Vaginal birth after caesarean section was not planned |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Where a woman is planning to have a VBAC and then becomes overdue at 42 weeks and has a caesarean section, the plan for VBAC should be recorded as VBAC not planned. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where total number of previous caesareans is greater than 00 |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Last birth – caesarean section indicator |
| Related business rules (Section 4): | Total number of previous caesareans and Plan for VBAC conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Postpartum complications – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 91 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report conditions in this field when there is no ICD-10-AM code available for selection in the software.<br><br>Postpartum complications arising after the delivery of the placenta up until the time of separation from care. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where complications are present in the postpartum period | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Postpartum complications – ICD-10-AM code | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Postpartum complications – ICD-10-AM code

## Specification

| | | | |
|---|---|---|---|
| Definition | Medical and obstetric complications of the mother occurring during the postnatal period, up to the time of separation from care | | |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x6) |
| Location | Episode record | Position | 92 |
| Permissible values | ICD-10-AM (8th edition) available on request, please email perinatal.data@dhhs.vic.gov.au<br><br>**Code** **Descriptor**<br>O142 HELLP Syndrome | | |
| Reporting guide | Postpartum complications arising after the delivery of the placenta up until the time of separation from care. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where complications are present in the postpartum period | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009<br>2. July 2015 |
| Codeset source | ICD-10-AM eighth edition | Collection start date | 2009 |

# Procedure – ACHI code

**Specification**

| | | | |
|---|---|---|---|
| Definition | The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium | | |
| Representation class | Code | Data type | Number |
| Format | NNNNNNN | Field size | 7 (x8) |
| Location | Episode record | Position | 56 |

Permissible values

ICD-10-AM library file available on request, please email perinatal.data@dhhs.vic.gov.au

| Code | Descriptor |
|---|---|
| 1651100 | Cervical suture for cervical shortening |
| 1321504 | ART - Intracytoplasmic sperm injection (ICSI) |
| 1321505 | ART - Donor Insemination |
| 1321506 | ART - Other |

Reporting guide

A procedure should only be coded once, regardless of how many times it is performed. Procedures that are reported in other data elements do not need to be reported in this field. These include anaesthesia or analgesia relating to the birth, augmentation or induction, caesarean section, forceps or vacuum extraction, suture/repair of tears, and allied health procedures.

The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM/ACHI Australian coding standards:

- Procedure performed for treatment of the principal diagnosis
- Procedure performed for treatment of an additional diagnosis
- Diagnostic/exploratory procedure related to the principal diagnosis
- Diagnostic/exploratory procedure related to an additional diagnosis.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes where a medical procedure and/or operation are performed |
| Related concepts (Section 2): | Procedure |
| Related data items (this section): | Artificial reproductive technology – indicator |
| Related business rules (Section 4): | Artificial reproductive technology – indicator conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. January 2009<br>3. July 2015<br>4. January 2018 |
| Codeset source | ICD-10-AM plus CCOPMM additions | Collection start date | 1982 |

# Procedure – free text

## Specification

| | | | |
|---|---|---|---|
| Definition | The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 55 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Report procedures in this field when there is no ACHI code available for selection in the software. This includes procedures and operations performed during the current pregnancy, labour, delivery and the puerperium. For example, cholecystectomy, ligation of vessels for twin-to-twin transfusion, hysterectomy and amniocentesis. A procedure should only be coded once, regardless of how many times it is performed. Procedures that are reported in other data elements do not need to be reported in this field. These include anaesthesia or analgesia relating to the birth, augmentation or induction, caesarean section, forceps or vacuum extraction, suture/repair of tears and allied health procedures. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Birth episodes where a medical procedure and/or operation is performed | | |
| Related concepts (Section 2): | Procedure | | |
| Related data items (this section): | Artificial reproductive technology – indicator, Procedure – ACHI code | | |
| Related business rules (Section 4): | Artificial reproductive technology – indicator conditionally mandatory data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Prophylactic oxytocin in third stage

## Specification

| | | | |
|---|---|---|---|
| Definition | Whether oxytocin was given prophylactically in the third stage of labour | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 83 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Oxytocin given prophylactically |
| 2 | Oxytocin not given prophylactically |
| 9 | Not stated / inadequately described |

Reporting guide

- Code 1 Oxytocin given prophylactically: record when oxytocin is used in order to prevent heavy blood loss, for example, with the birth of the anterior shoulder, or very soon after the birth.
- Code 2 Oxytocin not given prophylactically: record if no oxytocin was given on a routine prophylactic basis. This includes cases where a decision was made to administer oxytocin only after heavy blood loss was observed.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | Post-partum haemorrhage |
| Related data items (this section): | Estimated blood loss (ml) |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Reason for transfer out - baby

**Specification**

| | | | |
|---|---|---|---|
| Definition | Reason why the baby is transferred following separation from the birth hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 132 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Higher level of care |
| 2 | Lower level of care |
| 3 | Same level of care |
| 4 | HITH |

Reporting guide

Code 1 Higher level of care: includes conditions where tertiary neonatal care is more appropriate to the baby's needs. It also includes transfer where the intended hospital doesn't have the capability level to care for this baby; for example, prematurity, multiple pregnancy, complications at birth.

Code 2 Lower level of care: includes babies transferred back to their intended place of birth hospital following tertiary care, or from a hospital with increased capability to the intended hospital of birth.

Code 3 Same level of care: includes those babies who may have been born at the nearest hospital whilst mother was on holidays or travelling and is now being transferred to the intended birth hospital.

Code 4 HITH: includes all those babies referred to HITH. Please choose transferred rather than discharged in the baby's separation status.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All episodes where Separation status – baby is code 3 Transferred |
| Related concepts (Section 2): | Separation, Transfer |
| Related data items (this section): | Separation status – baby<br>Transfer destination – baby |
| Related business rules (Section 4): | Separation status – baby, reason for transfer - baby and Transfer destination – baby |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2018 |
| Codeset source | DHHS | Collection start date | 2018 |

# Reason for transfer out - mother

**Specification**

| | | | |
|---|---|---|---|
| Definition | Reason of the hospital campus to why the mother is transferred following separation from this hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 133 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Higher level of care |
| 2 | Lower level of care |
| 3 | Same level of care |
| 4 | HITH |

Reporting guide

Code 1 Higher level of care: includes conditions where tertiary maternity care is more appropriate to the mother's needs. It also includes transfer where the intended hospital doesn't have the capability level to care for this mother; for example, prematurity, multiple pregnancy, complications at birth.

Code 2 Lower level of care: includes mothers transferred back to their intended place of birth hospital following tertiary care, or from a hospital with increased capability to the intended hospital of birth.

Code 3 Same level of care: includes those mothers who may have given birth at the nearest hospital whilst the mother was on holidays or travelling and is now being transferred to the intended birth hospital.

Code 4 HITH: includes all those mothers referred to HITH. Please choose transferred rather than discharged in the mother's separation status.

Reported by: All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for: All episodes where Separation status – mother is code 3 Transferred

Related concepts (Section 2): Separation, Transfer

Related data items (this section): Separation status – mother; Transfer destination – mother

Related business rules (Section 4): Separation status – mother, reason for transfer - mother and Transfer destination – mother

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2018 |
| Codeset source | DHHS | Collection start date | 2018 |

# Residential locality

## Specification

| | | | |
|---|---|---|---|
| Definition | The geographic location of the woman's usual residence (suburb/town/locality for Australian residents, country for overseas residents), not the postal address | | |
| Representation class | Code | Data type | String |
| Format | A(46) | Field size | 46 |
| Location | Episode record | Position | 11 |
| Permissible values | Please refer to the 'Postcode - Locality reference file' available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files | | |
| Reporting guide | Locality must be blank if the postcode is 1000 (No fixed abode) or 9988 (Unknown). Where the postcode is 8888 (overseas), report the country where the patient lives in Locality. The four-digit country code must be one that corresponds with a code listed against 8888 (overseas) in the postcode/locality reference file. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items, Residential locality and Residential postcode valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | ABS National Locality Index (Cat. no. 1252) (DHHS Modified) | Collection start date | 1982 |

# Residential postcode

## Specification

| | | | |
|---|---|---|---|
| Definition | Postcode or locality in which the woman usually resides (not postal address) | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 12 |

**Permissible values**

Please refer to the 'Postcode - Locality reference file' available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files

| Code | Descriptor |
|---|---|
| 1000 | No fixed abode |
| 8888 | Overseas (report the four digit country code in the locality field) |
| 9988 | Unknown |
| 9999 | Not stated / inadequately described |

**Reporting guide**

The hospital may collect the woman's postal address for its own purposes. However, for data submission, the postcode must represent the woman's residential address. Data validation will reject non-residential postcodes (such as mail delivery centres). Where the postcode is 8888 (overseas), report the country the patient lives in under Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode / locality reference file.

**Reported by**

All Victorian hospitals where a birth has occurred and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts (Section 2):**

None specified

**Related data items (this section):**

Residential locality

**Related business rules (Section 4):**

Mandatory to report data items, Residential locality and Residential postcode valid combinations

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | ABS National Locality Index (Cat. no. 1252) (DHHS Modified) | Collection start date | 1982 |

# Residential road name – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The name of the road or thoroughfare of the mother's normal residential address | | |
| Representation class | Text | Data type | String |
| Format | A(45) | Field size | 45 |
| Location | Episode record | Position | 14 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | The name of the road on which the mother normally resides. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Residential road number – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The number in the road or thoroughfare of the mother's normal residential address | | |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 12 |
| Location | Episode record | Position | 13 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | The number of the road on which the mother normally resides. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Residential road name – mother | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Residential road suffix code – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The abbreviation code used to represent the suffix of the road or thoroughfare of the mother's normal residential address | | |
| Representation class | Code | Data type | String |
| Format | AA | Field size | 2 |
| Location | Episode record | Position | 15 |
| Permissible values | Codeset available on request, please email perinatal.data@dhhs.vic.gov.au | | |
| Reporting guide | The type of road on which the mother normally resides | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Residential road name – mother, Residential road number – mother | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Residential road type – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The type of road or thoroughfare of the mother's normal residential address | | |
| Representation class | Code | Data type | String |
| Format | AAAA | Field size | 4 |
| Location | Episode record | Position | 16 |
| Permissible values | Codeset available on request, please email perinatal.data@dhhs.vic.gov.au | | |
| Reporting guide | The type of road where the mother normally resides | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Residential road name – mother, Residential road number – mother, Residential road suffix code – mother | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009<br>2. January 2018 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Resuscitation method – drugs

## Specification

| | | | |
|---|---|---|---|
| Definition | Drugs administered immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x5) |
| Location | Episode record | Position | 106 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | None (no drug therapy) |
| 2 | Narcotic antagonist |
| 3 | Sodium bicarbonate |
| 4 | Adrenalin |
| 5 | Volume expander |
| 8 | Other drugs |
| 9 | Not stated / inadequately described |

Reporting guide

- Code 2 Narcotic antagonist: includes naloxone (Narcan)
- Code 5 Volume expander: includes normal saline and blood products
- Code 8 Other: includes all other drugs, for example, dextrose

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Birth status |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | Not applicable | Collection start date | 2009 |

# Resuscitation method – mechanical

**Specification**

| | | | |
|---|---|---|---|
| Definition | Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances | | |
| Representation class | Code | Data type | String |
| Format | NN | Field size | 2 (x10) |
| Location | Episode record | Position | 105 |

Permissible values

| Code | Descriptor |
|---|---|
| 01 | None |
| 02 | Suction |
| 03 | Oxygen therapy |
| 04 | Intermittent positive pressure respiration bag and mask with air |
| 05 | Endotracheal intubation and IPPR with air |
| 06 | External cardiac massage and ventilation |
| 07 | Continuous positive airway pressure with air |
| 14 | Intermittent positive pressure respiration bag and mask with oxygen |
| 15 | Endotracheal intubation an IPPR with oxygen |
| 17 | CPAP with oxygen |
| 88 | Other |
| 99 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | If during resuscitation both air and oxygen are given, report both codes. A combination of up to ten valid types of mechanical resuscitation methods can be used.<br><br>Code 01 None: includes such strategies as tactile stimulation. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Apgar score at one minute, Apgar score at five minutes, Birth status, Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code, Resuscitation method – drugs |
| Related business rules (Section 4): | Mandatory to report data items, Time to established respiration and Resuscitation method – mechanical valid combinations |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. January 1999<br>3. January 2009 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

# Separation date – baby

**Specification**

| | | | |
|---|---|---|---|
| Definition | The date on which the baby is separated or transferred from the place of birth or on which they died | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 119 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

**Reporting guide**

The relocation of the baby within the hospital of birth does not constitute a separation (or transfer).

Transfers from a private hospital located within a public hospital, to the public hospital for special or intensive care, are considered transfers (and therefore the baby is separated).

For babies who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs.

In the case of planned homebirths, occurring at home, the separation date is the date that the baby's immediate post birth care is completed and the midwife leaves the place of birth.

Please note that this date may be different to the baby's date of birth, for example if the birth occurs shortly before midnight.

Do not report a value for stillbirth episodes, leave blank.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Birth status. Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code |
| Related business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Date and time data item relationships, Date of birth – baby and Separation date – baby conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. January 2018 |
| Codeset source | DHHS | Collection start date | 1982 |

# Separation date – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The date on which the mother is separated, transferred or died after the birth episode | | |
| Representation class | Date | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 118 |
| Permissible values | A valid calendar date | | |

| Code | Descriptor |
|---|---|
| 99999999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | The relocation of the mother within the hospital of birth does not constitute a separation (or transfer).<br><br>For mothers who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs<br><br>In the case of planned homebirths, occurring at home, the separation date is the date that the mother's immediate post-birth care is completed and the midwife leaves the place of birth.<br><br>Please note that this date may differ from the baby's date of birth, for example, if the birth occurs shortly before midnight. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Date of admission – mother |
| Related business rules (Section 4): | Date and time data item relationships, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. January 2018 |
| Codeset source | DHHS | Collection start date | 1982 |

# Separation status – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | Status at separation of baby (discharge/transfer/death) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 121 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Discharged |
| 2 | Died |
| 3 | Transferred |
| 9 | Not stated / inadequately described |

Reporting guide

Do not report a value for stillbirth episodes, leave blank.

For babies who are transferred to Hospital in the Home (HITH), the Separation status – baby is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – baby should be left blank.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for

All live birth episodes

Related concepts (Section 2):

Infant death, Separation

Related data items (this section):

Birth status, Separation date – baby

Related business rules (Section 4):

Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Separation status – baby and Transfer destination – baby conditionally mandatory data item
Separation status – baby and Reason for transfer out – baby conditionally mandatory item

## Administration

Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

| | | | |
|---|---|---|---|
| Definition source | DHHS | Version | 1. January 1982<br>2. July 2015<br>3. January 2018 |
| Codeset source | DHHS | Collection start date | 1982 |

# Separation status – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Status at separation of mother (discharge/transfer/ death) | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 120 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Discharged |
| 2 | Died |
| 3 | Transferred |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | For mothers who are transferred to Hospital in the Home (HITH), Separation status – mother is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – mother should be left blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | Separation |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report data items, Separation status – mother and Transfer destination – mother – conditionally mandatory data item Separation status – mother and Reason for transfer out – mother conditionally mandatory item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982<br>2. July 2015<br>3. January 2018 |
| Codeset source | DHHS | Collection start date | 1982 |

# Setting of birth – change of intent

**Specification**

| | | | |
|---|---|---|---|
| Definition | Whether the change of intent between where the mother intended to give birth and the actual birth setting took place before or during labour | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 29 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Before onset of labour |
| 2 | During labour |
| 9 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | This field is to determine where a change has occurred in the intended model of care. If the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended place of birth. She is holidaying on the coast at 38 weeks and realises that she going to have this second baby quickly, so is admitted to Warrnambool Hospital. This becomes the actual hospital. The change of intent is during labour. The reason is unintended (see Setting of birth – actual and Setting of birth – change of intent – reason). Or, if the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended place of birth. She moves to Warrnambool for her husband's work at 39 weeks where she gives birth at term. This becomes the actual hospital. The change of intent is before onset of labour. The reason is geographical (see Setting of birth – actual and Setting of birth – change of intent – reason). |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All episodes where the actual birth place differs from the intended place of birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Setting of birth – actual |
| Related business rules (Section 4): | Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999 |
| Codeset source | DHHS | Collection start date | 1999 |

# Setting of birth – change of intent – reason

**Specification**

| | | | |
|---|---|---|---|
| Definition | Reason for change of intent between where the mother intended to give birth and where the actual birth took place | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 30 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Recognition of higher risk |
| 2 | Actual complication of pregnancy |
| 3 | Social or geographic |
| 4 | Unintended/unplanned |
| 8 | Other |
| 9 | Not stated / inadequately described |

Reporting guide

- Code 1 Recognition of higher risk: includes conditions or circumstances that suggest that maternity care would be better provided in a higher-level facility, for example, multiple pregnancy, thrombophilia
- Code 2 Actual complication of pregnancy: includes complications that have already occurred for example, threatened preterm labour, DVT, fetal growth restriction
- Code 3 Social or geographic: includes change in health insurance or change in local maternity service availability, moved house, preference
- Code 4 Unintended/unplanned: includes those in transit to booked hospital, on holidays

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All episodes where the actual birth place differs from the initially booked place of birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Setting of birth – change of intent, Setting of birth – actual |
| Related business rules (Section 4): | Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Setting of birth – actual

**Specification**

| | | | |
|---|---|---|---|
| Definition | The actual place where the birth occurred | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 27 |

Permissible values

Please refer to the 'Hospital Code Table available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files

| Code | Descriptor |
|---|---|
| 0002 | Birth centre |
| 0003 | Home (other) |
| 0005 | In transit |
| 0006 | Home – Private midwife care |
| 0007 | Home – Public homebirth program |
| 0008 | Other - specify |
| 0009 | Not stated / inadequately described |

Reporting guide

- Code 0002 Birth centre: reported when a birth occurs at the actual hospital's birth centre
- Code 0003 Home (other): includes a birth not intended to occur at home. Excludes homebirth with a private midwife (use code 0006) and homebirth under the public homebirth program (use code 0007)
- Code 0005 In transit: includes births occurring on the way to the intended place of birth or the car park of a hospital/birthing centre
- Code 0006 Home: private midwife care – reported when a birth is attended by a private midwife practitioner in the mother's own home or a home environment
- Code 0007 Home: Public homebirth program – reported when a birth is attended by a public midwife in the mother's home under the Public homebirth program
- Code 0008 Other – specify: Used when birth occurs at any location other than those listed above. May also include a community health centre. Report the location in Setting of birth – actual – other specified description

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |

| | |
|---|---|
| Related business rules (Section 4): | Mandatory to report data items, Setting of birth – actual and Admitted patient election status – mother valid combinations, Setting of birth – actual and Setting of birth – actual – other specified description conditionally mandatory data item |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1982<br>2. July 2015 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

# Setting of birth – actual – other specified description

## Specification

| | | | |
|---|---|---|---|
| Definition | The actual place where the birth occurred | | |
| Representation class | Text | Data type | String |
| Format | A(20) | Field size | 20 |
| Location | Episode record | Position | 28 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Only report the description of the place of birth if the place of birth is not one identified in the codeset of data element Setting of birth – actual. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Births where code 0008 Other – specify in Setting of birth – actual is reported | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Setting of birth – actual | | |
| Related business rules (Section 4): | Setting of birth – actual and Setting of birth – actual – other specified description conditionally mandatory data item | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999 |
| Codeset source | Not applicable | Collection start date | 1999 |

# Setting of birth – intended

**Specification**

| | | | |
|---|---|---|---|
| Definition | The intended place of birth | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 25 |

Permissible values

Please refer to the 'Hospital Code Table available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files

| Code | Descriptor |
|---|---|
| 0002 | Birth centre |
| 0003 | Home (other) |
| 0006 | Home – Private midwife care |
| 0007 | Home – Public homebirth program |
| 0008 | Other - specify |
| 0009 | Not stated / inadequately described |

Reporting guide

If unable to provide hospital code, record the hospital name in Setting of Birth – intended – other specified description. Home in the context of this data element means the home of the woman or a relative or a friend.

- Code 0002 Birth centre: if the birth was intended at the hospital's birth centre
- Code 0003 Home (other): excludes homebirth with a private midwife (use code 0006) and homebirth under the public homebirth program (use code 0007)
- Code 0008 Other – specify: includes community (health) centres. Record the location in Setting of birth – intended – other specified description
- Code 0009 Not stated / inadequately described: includes unbooked or unplanned

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2):

None specified

Related data items (this section):

Setting of birth – change of intent, Setting of birth – change of intent – reason, Setting of birth – actual

Related business rules (Section 4):

Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items, Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999<br>2. July 2015 |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1999 |

# Setting of birth – intended – other specified description

## Specification

| | | | |
|---|---|---|---|
| Definition | The intended place of birth at the onset of labour | | |
| Representation class | Text | Data type | String |
| Format | A(20) | Field size | 20 |
| Location | Episode record | Position | 26 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Only report the description of the intended place of birth if the intended place of birth is not one identified in the codeset of data element Setting of birth – intended. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | When Code 0008 Other – specify is reported in Setting of birth – intended birth | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Setting of birth – intended | | |
| Related business rules (Section 4): | Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 1999 |
| Codeset source | Not applicable | Collection start date | 1999 |

# Sex – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | The biological distinction between a male and female baby | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 97 |

Permissible values

| Code | Descriptor |
|---|---|
| 1 | Male |
| 2 | Female |
| 3 | Indeterminate |
| 9 | Not stated / inadequately described |

Reporting guide

Sex is the biological distinction between male and female.

Code 3 Indeterminate: this should be used for infants with ambiguous genitalia or macerated fetus where the biological sex is unable to be or has not yet been determined (genetic testing not yet complete).

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Congenital anomalies – free text |
| Related business rules (Section 4): | Mandatory to report data items, Sex – baby and Congenital anomalies – indicator conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD (modified) | Version | 1. January 1982 |
| Codeset source | NHDD | Collection start date | 1982 |

# Spoken English Proficiency

## Specification

| | | | |
|---|---|---|---|
| Definition | Self assessment by a mother, born in a country other than Australia, of her own English language fluency. | | |
| Representation class | Code | Data type | Numeric |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 127 |

Permissible values

| Code | Descriptor |
|---|---|
| 1. | Very well |
| 2. | Well |
| 3. | Not well |
| 4. | Not at all |
| 9. | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Each woman should be asked - “How well do you speak English”? Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes, where the Country of Birth is not Australia |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Country of Birth |
| Related business rules (Section 4): | None specified |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | METeOR ID 270203 | Version | 1. January 2017 |
| Codeset source | NHDD | Collection start date | 2017 |

# Submission number

### Specification

| | | | |
|---|---|---|---|
| Definition | The number of times a particular piece of data is submitted or resubmitted | | |
| Representation class | Identifier | Data type | String |
| Format | NN | Field size | 2 |
| Location | Header record, File name | Position | Not applicable |
| Permissible values | Range: one to 99 (inclusive) | | |
| Reporting guide | Software-system generated. The incrementing submission number must cycle back to ‘01’ each time the Data submission identifier (submission end date) changes. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | None specified | | |

### Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Surname / family name – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | The surname of the mother | | |
| Representation class | Text | Data type | String |
| Format | A(40) | Field size | 40 |
| Location | Episode record | Position | 8 |
| Permissible values | Permitted characters:<br>• a–z and A–Z<br>• special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)<br>• numeric characters<br>• blank characters | | |
| Reporting guide | Surname of the mother | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | First given name – mother | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | Not applicable | Collection start date | 1982 |

# Time of birth

## Specification

| | | | |
|---|---|---|---|
| Definition | The time of birth measured as hours and minutes using a 24-hour clock | | |
| Representation class | Time | Data type | Date/time |
| Format | HHMM | Field size | 4 |
| Location | Episode record | Position | 96 |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400) | | |

| Code | Descriptor |
|---|---|
| 9999 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report hours and minutes using a 24-hour clock. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Time of onset of labour, Time of onset of second stage of labour, Time of rupture of membranes |
| Related business rules (Section 4): | Date and time data item relationships, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Time of onset of labour

## Specification

| | | | |
|---|---|---|---|
| Definition | The time of onset of labour measured as hours and minutes using a 24-hour clock | | |
| Representation class | Time | Data type | Date/time |
| Format | HHMM | Field size | 4 |
| Location | Episode record | Position | 62 |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400)<br><br>**Code** **Descriptor**<br>8888 No labour<br>9999 Not stated / inadequately described | | |
| Reporting guide | Report hours and minutes using a 24-hour clock. Code 8888 No labour is to be used when the mother has a planned or unplanned caesarean section with no labour. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Method of birth | | |
| Related business rules (Section 4): | Date and time data item relationships, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations, Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Time of onset of second stage of labour

**Specification**

| | | | |
|---|---|---|---|
| Definition | The time of the start of the second stage of labour measured as hours and minutes using a 24-hour clock | | |
| Representation class | Time | Data type | Date/time |
| Format | HHMM | Field size | 4 |
| Location | Episode record | Position | 64 |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400).<br><br>**Code** **Descriptor**<br>8888 No labour<br>9999 Not stated / inadequately described | | |
| Reporting guide | Report hours and minutes using a 24-hour clock. Code 8888 No second stage of labour is to be used when the mother has a planned or unplanned caesarean section and did not reach second stage of labour.<br><br>In the instance of a woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:<br>1. Had she had a show or ROM?<br>2. Had she vomited at all within the hour prior to giving birth or think she was going to vomit?<br>3. Had there been any noticeable urge to push?<br>4. Did she notice if she had bowel pressure prior to having the baby and how long before?<br>5. Had any family members noticed any change in her behaviour (restless, agitated) prior to having the baby?<br>If none of these questions can be answered then a reasonable assumption would be that the birth occurred within one to two contractions prior to the birth and second stage may be judged to be two and five minutes prior to the birth. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Method of birth, Time of onset of labour | | |
| Related business rules (Section 4): | Date and time data item relationships, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations, Mandatory to report data items | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Time of rupture of membranes

## Specification

| | | | |
|---|---|---|---|
| Definition | The time at which the mother's membranes ruptured (spontaneously or artificially) measured as hours and minutes using a 24-hour clock | | |
| Representation class | Time | Data type | Date/time |
| Format | HHMM | Field size | 4 |
| Location | Episode record | Position | 66 |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400) | | |

| Code | Descriptor |
|---|---|
| 7777 | No record of rupture of membranes |
| 8888 | No labour |
| 9999 | Not stated / inadequately described |

**Reporting guide**

Report hours and minutes using a 24-hour clock. Report the time at which the membranes were believed to have ruptured, whether spontaneously or artificially. If there is a verified hindwater leak that is followed by a forewater rupture, record the earlier date. If there is some vaginal loss that is suspected to be ruptured membranes, but in hindsight seems unlikely, record the time at which the membranes convincingly ruptured. In unusual situations, a brief text description will minimise queries. In the case of a caul birth, report the date and time of ROM as the date and time of birth. If date of ROM is known but time of ROM is not, report the date and unknown time. Only report unknown date and time of ROM for episodes where there is absolutely no evidence in the medical record to indicate the timing of the rupture of membranes. An estimate of at least the date of ROM is far preferable to no record. Use of the no record codes will be monitored and sites reporting a high frequency of no record codes will be followed up.

Code 8888 Membranes ruptured at caesarean: to be used when the mother has a planned or unplanned caesarean section and membranes were ruptured during caesarean.

| | |
|---|---|
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Method of birth, Time of onset of labour, Time of onset of second stage of labour |
| Related business rules (Section 4): | Date and time data item relationships, Labour type 'Woman in labour' and associated data items valid combinations, Labour type 'Woman not in labour' and associated data items valid combinations, Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Time to established respiration

**Specification**

| | | | |
|---|---|---|---|
| Definition | Time in minutes taken to establish regular, spontaneous breathing. This is not the same as the time of first breath. | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 104 |
| Permissible values | Range: zero to 30 (inclusive)<br><br>**Code** **Descriptor**<br>98 Newborn does not take a breath is intubated and ventilated<br>99 Not stated / inadequately described | | |
| Reporting guide | Most newborns establish spontaneous respirations within one to two minutes of birth. If spontaneous respirations are not established within this time, active intervention is required. Round up the time the baby took to establish regular spontaneous breathing to the next whole minute. For example a baby who takes 2.5 minutes to establish regular breathing should have three minutes recorded.<br><br>If the baby breathes immediately and continues to have regular spontaneous breathing upon delivery the TER is one minute. If the baby does not take a breath and is intubated and ventilated and accurate assessment of time is not possible report 98 Newborn does not take a breath – is intubated and ventilated. If the baby is born before arrival, where the time to established respiration is unknown report 99 Not stated / inadequately described.<br><br>For stillbirth episodes, report the time to established respiration as 00. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Apgar score at one minute, Apgar score at five minutes, Birth status, Resuscitation method – drugs, Resuscitation method – mechanical | | |
| Related business rules (Section 4): | Birth status ‘Stillborn’ and associated data items valid combinations, Mandatory to report data items, Time to established respiration and Resuscitation method – mechanical valid combinations | | |

**Administration**

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous abortions – induced

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of previous pregnancies resulting in induced abortion (termination of pregnancy before 20 weeks' gestation) | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 39 |
| Permissible values | Range: zero to 30 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | Report the number of previously induced abortions. Aborted pregnancies of multiple fetuses should be counted as only one pregnancy. That is, a twin pregnancy, for example, is counted as one pregnancy. In the case of No previous abortions – induced, report 0 No previous abortions – induced. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Gravidity | | |
| Related business rules (Section 4): | Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous abortions – spontaneous

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 grams birthweight if gestational age is unknown, and showed no sign of life after birth) | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 38 |
| Permissible values | Range: zero to 30 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | Report the number of previous spontaneous abortions. Aborted pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy. In the case of no previous abortions – spontaneous, report 0 No previous abortions – spontaneous. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Gravidity | | |
| Related business rules (Section 4): | Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous caesareans

## Specification

| | | | |
|---|---|---|---|
| Definition | Total number of previous pregnancies where the method of delivery was caesarean section | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 45 |
| Permissible values | Range: zero to 9 (inclusive) | | |

| Code | Descriptor |
|---|---|
| 99 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | This relates to all births including the last birth. If the mother has had any previous births, then check and report the total number of births by caesarean section, regardless of whether the last birth was a caesarean section or not. If neither the last birth nor any other previous births were by caesarean section, report 0. For multiple births, if one baby is delivered via caesarean section and the other baby or babies via any other form of delivery (excluding caesarean), record this pregnancy as a previous caesarean. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Last birth – caesarean section indicator |
| Related business rules (Section 4): | Mandatory to report data items, Total number of previous caesareans and Plan for VBAC conditionally mandatory data item |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1998 |
| Codeset source | DHHS | Collection start date | 1998 |

# Total number of previous ectopic pregnancies

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of previous pregnancies that were ectopic | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 40 |
| Permissible values | Range: zero to 20 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | Report the number of previous ectopic pregnancies. Ectopic pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy. In the case of no previous ectopic pregnancies, report 0 No previous ectopic pregnancies. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where a previous ectopic outcome occurred. | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Gravidity | | |
| Related business rules (Section 4): | Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999 |
| Codeset source | DHHS | Collection start date | 1999 |

# Total number of previous live births

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of live births that resulted from each previous pregnancy and who lived at least 28 days | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 34 |
| Permissible values | Range: zero to 20 (inclusive) | | |

| Code | Descriptor |
|---|---|
| 99 | Not stated / inadequately described |

| | |
|---|---|
| Reporting guide | Report the number of known previous live births, excluding those who die in the first 28 days. For those who die in the first 28 days, they are reported as a neonatal death. This includes all multiples. For example live born twins are reported as two. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | Live birth |
| Related data items (this section): | Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans |
| Related business rules (Section 4): | Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous neonatal deaths

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of live births that died during the first 28 days of life from each previous pregnancy | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 37 |
| Permissible values | Range: zero to 20 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | A neonatal death refers to the death of a live born which occurs during the first 28 days of life. A live born resulting in a neonatal death should be recorded only as a neonatal death. This includes all multiples. For example twins that died during the first 28 days of life are reported as two. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | Neonatal death | | |
| Related data items (this section): | Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans | | |
| Related business rules (Section 4): | Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous stillbirths (fetal deaths)

## Specification

| | | | |
|---|---|---|---|
| Definition | The total number of stillbirths from previous pregnancies (at least 20 weeks gestational age or 400g birthweight) | | |
| Representation class | Code | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 36 |
| Permissible values | Range: zero to 20 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | This includes all multiples. For example, stillborn twins are reported as two. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | Stillbirth (fetal death) | | |
| Related data items (this section): | Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans | | |
| Related business rules (Section 4): | Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Total number of previous unknown outcomes of pregnancy

## Specification

| | | | |
|---|---|---|---|
| Definition | Total number of previous pregnancies where the outcome is unknown | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 41 |
| Permissible values | Range: zero to 20 (inclusive)<br><br>**Code** **Descriptor**<br>99 Not stated / inadequately described | | |
| Reporting guide | Record the number of previous outcomes that do not meet the criteria of live birth, stillbirth, neonatal death, spontaneous or induced abortions or ectopic pregnancies. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Gravidity | | |
| Related business rules (Section 4): | Gravidity ‘Primigravida’ and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1982 |
| Codeset source | DHHS | Collection start date | 1982 |

# Transaction type flag

## Specification

| | | | |
|---|---|---|---|
| Definition | An indicator that identifies the type of transaction to the VPDC | | |
| Representation class | Code | Data type | String |
| Format | A | Field size | 1 |
| Location | Episode record | Position | 3 |

Permissible values

| Code | Descriptor |
|---|---|
| C | Confirmation of previously accepted record |
| N | New record |
| U | Updated/corrected record |
| X | Record to be deleted |

| | |
|---|---|
| Reporting guide | Software-system generated. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Each VPDC electronic submission file |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
| Related business rules (Section 4): | Mandatory to report data items |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 |
| Codeset source | DHHS | Collection start date | 2009 |

# Transfer destination – baby

## Specification

| | | | |
|---|---|---|---|
| Definition | Identification of the hospital campus to which the baby is transferred following separation from this hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 123 |
| Permissible values | Please refer to the 'Hospital Code Table available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files<br><br>**Code** **Descriptor**<br>9999 Not stated / inadequately described | | |
| Reporting guide | For babies transferred to Hospital in the Home (HITH), the transfer destination should be left blank. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All episodes where Separation status – baby is code 3 Transferred | | |
| Related concepts (Section 2): | Transfer | | |
| Related data items (this section): | Reason for transfer out – baby<br>Separation status – baby | | |
| Related business rules (Section 4): | Separation status – baby and Transfer destination – baby conditionally mandatory data item | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009<br>3. July 2015<br>4. January 2018 |
| Codeset source | DHHS | Collection start date | 1999 |

# Transfer destination – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Identification of the hospital campus to which the mother is transferred following separation from the original hospital campus | | |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 122 |
| Permissible values | Please refer to the 'Hospital Code Table available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files<br><br>**Code** **Descriptor**<br>9999 Not stated / inadequately described | | |
| Reporting guide | For mothers transferred to Hospital in the Home (HITH), the transfer destination should be left blank. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All episodes where Separation status – mother is code 3 Transferred | | |
| Related concepts (Section 2): | Transfer | | |
| Related data items (this section): | Reason for transfer out – mother,<br>Separation status – mother | | |
| Related business rules (Section 4): | Separation status – mother and Transfer destination – mother – conditionally mandatory data item | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 1999<br>2. January 2009<br>3. July 2015<br>4. January 2018 |
| Codeset source | DHHS | Collection start date | 1999 |

# Version identifier

## Specification

| | | | |
|---|---|---|---|
| Definition | Version of the data collection | | |
| Representation class | Identifier | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record, Header record | Position | 2 |
| Permissible values | **Code**<br>2009<br>2015<br>2017<br>2018<br>2019 | | |
| Reporting guide | Software-system generated. A VPDC electronic submission file with a missing or invalid Version identifier will be rejected and the submission file will not be processed. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | Each VPDC electronic submission file | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009<br>2. July 2015<br>3. January 2017<br>4. January 2018 |
| Codeset source | DHHS | Collection start date | 2009 |

# Weight – self-reported – mother

## Specification

| | | | |
|---|---|---|---|
| Definition | Mother's self-reported weight (body mass) about the time of conception | | |
| Representation class | Total | Data type | Number |
| Format | NN[N] | Field size | 3 |
| Location | Episode record | Position | 24 |
| Permissible values | Range: 20 to 300 (inclusive)<br><br>**Code** **Descriptor**<br>999 Not stated / inadequately described | | |
| Reporting guide | A weight in kilograms (kg). | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Height – self-reported – mother | | |
| Related business rules (Section 4): | Mandatory to report data items | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | NHDD | Version | 1. January 2009 |
| Codeset source | NHDD | Collection start date | 2009 |

# Year of arrival in Australia

## Specification

| | | | |
|---|---|---|---|
| Definition | The year a person (born outside of Australia) first arrived in Australia, from another country. | | |
| Representation class | Code | Data type | Numeric |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 128 |
| Permissible values | Valid year, between 1900 and current year<br>9998 Not intending to stay in Australia for one year or more<br>9999 Not stated/inadequately described | | |
| Reporting guide | Recommended question:<br>In what year did you/the person first arrive in Australia to live here for one year or more?<br>It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. An instruction such as 'Please indicate the year of first arrival only' should be included with the question.<br>If mother is born in Australia, leave blank. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Country of Birth | | |
| Related business rules (Section 4): | None specified | | |

## Administration

| | | | |
|---|---|---|---|
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | METeOR ID 269929 | Version | 1. January 2017 |
| Codeset source | NHDD | Collection start date | 2017 |