

Victorian Perinatal Data Collection



User Manual – paper

For checking and submitting the Victorian Birth Report

Department of Human Services

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Monash Medical Centre	St John of God Bendigo
St Vincent's	Mercy Private
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The VPDCU has tried to ensure the Guide is free of errors and is comprehensive and clear. If you detect any errors, or if you have any queries, please notify the Research and Liaison Midwife.

From time to time improvements and changes will be made to the Guide; the design of the guide allows for pages to be replaced or inserted.

Glossary of terms and abbreviation

Abbreviation	Description
ACHI	Australian Classification of Health Intervention
ACHS	Australian Council on Healthcare Standards
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
APH	Antepartum haemorrhage
ARM	Artificial rupture of membranes
ART	Artificial reproductive technology
ATSI	Aboriginal and Torres Strait Islander
BBA	Born before arrival
BPA	British Paediatric Association
CCDS	Common Client Data Set, Version 2
CCU	Coronary care unit
CI	Clinical indicator
Clomid	Ovarian Stimulant
CS	Caesarean section
CTG	Cardiotocography
DOM	Domiciliary
DVA	Department of Veterans Affairs
DVT	Deep Venous Thrombosis
EDB	Estimated date of birth
ETOD	Electronic transfer of data
FSE	Fetal scalp electrode
GIFT	Gamete inter-Fallopian transfer
HDC	High dependency care
HDU	High dependency unit
HITH	Hospital in the home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICSI	Intracytoplasmic sperm injection
ICU	Intensive care unit
IDDM	Insulin dependent diabetes mellitus
IPPR	Intermittent positive pressure respiration
ITA	Infertility Treatment Authority
IUGR	Intra uterine growth restriction
IVF	In vitro fertilisation
LNMP	Last normal menstrual period
N/A	Non applicable
NETS	Newborn emergency transport service
NHDD	National Health Data Dictionary
NICU	Neonatal intensive care unit
NPSU	National Perinatal Statistics Unit
NSW	New South Wales
NT	Northern Territory
PPH	Post Partum Haemorrhage
PROM	Pre-labour ruptured membranes
RHCA	Reciprocal Health Care Agreement
SA	South Australia

SCN	Special care nursery
SLA	Statistical local area
TAC	Transport Accident Commission
TER	Time to establish respiration
the department	Department of Human Services
U/S	Ultrasound
UR	Unit report
VBAC	Vaginal birth after caesarean
VIMD	Victorian Inpatient Minimum Dataset
VPDCU	Victorian Perinatal Data Collection Unit
WA	Western Australia
WHO	World Health Organisation
WorkCover	WorkCover Authority

Where possible, the variables on the birth report are compliant with the definitions and format of data items in the National Health Data Dictionary, which are standard in the health sector. These data items can be browsed alphabetically by name by accessing the website below:
<http://meteor.aihw.gov.au/content/index.phtml/itemId/268110>

Section 1: introduction

Background

The Victorian Perinatal Data Collection Unit (VPDCU) was set up in 1982 by an amendment to the Victorian Health Act (1958), for the purpose of:

- collecting, studying, researching and interpreting information on and in relation to births in Victoria
- identifying and monitoring trends in respect of perinatal health including congenital anomalies
- providing information for requirements of and planning of neonatal care units
- providing information to the medical profession for research into the epidemiology of perinatal mortality and disorders including congenital anomalies and establishing and maintaining a register of congenital anomalies.

The VPDCU is now a unit within the Statewide Quality Branch, a Division of the Department of Human Services. It is responsible to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity which has been the advisory body to the Victorian Minister for Health on maternal and perinatal deaths for over 30 years.

The perinatal data collection contains information on obstetric conditions, procedures and outcomes, neonatal morbidity and congenital anomalies relating to every birth in Victoria after 20 weeks gestation, or where gestation is unknown, where the birth weight is at least 400gm. The information is strictly confidential. The collection is used by CCOPMM to undertake research on perinatal and maternal health. Only coded information, which will not identify the mother, her baby, the practitioner or the hospital, is used to compile reports released to the public.

The majority of data items comply with the National Perinatal Minimum Data Set which is collected by all states and territories and sent to the National Perinatal Statistics Unit for production of the annual report on Australia's Mothers and Babies.

The definitions used for these data items are from the National Health Data Dictionary Version 6 or from the VPDCU. It is important the data items and their definitions are consistent for all data being coded and entered into the collection (see Glossary of Terms and abbreviation p6, p7).

The collection can be used to provide a picture of statewide pregnancy characteristics and outcomes, as well as trends over time. It is used to provide individual hospital profiles and may also be used to provide profiles of selected subgroups of women, for example, women born overseas, or women who have caesarean sections.

The collection is also used to compile state and national morbidity and mortality statistics to assist clinicians, service planners, educators, researchers, and policy makers.

One of the roles of the VPDCU was to establish a Birth Defects Register (BDR), which contains not only data collected through the Perinatal Data Collection, but also data from a number of other sources.

Birth Report Form

MOTHER Mother UR number: <input type="text"/>		Hospital: Intended Place of Birth: Hospital (specify) <input type="checkbox"/> Birth Centre <input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Other (specify) <input type="checkbox"/>		Actual Place of Birth: Hospital (specify) <input type="checkbox"/> Birth Centre <input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Other (specify) <input type="checkbox"/>	
Admission date: <input type="text"/>		Birthdate (Mother): <input type="text"/>		If place of birth changes, specify if change occurred: Before onset of labour <input checked="" type="checkbox"/> During labour <input checked="" type="checkbox"/>	
Suburb: <input type="text"/> Postcode: <input type="text"/>		Country of Birth: (Mother) <input type="text"/>		Reason for change: Recognition of higher risk <input checked="" type="checkbox"/> Unintended/unplanned <input checked="" type="checkbox"/> Complication of pregnancy <input checked="" type="checkbox"/> Not stated <input checked="" type="checkbox"/> Social or geographic <input checked="" type="checkbox"/> Other (specify) <input type="checkbox"/>	
Public/Private Patient: Public <input checked="" type="checkbox"/> Private <input checked="" type="checkbox"/>		Indigenous Status (Mother): (circle one or more) Aboriginal <input checked="" type="checkbox"/> TSI <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> (Baby): (circle one or more) Aboriginal <input checked="" type="checkbox"/> TSI <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		Smoking <20 weeks: Non-smoker <input checked="" type="checkbox"/> Quit <input checked="" type="checkbox"/> Smoked <input checked="" type="checkbox"/>	
Marital Status (Mother): Married <input checked="" type="checkbox"/> Single <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Separated <input checked="" type="checkbox"/> Defacto <input checked="" type="checkbox"/> Unknown <input checked="" type="checkbox"/>		Height: <input type="text"/> cm Weight: <input type="text"/> kg		Smoking ≥ 20 weeks: Non-smoker <input checked="" type="checkbox"/> Smoked (n/day) <input type="text"/> Occasional (<1/day) <input checked="" type="checkbox"/>	
REPRODUCTIVE HISTORY G: <input type="text"/> P: <input type="text"/> Total number: (Excluding this pregnancy) Livebirth - (lived ≥ 28 days) <input type="text"/> - (died < 28 days) <input type="text"/> Stillbirth <input type="text"/> Abortion - spontaneous <input type="text"/> - induced <input type="text"/> Ectopic <input type="text"/> Unknown <input type="text"/> Date of completion of last pregnancy: (mth/yr) <input type="text"/> Outcome of last pregnancy: Livebirth - lived ≥ 28 days <input checked="" type="checkbox"/> - died < 28 days <input checked="" type="checkbox"/> Abortion - spontaneous <input checked="" type="checkbox"/> - induced <input checked="" type="checkbox"/> Stillbirth <input checked="" type="checkbox"/> Ectopic <input checked="" type="checkbox"/> Unknown <input checked="" type="checkbox"/> Was last birth a caesarean section?: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Total no. of previous caesarean sections: <input type="text"/> Plan for VBAC: (if prev CS) <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N		LABOUR, BIRTH & POSTNATAL Onset labour: Date <input type="text"/> Time <input type="text"/> Onset 2nd stage: Date <input type="text"/> Time <input type="text"/> Rupture of membranes: Date <input type="text"/> Time <input type="text"/> Labour: Spontaneous <input checked="" type="checkbox"/> Augmented <input checked="" type="checkbox"/> Induced - medical <input checked="" type="checkbox"/> surgical <input checked="" type="checkbox"/> No labour <input checked="" type="checkbox"/> If labour induced or augmented: (circle one or more) Oxytocin <input checked="" type="checkbox"/> ARM <input checked="" type="checkbox"/> Prostaglandins <input checked="" type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Specify indication for induction: Fetal monitoring in labour: (circle one or more) Intermittent Ausc <input checked="" type="checkbox"/> Internal CTG <input checked="" type="checkbox"/> Admission CTG <input checked="" type="checkbox"/> Fetal blood sampling <input checked="" type="checkbox"/> Intermittent CTG <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/> Cont. external CTG <input checked="" type="checkbox"/> Presentation: Vertex <input checked="" type="checkbox"/> Brow <input checked="" type="checkbox"/> Shoulder <input checked="" type="checkbox"/> Breech <input checked="" type="checkbox"/> Compound <input checked="" type="checkbox"/> Unknown <input checked="" type="checkbox"/> Face <input checked="" type="checkbox"/> Cord <input checked="" type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Method of birth: Unassisted vaginal <input checked="" type="checkbox"/> Forceps <input checked="" type="checkbox"/> Vacuum <input checked="" type="checkbox"/> Planned C/S - No labour <input checked="" type="checkbox"/> Labour <input checked="" type="checkbox"/> Unplanned C/S - No labour <input checked="" type="checkbox"/> Labour <input checked="" type="checkbox"/> Indications for operative birth: Analgesia for labour: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Specify <input type="text"/> Anaesthesia for operative delivery: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Specify <input type="text"/> Complications/events of labour and birth: Antibiotics <input checked="" type="checkbox"/> Shoulder dystocia <input checked="" type="checkbox"/> Water birth <input checked="" type="checkbox"/> Specify <input type="text"/> Lead intrapartum care provider: Obstetrician <input checked="" type="checkbox"/> Midwife <input checked="" type="checkbox"/> GP <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/> Prophylactic oxytocin 3rd stage: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Manual removal of placenta: (excl c/s) <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Perineal status: Episiotomy <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Laceration: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Degree/type: (specify) <input type="text"/> Repaired: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Blood loss: (mls) <input type="text"/> Transfusion: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Postpartum complications: Specify <input type="text"/> Admitted to HDU/ICU: (Mother) <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N		BABY UR: <input type="text"/> (Complete a separate form in full for each baby of a multiple birth) Birthdate: Date <input type="text"/> Time <input type="text"/> Estimated gestation at birth: (weeks) <input type="text"/> Sex: Male <input checked="" type="checkbox"/> Female <input checked="" type="checkbox"/> Indeterminate <input checked="" type="checkbox"/> Plurality: (eg. Single <input checked="" type="checkbox"/> , Twins <input checked="" type="checkbox"/>) (this record refers to <input type="checkbox"/> born) Condition: Liveborn <input checked="" type="checkbox"/> Stillborn (before labour) <input checked="" type="checkbox"/> (during labour) <input checked="" type="checkbox"/> Birthweight: (grams) <input type="text"/> Apgar: 1 minute <input type="text"/> 5 minutes <input type="text"/> Time to established respiration: (mins.) <input type="text"/> Resuscitation - mechanical: None <input checked="" type="checkbox"/> ETT with air <input checked="" type="checkbox"/> Suction <input checked="" type="checkbox"/> ETT with O ₂ <input checked="" type="checkbox"/> O ₂ therapy <input checked="" type="checkbox"/> CPAP with air <input checked="" type="checkbox"/> IPPR with air <input checked="" type="checkbox"/> CPAP with O ₂ <input checked="" type="checkbox"/> IPPR with O ₂ <input checked="" type="checkbox"/> Cardiac massage <input checked="" type="checkbox"/> Other (specify) <input type="text"/> Resuscitation - drugs: (specify) <input type="text"/> Congenital anomalies: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N CVS / CNS / MS / GI / UG / Resp / Skin / Other Circle & Specify <input type="text"/> Paediatrician: <input type="text"/> Neonatal morbidity: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Specify <input type="text"/> Admitted: SCN <input checked="" type="checkbox"/> NICU <input checked="" type="checkbox"/> Hepatitis B vaccine received: ≤ 7 days <input checked="" type="checkbox"/> > 7 days <input checked="" type="checkbox"/> Not given <input checked="" type="checkbox"/> Breastfeeding attempted: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Formula given in hospital: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Last feed taken exclusively from breast: <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N	
THIS PREGNANCY Agreed due date: <input type="text"/> Estimated gest. age at 1st A/N visit: <input type="text"/> Maternal medical conditions: Pre-existing Diabetes Type 1 <input checked="" type="checkbox"/> Diabetes Type 2 <input checked="" type="checkbox"/> Circulatory <input checked="" type="checkbox"/> Hypertension <input checked="" type="checkbox"/> Renal (specify) <input checked="" type="checkbox"/> Psychosocial (specify) <input checked="" type="checkbox"/> Other (specify) <input type="text"/> Obstetric complications: Gestational diabetes Diet <input checked="" type="checkbox"/> Insulin <input checked="" type="checkbox"/> Pre-eclampsia <input checked="" type="checkbox"/> IUGR <input checked="" type="checkbox"/> GBS+ <input checked="" type="checkbox"/> Placenta praevia - with haemorrhage <input checked="" type="checkbox"/> - without haemorrhage <input checked="" type="checkbox"/> Placental abruption <input checked="" type="checkbox"/> Other APH <input checked="" type="checkbox"/> Other (specify) <input type="text"/> A/N care provider: Obstetrician <input checked="" type="checkbox"/> Midwife <input checked="" type="checkbox"/> GP <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/> Procedures and operations: Ultrasound 10 - 14 weeks (specify no.) <input type="text"/> Ultrasound 15 - 26 weeks (specify no.) <input type="text"/> Ultrasound ≥ 27 weeks (specify no.) <input type="text"/> Cervical suture <input checked="" type="checkbox"/> X IM Steroids (2 doses) <input checked="" type="checkbox"/> X ART (specify) <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Other (specify) <input type="text"/> Occasional data: ● <input type="text"/> ● <input type="text"/> ● <input type="text"/>		DISCHARGE Date of discharge from place of birth: Mother date <input type="text"/> 2,0 Baby date <input type="text"/> 2,0 Discharge status: Mother Baby Discharged <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X Died <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X Transferred to (specify) <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X Mother <input type="text"/> Baby <input type="text"/> Date <input type="text"/> 2,0			

Criteria for completing (Birth Report)

A Birth Report must be completed for every birth of at least 20 weeks gestation, or where gestation is unknown, where the birth weight is at least 400 grams (this includes termination of pregnancies of 20 weeks or more gestation).

For births in Victoria, the perinatal data collection contains information on obstetric conditions, procedures and outcomes, neonatal morbidity and congenital anomalies. The reports and publications of the VPDCU are based on births which meet the above criteria for the completion of a Birth Report.

For MIPPS (Midwives in Private Practice) it would be helpful if you could add your name in BLOCK letters after the word "Homebirth" in the section titled "Hospital". This assists in knowing where to forward the queries that may be generated from the form.

Criteria for completing (Form B)

To adhere to the VPDCU confidentiality policy, manual hospitals are required to send a list of the following information, on a separate form, which is known as the Form B:

- **UR number**
- **mothers' names**
- **full residential address of the mother.**

The list should contain all the women for which a Birth Report has also been completed and sent to VPDCU. The same UR number must be used on the Birth Report and Form B to identify the women.

For mothers who have had a *multiple birth*, for example twins, record the mother's name twice *or* clearly indicate twins next to the mother's name.

This *Form B* is sent in a *separate envelope* to the Birth Report, which has no names of the mothers or their babies entered on it.

Hospital labels may be used on the Form B but not on the Birth Report because they contain the mother's name.

The Birth Reports are matched up to the Form B's at the VPDCU.

Responsibility for completing

All data providers should use this manual when producing both the Birth Report and Form B. It is intended to be a reference for all public hospitals, private hospitals and private midwifery or medical practitioners who assist in the birth of babies regardless of setting.

The hospital where the birth took place is responsible for ensuring a Birth Report is completed for every birth and mailed to the VPDCU. If the birth occurs outside a hospital facility, such as babies born before arrival, the hospital where the mother and baby are transferred to are responsible for the completion of the Birth Report and Form B.

In situations where the birth occurs at a non-obstetric hospital and they are not aware of the responsibility of completing a Birth Report, the obstetric hospital where the mother and baby are transferred to should notify the VPDCU that such a transfer has occurred *or* should take responsibility for completing the Birth Report and provide the name of the non-obstetric hospital where the birth took place.

Note: A multiple birth requires a separate Birth Report to be completed for each baby with the same identifying maternal demographic information. Please make sure that the second twin's Birth Report is also transferred.

Important points for the completion of a Birth Report

Remember:

- Pre-coded conditions do not exclude other conditions from being reported and the 'other' prompt allows for these to be reported as text.
- Where the form indicates 'specify' or 'other', other appropriate data should appear as text.

Queries

The quality of the data collection depends on the accurate and consistent completion of the forms.

Queries relating to missing, contradictory or ambiguous data are directed to the hospital or independent practitioner for clarification. By reducing queries, the quality of the data is improved.

The VPDCU believes that the number of queries can be reduced by:

1. Building edit checks into the electronic system that alert the midwife that there are inconsistencies in the data before they are sent to the VPDCU.
2. Midwives learning from the feedback that the queries provide.
3. A 'learn by your mistake' approach. Queries are directed back to the staff member who completed the Birth Report.
4. Information and education sessions and visits from the VPDCU midwife. To organise such sessions please contact the VPDCU Research and Liaison Midwife.

A designated midwife should undertake the compilation of the responses to queries that may result from missing or incorrect data on the forms.

New or modified data items

New or modified data items have been highlighted throughout the document for easy reference.

Section 2: identifying information/demographics

Mother's name (Form B)

Definition The first, middle and surname of the mother

Valid response/s

- Mother's full name.

Reporting guide Hospital labels may be used.

Ensure that the Mother's name has been recorded not the baby's name and that no part of the name has been truncated.

Residential address (Form B)

Definition The residential address where the mother usually resides. Includes road number, name, type, suffix code, locality and postcode.

Valid response/s

- The full street address of the mother.

Reporting guide If the details are not available from the PAS and are not checked before being transmitted then a query will be generated.

Report the residential, not any postal address of the usual residence of the mother. Do not use Post Office Box numbers, (RSD, RMB) or any other purely postal address.

It is important that the spelling of the suburb/town, and postcode, is in accordance with Australia Post postcode booklet, for example:

Box Hill - not Boxhill
Parkville - not Park Ville

and not abbreviated, for example:

Kangaroo Flat - not Kang. Fl.
Ferntree Gully - not F.T. Gully
South Caulfield - not S. Caulfield

The Australian Post listing of postcodes and localities is available from:
www.auspost.com.au

If the mother has more than one usual residence, report the address and postcode of the residence in which she resides for the greater part of the year.

Postcode must be blank if postcode is 1000 (No fixed abode) or 9988 (Unknown).

Where the postcode is 8888 (overseas), report the country the patient lives in, in 'Postcode'.

These items enable the analysis of service utilisation and need for services by persons residing in statistical local areas (SLAs).

Mother UR number (patient identifier – mother) (Form B and Birth Report)

Definition An identifier, unique to the mother within the hospital or campus (patient's record number/unit record number)

Valid response/s

MOTHER	
Mother UR number:	<input type="text"/>
Admission date:	<input type="text" value="20"/>

- If the Mother UR Number is not stated, fill with 9s.

Reporting guide

The UR number is an identifier, unique to the mother within the hospital or campus (patient's report number/unit report number). In hospitals this will usually be either a six or seven digit number. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

Ensure that the UR number has been recorded, not the episode number.

For planned births occurring outside the hospital system enter the birth number or an equivalent number used to identify the mother.

Hospital name (Form B and Birth Report)

Definition The name or numeric code for the hospital responsible for completing the birth report.

Valid response/s

Hospital:

Reporting guide

For the numeric code, refer to the Hospital Code Table reference file available from:

<http://www.health.vic.gov.au/hdss/reffiles/2007-08/hct2007.xls>

Admission date - mother

Definition

Enter the date on which:

- the mother commences an episode of care for the birth of the baby, OR
- a homebirth practitioner attends to the mother either at the mother's home or at the practitioner's facilities.

Valid response/s

MOTHER	
Mother UR number:	<input type="text"/>
Admission date:	<input type="text"/> 20 <input type="text"/>

- If admission date is not stated, fill with 9s.

Reporting guide

Do not report any antenatal admission dates, however report any conditions that necessitated antenatal admissions before the admission for the current birth episode, under medical or obstetric complications.

If the mother is admitted four or more days prior to the birth taking place, report why the mother was admitted days before the birth of her baby either in Obstetric complications or Maternal medical conditions.

Examples of reason for early admission:

- pre-eclampsia
- threatened premature labour
- twins for rest
- cervical incompetence
- unstable gestational diabetes.

If the reason is not reported, the VPDCU will need to send a **query**.

The admission date is used to identify the period in which the admitted patient episode and stay occurred.

Suburb

Definition

The geographic location of the client's usual residence (Suburb/town for Australian residents, country for overseas residents) not the postal address.

Valid response/s

MOTHER	
Mother UR number:	<input type="text"/>
Admission date:	<input type="text"/> 20 <input type="text"/>
Suburb:.....	Postcode <input type="text"/>

The Australia Post listing of postcodes and suburbs is available from www.auspost.com.au

Reporting guide

Suburb 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 'Suburb'.

Postcode

Definition

Postcode or suburb in which the person usually resides (*not* postal address).

Valid response/s

MOTHER	
Mother UR number:	<input type="text"/>
Admission date:	<input type="text"/> 20 <input type="text"/>
Suburb:.....	Postcode <input type="text"/>

The Australia Post listing of postcodes and is available from www.auspost.com.au

- 1000 – No fixed abode
- 8888 – Overseas
- 9988 – Unknown
- 9999 – Not stated

Reporting guide

The hospital may collect the patient's postal address for its own purposes. However, for transmission to the VPDCU, the Postcode must represent the patient's *residential* address. Data processing will *reject* non-residential Postcodes (such as mail delivery centres).

Public or private patient

Definition

Whether the patient is admitted as a public or private patient.

Valid response/s

Public/Private Patient:	Country of Birth: (Mother)
Public <input checked="" type="checkbox"/> Private <input checked="" type="checkbox"/>	<input type="text"/>

Reporting guide

Homebirths under the care of an independent midwife or medical practitioner should be recorded as private.

TAC, DVA and WorkCover patients should be recorded as public.

Hospitals may be classified as public or private. This does not always reflect the private or public status of those who receive their services. For example, you can choose to be a private patient in a public hospital.

Country of birth

Definition

The country in which the mother was born

Valid response/s

Public/Private Patient:	Country of Birth: (Mother)
Public <input checked="" type="checkbox"/> Private <input checked="" type="checkbox"/>	<input type="text"/>

Reporting guide

Record the specific country of birth rather than a region. For example, Iran, Israel or Saudi Arabia rather than the Middle East. Indonesia, Philippines or Thailand rather than South East Asia.

Mother's country of birth is an important concept for the study of the need for and the provision of services. It is the most easily collected and consistently reported of possible ethnicity data items.

Indigenous status - baby

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 she lives.

There are three components to the definition: descent, self-identification, and community acceptance. In practice, it is not feasible to collect information on community acceptance, therefore the question of 'Indigenous Status' relates to self-identification and descent only.

Standard question

'Is your baby of Aboriginal or Torres Strait Islander Origin?'

The question should always be asked even if the person does not 'look' Aboriginal or Torres Strait Islander. Physical appearance is not a good indicator of Indigenous descent or identification.

Valid response/s

Indigenous Status (Mother): (circle one or more)	Aboriginal	<input type="checkbox"/>	TSI	<input type="checkbox"/>	No	<input type="checkbox"/>
(Baby): (circle one or more)	Aboriginal	<input type="checkbox"/>	TSI	<input type="checkbox"/>	No	<input type="checkbox"/>

Reporting guide

Circle **all** that apply.

If the baby is both Aboriginal and Torres Strait Islander circle both.

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.

The mother must be asked about the Indigenous origin of the baby independently of the mother's. If a mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, **do not** assume the baby is non-Indigenous; the father may be of Aboriginal or Torres Strait Islander descent.

Information should not be derived from the PAS as issues of under-identification of Indigenous Status in hospital collections may lead to inaccuracies in the Perinatal Data Collection.

Indigenous status - mother

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.

There are three components to the definition: descent, self-identification, and community acceptance. In practice, it is not feasible to collect information on community acceptance, therefore the question of 'Indigenous Status' relates to self-identification and descent only.

Standard question 'Are you of Aboriginal or Torres Strait Islander Origin?'

The question should always be asked even if the person does not 'look' Aboriginal or Torres Strait Islander. Physical appearance is not a good indicator of Indigenous descent or identification.

Valid response/s

Indigenous Status (Mother): (circle one or more)	Aboriginal	<input checked="" type="checkbox"/>	TSI	<input checked="" type="checkbox"/>	No	<input checked="" type="checkbox"/>
(Baby): (circle one or more)	Aboriginal	<input checked="" type="checkbox"/>	TSI	<input checked="" type="checkbox"/>	No	<input checked="" type="checkbox"/>

Reporting guide Circle **all** that apply.

If the mother is both Aboriginal and Torres Strait Islander circle both.

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.

Information should NOT be derived from the PAS as issues of under-identification of Indigenous Status in hospital collections may lead to inaccuracies in the Perinatal Data Collection.

Marital status

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.

Valid response/s

Marital Status (Mother):	Married	<input checked="" type="checkbox"/>			
Single	<input checked="" type="checkbox"/>	Widowed	<input checked="" type="checkbox"/>	Defacto	<input checked="" type="checkbox"/>
Divorced	<input checked="" type="checkbox"/>	Separated	<input checked="" type="checkbox"/>	Unknown	<input checked="" type="checkbox"/>
Birthdate (Mother):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Height (cm)	<input type="text"/>	<input type="text"/>	<input type="text"/>	Weight (kg)	<input type="text"/>

Reporting guide **Circle** the box (one box only) that corresponds to the marital status of the mother.

Birthdate - mother

Definition The date of birth of the person (Mother).

Valid response/s

Birthdate (Mother):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Height:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Weight:	<input type="text"/>	<input type="text"/>	<input type="text"/>
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- A valid date (ddmmyyyy).
- If not stated, fill with 9s.

Height

Definition A person's self-reported height, measured in centimetres at around the time of conception.

Valid response/s

Birthdate (Mother):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Height:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Weight:	<input type="text"/>	<input type="text"/>	<input type="text"/>
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- If not stated, record 999
- Valid range: 100-250, 999

Reporting guide

It is acceptable to report the measured height of the mother.

The weight and height assist in the calculation of the body mass index (BMI) and enable analysis of morbidity related to BMI.

Weight

Definition Mother's self-reported weight (body mass) around the time of conception.

Valid response/s

Birthdate (Mother):	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Height:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Weight:	<input type="text"/>	<input type="text"/>	<input type="text"/>
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- If unknown, record 888
- If not stated, record 999
- Valid range: 20-300, 888, 999

Reporting guide

Report the mother's self-reported weight (body mass) in kilograms around the time of conception.

Unknown:

Record 888 for late antenatal admission where the mother is unable to recall their weight around the time of conception.

Intended Place of Birth

Definition The intended place of birth at the onset of labour.

Valid response/s

Intended Place of Birth:		Actual Place of Birth:	
Hospital (<i>specify</i>).....	<input type="checkbox"/>	Hospital (<i>specify</i>).....	<input type="checkbox"/>
Birth Centre <input type="checkbox"/>	Home <input type="checkbox"/>	Birth Centre <input type="checkbox"/>	Home <input type="checkbox"/>
Other (<i>specify</i>).....	<input type="checkbox"/>	Other (<i>specify</i>).....	<input type="checkbox"/>

Reporting guide

Circle and specify if required the intended place of birth at the onset of labour.

Hospital (specify):

Record the name or numerical code of the hospital the mother intended to birth at.

Birth Centre:

Is a facility where women are able to birth in an environment that:

- is free-standing or physically separate from a labour ward but has access to emergency medical facilities for both mother and child if required; and
- has home-like atmosphere; and
- focuses on a model of care (for example, midwifery model) which ensures continuity of care/caregiver, a family-centred approach, and informed client participation in choices related to the management of care.

Home:

May be the mother's own home or where the baby is born in a home environment where 'home' may actually be that of a midwifery practitioner or any other person and attended by a midwifery practitioner.

Other – specify:

Includes community (health) centres, unplanned or unbooked. Ensure that the other intended place of birth is clearly specified in the space provided.

If intended and actual place of birth differ from each other provide when the change occurred in Change of intent and the reason for change in Reason for change.

This field is to monitor the models of care and to identify where there is a change of intent.

Actual Place of birth

Definition The actual place where the birth occurred.

Valid response/s

Intended Place of Birth:		Actual Place of Birth:	
Hospital (<i>specify</i>).....	<input type="checkbox"/>	Hospital (<i>specify</i>).....	<input type="checkbox"/>
Birth Centre <input type="checkbox"/>	Home <input type="checkbox"/>	Birth Centre <input type="checkbox"/>	Home <input type="checkbox"/>
Other (<i>specify</i>).....	<input type="checkbox"/>	Other (<i>specify</i>).....	<input type="checkbox"/>

Reporting guide

Circle and specify if required the actual place of birth.

Hospital (specify):

Record the name or numerical code of the hospital the mother where the mother birthed.

Birth Centre:

Is a facility where women are able to birth in an environment which:

- is free-standing or physically separate from a labour ward but has access to emergency medical facilities for both mother and child if required
- has home-like atmosphere
- focuses on a model of care (for example, midwifery model) which ensures continuity of care/caregiver' a family-centred approach' and informed client participation in choices related to the management of care.

Home:

May be the mother's own home or where the baby is born in a home environment where 'home' may actually be that of a midwifery practitioner or any other person and attended by a midwifery practitioner.

Other – specify:

Includes community (health) centres and in-transit. Ensure that the other actual place of birth is specified, for example, in the ambulance.

If intended and actual place of birth differ from each other provide when the change occurred in Change of intent and the reason for change in Reason for change.

This field is to monitor the models of care and to identify where there is a change of intent.

Setting of birth - change of intent

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.

Valid response/s

Intended Place of Birth:		Actual Place of Birth:	
Hospital (specify).....	<input checked="" type="checkbox"/>	Hospital (specify).....	<input checked="" type="checkbox"/>
Birth Centre <input checked="" type="checkbox"/>	Home <input checked="" type="checkbox"/>	Birth Centre <input checked="" type="checkbox"/>	Home <input checked="" type="checkbox"/>
Other (specify).....	<input checked="" type="checkbox"/>	Other (specify).....	<input checked="" type="checkbox"/>
If place of birth changes, specify if changed occurred:			
Before onset of labour	<input checked="" type="checkbox"/>	Or during labour	<input checked="" type="checkbox"/>

Reporting guide

If intended and actual place of birth differ from each other, circle whether the change occurred before the onset of labour, or during labour.

This field is to ascertain where a change has occurred in the intended model of care.

Scenarios

Data items involved

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

Scenario 1

If the woman is booked into a tertiary hospital, for example, 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** and the reason is **unintended**.

Scenario 2

If the woman is booked into a tertiary hospital, for example, 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** and the reason is **geographical**.

Reason for change

Definition Reason for change of intent between where the mother intended to give birth and where the actual birth took place.

Valid response/s

If place of birth changes, specify if change occurred:			
Before onset of labour	<input checked="" type="checkbox"/>	During labour	<input checked="" type="checkbox"/>
Reason for change:			
Recognition of higher risk	<input checked="" type="checkbox"/>	Unintended/unplanned	<input checked="" type="checkbox"/>
Complication of pregnancy	<input checked="" type="checkbox"/>	Not stated	<input checked="" type="checkbox"/>
Social or geographic	<input checked="" type="checkbox"/>	Other (specify).....	<input checked="" type="checkbox"/>

Reporting guide

For all episodes where the actual place of birth differs from the intended place of birth, **circle the reason** for change of intent between where the mother intended to give birth and where the actual birth took place.

Recognition of higher risk:

Includes conditions or circumstances that suggest that maternity care would be better provided in a higher-level facility.

Examples include:

- multiple pregnancy
- thrombophilia
- severe iso-immunisation.

Actual complication of pregnancy:

Includes complications that have already occurred.

Examples include:

- threatened preterm labour
- DVT
- IUGR.

The specific complication/s of pregnancy should be recorded in Obstetric Complications.

Social or geographic:

Includes change in health insurance or change in local maternity service availability.

Unintended/unplanned:

Includes those women in transit to booked hospital or on holidays.

Other (specify):

Record any other reasons in the space provided.

This field assists in determining why women give birth in places other than where they originally book and allows for better service planning.

Smoking < 20 weeks

Definition Cigarette smoking before 20 weeks gestation.

Valid response/s

Smoking <20 weeks:		Smoking ≥ 20 weeks:	
Non-smoker	<input checked="" type="checkbox"/>	Non-smoker	<input checked="" type="checkbox"/>
Quit	<input checked="" type="checkbox"/>	Smoked (<i>n/day</i>)	<input type="text"/>
Smoked	<input checked="" type="checkbox"/>	Occasional (<1/day)	<input checked="" type="checkbox"/>

Reporting guide

Circle the box that best describes maternal smoking behaviour before 20 weeks gestation.

Quit:

Describes the mother who ceased smoking on learning she was pregnant or has given it up prior to the 20 week gestation.

Smoking during pregnancy is associated with a number of adverse perinatal outcomes including pregnancy loss, low birth weight and preterm birth. Collecting data about maternal smoking will enable analysis of associations with perinatal outcomes and identification of groups of women in particular need of smoking cessation support.

Smoking ≥ 20 weeks

Definition Cigarette smoking at 20 or more weeks gestation.

Valid response/s

Smoking <20 weeks:		Smoking ≥ 20 weeks:	
Non-smoker	<input checked="" type="checkbox"/>	Non-smoker	<input checked="" type="checkbox"/>
Quit	<input checked="" type="checkbox"/>	Smoked (<i>n/day</i>)	<input type="text"/>
Smoked	<input checked="" type="checkbox"/>	Occasional (<1/day)	<input checked="" type="checkbox"/>

Reporting guide

Circle the box that best describes maternal smoking behaviour after 20 weeks gestation or indicate the number of cigarettes smoked per day.

Smoked (n/day)

Report the mother's stated average number of cigarettes smoked per day.

If she smokes tobacco, but not cigarettes, estimate the number of cigarettes that would approximate the amount of tobacco used, for example, in a pipe.

Smoking during pregnancy is associated with a number of adverse perinatal outcomes including pregnancy loss, low birth weight and preterm birth. Collecting data about maternal smoking will enable analysis of associations with perinatal outcomes and identification of groups of women in particular need of smoking cessation support.

Section 3: reproductive history

Gravidity

Definition

The total number of pregnancies including the current one.

Valid response/s

G:	<input type="text"/>	<input type="text"/>	P:	<input type="text"/>	<input type="text"/>
Total number: (Excluding this pregnancy)					
Livebirth	- (lived ≥ 28 days)			
	- (died < 28 days)			
Stillbirth				
Abortion	- spontaneous			
	- induced			
Ectopic				
Unknown				
Date of completion of last pregnancy: (mth/yr)					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Outcome of last pregnancy:					
Livebirth			Abortion		
- lived ≥28 days	<input checked="" type="checkbox"/>		- spontaneous	<input checked="" type="checkbox"/>	
- died <28 days	<input checked="" type="checkbox"/>		- induced	<input checked="" type="checkbox"/>	
Stillbirth	<input checked="" type="checkbox"/>		Ectopic	<input checked="" type="checkbox"/>	
Unknown	<input checked="" type="checkbox"/>				

- If not stated record 99
- Valid range: 01-30, 99

Reporting guide

Add the numbers of known pregnancies regardless of the gestation. That is, count all pregnancies that result in livebirths, stillbirths, and spontaneous or induced abortions.

Include the current pregnancy. If this is the first pregnancy, record 01.

Pregnancies of multiple babies should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy, even though it has two outcomes.

The number of previous pregnancies is an important component of the woman's reproductive history. Gravidity may be associated with adverse maternal and perinatal outcomes.

Parity

Definition

The total number of previous pregnancies experienced by the woman that have resulted in a livebirth or a stillbirth.

Valid response/s

G:	<input type="text"/>	P:	<input type="text"/>
Total number: (Excluding this pregnancy)			
Livebirth	- (lived ≥ 28 days)	<input type="text"/>	<input type="text"/>
	- (died < 28 days)	<input type="text"/>	<input type="text"/>
Stillbirth	<input type="text"/>	<input type="text"/>
Abortion	- spontaneous	<input type="text"/>	<input type="text"/>
	- induced	<input type="text"/>	<input type="text"/>
Ectopic	<input type="text"/>	<input type="text"/>
Unknown	<input type="text"/>	<input type="text"/>
Date of completion of last pregnancy: (mth/yr)		<input type="text"/>	<input type="text"/>
Outcome of last pregnancy:			
Livebirth	<input checked="" type="checkbox"/>	Abortion	<input checked="" type="checkbox"/>
- lived >28 days	<input checked="" type="checkbox"/>	- spontaneous	<input checked="" type="checkbox"/>
- died <28 days	<input checked="" type="checkbox"/>	- induced	<input checked="" type="checkbox"/>
Stillbirth	<input checked="" type="checkbox"/>	Ectopic	<input checked="" type="checkbox"/>
Unknown	<input checked="" type="checkbox"/>		

- If not stated record, 99.
- Valid range: 00-20, 99

Reporting guide

The number of known previous pregnancies that ended in births at 20 or more weeks gestation and/or 400 grams are reported in this field. That is, count all pregnancies that result in livebirths – survived 28 days, livebirths-neonatal death, and stillbirths. Exclude the current pregnancy. If this is the first pregnancy, record 00.

Pregnancies of multiple babies should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy, even though it has two outcomes.

A woman who is currently pregnant and has had a singleton birth and a set of twins is parity 2.

A woman who is currently pregnant and had one set of twins who both died at two days of age is parity 1.

The number of previous pregnancies that progressed to 20 or more weeks is an important component of the woman's reproductive history. Parity is associated with a number of adverse maternal and perinatal outcomes.

Total number of previous outcomes (excluding this pregnancy)

Definition

The total number of livebirths, neonatal deaths, stillbirths, spontaneous abortions, induced abortions, ectopic or unknown outcomes

Valid

response/s

G:	<input type="text"/>	<input type="text"/>	P:	<input type="text"/>	<input type="text"/>
Total number: (Excluding this pregnancy)					
Livebirth	- (lived ≥ 28 days)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	- (died < 28 days)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stillbirth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Abortion	- spontaneous	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	- induced	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ectopic	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Unknown	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of completion of last pregnancy: (mth/yr)					
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Outcome of last pregnancy:					
Livebirth		Abortion			
- lived ≥28 days	<input checked="" type="checkbox"/>	- spontaneous	<input checked="" type="checkbox"/>		
- died <28 days	<input checked="" type="checkbox"/>	- induced	<input checked="" type="checkbox"/>		
Stillbirth	<input checked="" type="checkbox"/>	Ectopic	<input checked="" type="checkbox"/>		
Unknown	<input checked="" type="checkbox"/>				

- If not stated record, 99
- Valid range: 00-20, 99
- If Gravity is 01 these fields can be left blank.

This field is to ascertain the number of previous specific outcomes for each baby of singleton or a multiple pregnancy.

Remember: a ***twin pregnancy*** is counted as ***one pregnancy*** but has ***two outcomes***, for example, two livebirths or one livebirth and one stillbirth.

The previous outcomes are captured in this section.

Livebirth:

The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered a livebirth.

Neonatal death:

A live born baby who dies within 28 days of the birth.

Stillbirth:

Any baby born who is at least 20 weeks gestation or if the gestation is unknown, weighs 400 grams or more, who did not, at any time after being born, breathe or show any other sign of life.

Abortion:

The removal or expulsion of the products of conception before 20 weeks gestation. An abortion can be ***spontaneous*** or ***induced***.

Ectopic pregnancy:

The implantation of the fertilised ovum outside the uterus, usually in the fallopian tube, rarely in the ovary or abdominal cavity. This covers the period from conception to 8-10 weeks gestation. After this time the embryo becomes a fetus. (Incidence ranges from 0.5% to 1% of all pregnancies).

Ref: Glossary of Health Care Terminology, James Hogarth, WHO Copenhagen page 215 Year 1975.

Date of completion of last pregnancy

Definition

Date on which the pregnancy preceding the current pregnancy was completed.

Valid response/s

G:	<input type="text"/>	<input type="text"/>	P:	<input type="text"/>	<input type="text"/>
Total number: (Excluding this pregnancy)					
Livebirth	- (lived ≥ 28 days)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	- (died < 28 days)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Stillbirth		<input type="text"/>	<input type="text"/>	<input type="text"/>
Abortion	- spontaneous	<input type="text"/>	<input type="text"/>	<input type="text"/>
	- induced	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ectopic		<input type="text"/>	<input type="text"/>	<input type="text"/>
Unknown		<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of completion of last pregnancy: (mth/yr)			<input type="text"/>	<input type="text"/>	<input type="text"/>
Outcome of last pregnancy:					
Livebirth			Abortion		
- lived >28 days	<input checked="" type="checkbox"/>		- spontaneous	<input checked="" type="checkbox"/>	
- died <28 days	<input checked="" type="checkbox"/>		- induced	<input checked="" type="checkbox"/>	
Stillbirth	<input checked="" type="checkbox"/>		Ectopic	<input checked="" type="checkbox"/>	
Unknown	<input checked="" type="checkbox"/>				

- A valid date (mmyyyy).
- If month is not stated record, 99yyyy
- If the month and year are not stated, fill with 9s.
- If Gravity is 01 this field can be left blank.

Reporting guide

The month and year of the pregnancy preceding the current pregnancy are captured in this field.

If the month is unknown, then 99 and the year is acceptable; for example, a woman remembers that the completion of her last pregnancy was in 2003, but cannot remember the month, record 992003.

If the month and year are unknown record 999999.

The interval between pregnancies may be an important risk factor for the outcome of the current pregnancy and can be used to assess trends in family planning.

Outcome of last pregnancy

Definition Outcome of the most recent pregnancy preceding the current pregnancy.

Valid response/s

G:	<input type="text"/>	P:	<input type="text"/>
Total number: (Excluding this pregnancy)			
Livebirth	- (lived ≥ 28 days)		<input type="text"/>
	- (died < 28 days)		<input type="text"/>
Stillbirth			<input type="text"/>
Abortion	- spontaneous		<input type="text"/>
	- induced		<input type="text"/>
Ectopic			<input type="text"/>
Unknown			<input type="text"/>
Date of completion of last pregnancy: (mth/yr)			
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Outcome of last pregnancy:			
Livebirth		Abortion	
- lived ≥28 days	<input checked="" type="checkbox"/>	- spontaneous	<input checked="" type="checkbox"/>
- died <28 days	<input checked="" type="checkbox"/>	- induced	<input checked="" type="checkbox"/>
Stillbirth	<input checked="" type="checkbox"/>	Ectopic	<input checked="" type="checkbox"/>
Unknown	<input checked="" type="checkbox"/>		

- If Gravidity is 01 this field can be left blank.

Reporting guide

This field asks about the outcome of **the last pregnancy**

In the case of multiple pregnancy with fetal loss before 20 weeks, code on the outcome of surviving fetus(s) beyond 20 weeks.

In multiple pregnancies with more than one type of outcome, the outcome should be recorded in the following order:

- neonatal death
- stillbirth
- livebirth.

Was last birth a caesarean section?

Definition Whether a caesarean section was performed for the woman's last previous birth.

Valid response/s

Was last birth a caesarean section?:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Total no. of previous caesarean sections:	<input type="text"/>	
Plan for VBAC: (if prev CS)	<input type="checkbox"/> Y	<input type="checkbox"/> N

- If Gravidity is 01 this field should be blank.

Reporting guide

Select whether the last **birth** (not pregnancy) was a caesarean section.

This field only relates to the last birth, not the last pregnancy, when the last pregnancy was an abortion or ectopic pregnancy.

This data helps to identify repeat caesareans or vaginal births (VBAC) after caesarean sections. This enables clinical analysis and health indicators to comply with ACHS and the Maternity Services Indicators.

Total number of previous caesarean sections

Definition Total number of previous pregnancies where the method of delivery was caesarean section.

Valid response/s

Was last birth a caesarean section?:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Total no. of previous caesarean sections:	<input type="text"/>	
Plan for VBAC: (if prev CS)	<input type="checkbox"/> Y	<input type="checkbox"/> N

- If not stated record, 99
- Valid range: 00-20, 99
- If Gravidity is 01 this field should be blank.

Reporting guide

This relates to **ALL births** including the last birth.

If the mother has had any previous births, then check and record 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 record 00.

For multiple births, if one baby is delivered via caesarean section and the other baby(s) via any other form of delivery (excluding caesarean), record this pregnancy as a previous caesarean.

Plan for vaginal birth after caesarean (VBAC)

Definition Where, at the time of admission to hospital for the birth, the woman hoped to have a vaginal birth after one or more previous caesarean sections.

Valid response/s

Was last birth a caesarean section?:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Total no. of previous caesarean sections:	<input type="text"/>	
Plan for VBAC: (if prev CS)	<input type="checkbox"/> Y	<input type="checkbox"/> N

- If Gravity is 01 this field should be blank.

Reporting guide

VBAC planned is only valid if Total number of previous caesarean sections is greater than 00.

The caesarean section rate has been steadily increasing over recent years and there are clinical and cost reasons driving a widespread interest in reversing or halting this trend. One of the two means of achieving this is enabling suitable women who have had one or more prior caesarean sections to give birth vaginally in subsequent births. Collecting this data enables surveillance of the frequency and outcomes of this strategy.

Scenario

Data items involved

- Vaginal birth after caesarean was planned
- Vaginal birth after caesarean was not planned
- Not stated

Scenario 1

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. The collection of data is to determine those women who are aiming to have a VBAC and are successful in achieving a vaginal birth.

Section 4: this pregnancy

Agreed due date

Definition The estimated date of confinement.

Valid response/s

Agreed due date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Estimated gest. age at 1st A/N visit:	<input type="text"/>	<input type="text"/>					

- A valid date (ddmmyyyy).
- If not stated, fill with 9s

Reporting guide

The 'Estimated date of confinement' 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.

This field aims to estimate gestational age, which is vital pregnancy information and an important risk factor for neonatal outcomes.

Estimated gestational age at first antenatal visit

Definition The number of completed weeks gestation at the time of the first antenatal visit (excluding a consultation for confirmation of pregnancy) as measured from the first day of the last normal menstrual period.

Valid response/s

Agreed due date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Estimated gest. age at 1st A/N visit:	<input type="text"/>	<input type="text"/>					

- If no antenatal care record, 88
- If not stated, record 99
- Valid range: 02-45, 88, 99

Reporting guide

Report the number of completed weeks gestation at the time of the first antenatal visit (excluding a consultation for confirmation of pregnancy) as measured from the first day of the last normal menstrual period.

The first antenatal visit is the first visit to a midwife or doctor arranged specifically for the purpose of providing maternity care. It excludes visits for confirmation of pregnancy, and medical visits for incidental problems while pregnant.

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.

Determination of gestational age at first antenatal visit is a marker of the quality and accessibility of antenatal care. Collection enables its associations with pregnancy outcomes to be analysed.

Maternal medical conditions

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.

Valid response/s

Maternal medical conditions:			
Pre-existing			
Diabetes Type 1	<input checked="" type="checkbox"/>	Diabetes Type 2	<input checked="" type="checkbox"/>
Circulatory	<input checked="" type="checkbox"/>	Hypertension	<input checked="" type="checkbox"/>
Renal (<i>specify</i>)	<input checked="" type="checkbox"/>	Psychosocial (<i>specify</i>)	<input checked="" type="checkbox"/>
Other (<i>specify</i>).....			
.....			

Reporting guide

This field includes conditions that affected the care or surveillance of this pregnancy.

The list of **pre-coded** conditions includes:

- pre-existing hypertension
- pre-existing diabetes mellitus, non-insulin treated
- pre-existing diabetes mellitus, insulin treated
- renal disease - specify
- psychosocial problems - specify
- diseases of the circulatory system – specify.

Further specificity relating to the pre-coded items, renal disease, psychosocial problems and circulatory disease is required to be recorded in the space provided.

Psychosocial problems:

Includes mental illnesses, violent relationships, and alcohol or drug misuse.

Transient conditions such as depression or urinary tract infection (UTI) that are completely resolved prior to this pregnancy should not be reported.

A few examples of maternal medical conditions that should be recorded in Other (specify) include:

- rheumatoid arthritis
- asthma
- deafness
- polycystic ovaries
- multiple sclerosis.

Do not include past operations such as appendicectomy, knee reconstruction and so forth, which do not affect or have not occurred during this pregnancy.

Some conditions may alter pregnancy outcomes requiring antenatal admission to hospital and/or treatment that could have adverse effects on the baby and perinatal morbidity.

Obstetric complications

Definition Complications arising during the period immediately ***preceding 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.

Valid response/s

Obstetric complications:			
Gestational diabetes	Diet <input checked="" type="checkbox"/>	Insulin	<input checked="" type="checkbox"/>
Pre-eclampsia <input checked="" type="checkbox"/>	IUGR <input checked="" type="checkbox"/>	GBS+	<input checked="" type="checkbox"/>
Placenta praevia - with haemorrhage			<input checked="" type="checkbox"/>
- without haemorrhage			<input checked="" type="checkbox"/>
Placental abruption <input checked="" type="checkbox"/>	Other APH		<input checked="" type="checkbox"/>
Other (<i>specify</i>).....			
.....			

This field includes conditions that affect the care or surveillance of this pregnancy.

The list of **pre-coded** conditions include:

- pre-eclampsia
- diabetes mellitus arising at or after 24 weeks gestation, diet controlled
- diabetes mellitus arising at or after 24 weeks gestation, insulin treated
- suspected fetal growth restriction (IUGR)
- placenta praevia without haemorrhage
- placenta praevia with haemorrhage
- premature separation of placenta (abruptio placentae)
- other antepartum haemorrhage (APH)
- carrier of streptococcus group b (GBS+).

Pre-eclampsia:

A serious disorder of human pregnancy that carries a severe morbidity and mortality risk for both mother and child.

About one in ten pregnancies is complicated by hypertension: about 3–4 per cent have pre-eclampsia, a similar proportion have gestational hypertension and 1–2 per cent have pre-existing chronic hypertension. (MJA 2003; 179 (4): 182-184)

Gestational diabetes mellitus:

The manifestation of diabetes mellitus during pregnancy that resolves post birth.

Placenta praevia:

Where the placenta is located over or very near to the cervical os which may result in haemorrhage.

Antepartum haemorrhage (APH):

Bleeding of 15 ml or more from the birth canal **after 20 weeks gestation** and before the birth of the baby.

Intrauterine growth restriction (IUGR):

A birth-weight below the 10th percentile according to gestational age for infants born in the community concerned. It is verified with an Ultrasound confirming evidence of asymmetrical growth +/- oligohydramnious or abnormal umbilical artery Doppler flow study.

Group beta haemolytic streptococcus positive (GBS+):

GBS+ is present in the vaginal and rectal flora of approximately 25 per cent (one in four) pregnant women. For most women there are no symptoms of carrying GBS bacteria.

Pre-coded conditions do not exclude other obstetric complications from being reported.

A few examples of obstetric complications that should be recorded in Other (specify) include:

- threatened abortion
- pregnancy induced hypertension
- haemorrhoids
- hyperemesis.

Antenatal care provider

Definition The discipline of the clinician who **provided most occasions of antenatal care**.

Valid response/s

A/N care provider:			
Obstetrician	<input checked="" type="checkbox"/>	Midwife	<input checked="" type="checkbox"/>
GP	<input checked="" type="checkbox"/>	None	<input checked="" type="checkbox"/>

Reporting guide

Circle the discipline of the clinician who provided most occasions of antenatal care.

Obstetrician:

Includes public and private obstetric care together with care provided by medical staff in hospitals under the supervision of an obstetrician.

Midwife:

Includes public and private midwifery care including care provided by midwife-led units and caseload midwives in hospitals with limited medical input.

General practitioner:

Includes public and private care by general practitioners (including those with a diploma of obstetrics) including care provided by medical staff in hospitals under the supervision of a general practitioner.

Pregnancy outcomes are analysed according to the discipline of antenatal care providers.

Scenarios

Data item involved

Antenatal care provider

Scenario 1

Where a woman sees her GP for most of her care and has 30/40 and 36/40 specialist visits because her baby will be born at the specialist hospital, then the GP is the **antenatal care provider** as he/she has provided the most occasions of care.

Scenario 2

Where a woman sees a midwife in an obstetricians' surgery for most of her care and has visits with the obstetrician at 30/40 and 36/40 and is booked into a private hospital then the discipline of the antenatal care provider is the **obstetrician**.

Ultrasounds

Definition

The total number of ultrasounds between 10 and 14 weeks gestation.
 The total number of ultrasounds between 15 and 26 weeks gestation
 The total number of ultrasounds \geq 27 weeks gestation

Valid response/s

Procedures and operations:	
Ultrasound 10 - 14 weeks (specify no.)	<input type="text"/>
Ultrasound 15 - 26 weeks (specify no.)	<input type="text"/>
Ultrasound \geq 27 weeks (specify no.)	<input type="text"/>
Cervical suture	<input checked="" type="checkbox"/>
IM Steroids (2 doses).....	<input checked="" type="checkbox"/>
ART (specify).....	<input type="checkbox"/> Y <input type="checkbox"/> N
Other (specify).....	<input type="text"/>

- If none, record 00
- If not stated record, 99
- Valid range: 00-20, 99

Reporting guide

Ultrasounds 10-14 Weeks (specify no.):

Record the number of ultrasounds performed between 10-14 weeks gestation. These are used primarily for assessing gestation, and also for first trimester screening for Down Syndrome and other congenital anomalies. They may contribute to a change in the management of the pregnancy.

Ultrasounds 15-26 Weeks (specify no.):

Record the number of ultrasounds performed at 15-26 weeks gestation. Many fetal structural anomalies can be detected by ultrasound and routine screening is recommended (15-26 weeks).

Ultrasounds \geq 27 Weeks (specify no.):

Record the number of ultrasounds performed \geq 27 weeks gestations. This data determines management of compromised pregnancies.

Artificial reproductive technology - indicator

Definition Whether artificial reproductive technology (ART) was used to assist this current pregnancy.

Valid response/s

Procedures and operations:	
Ultrasound 10 - 14 weeks (specify no.)	<input type="checkbox"/>
Ultrasound 15 - 26 weeks (specify no.)	<input type="checkbox"/>
Ultrasound ≥ 27 weeks (specify no.)	<input type="checkbox"/>
Cervical suture	<input checked="" type="checkbox"/>
IM Steroids (2 doses).....	<input checked="" type="checkbox"/>
ART (specify).....	<input type="checkbox"/> Y <input type="checkbox"/> N
Other (specify).....	

Reporting guide

Circle whether Artificial Reproductive Technology (ART) was used to assist this current pregnancy. Report the type of ART used in the space provided. Examples of ART are outlined below.

Type and definitions of ART:

Ovulation induction:

Ovulation is induced by pharmacological therapy such as clomid.

In vitro fertilisation (IVF):

Co-incubation of a sperm and an oocyte outside the body of a woman.

Intracytoplasmic sperm injection (ICSI):

Involves the injection under laboratory conditions of a single sperm into each egg. The egg is fertilised in vitro and then transferred to the body of a woman.

Donor insemination (GIFT):

Artificial insemination using donor sperm.

Artificial insemination (AIH/AID):

Uses the husband's sperm or male partner's sperm or donor sperm.

Others types of ART may include;

- assisted hatching
- blastocyst culture.

Record these in Procedures and operations – free text.

A query will be generated if this field is left blank as 'no' ART cannot be assumed.

Outcomes of pregnancies resulting from ART e.g. gestation, perinatal mortality, plurality, birth weight and congenital anomalies are analysed using this data.

Procedures and operations

Definition

The interventions used for the diagnostic and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium.

Valid

response/s

Procedures and operations:	
Ultrasound 10 - 14 weeks (<i>specify no.</i>)	<input type="checkbox"/>
Ultrasound 15 - 26 weeks (<i>specify no.</i>)	<input type="checkbox"/>
Ultrasound \geq 27 weeks (<i>specify no.</i>)	<input type="checkbox"/>
Cervical suture	<input checked="" type="checkbox"/>
IM Steroids (2 doses).....	<input checked="" type="checkbox"/>
ART (<i>specify</i>).....	<input type="checkbox"/> Y <input type="checkbox"/> N
Other (<i>specify</i>).....	

This field collects data on the types of interventions which may impact on the pregnancy or birth as well as monitoring complications/morbidity.

The list of **precoded** conditions include;

- Cervical suture for cervical shortening
- Intramuscular administration of 2 doses of steroids antenatally

Cervical suture for cervical shortening:

This suture is the insertion of a purse/string suture into the cervix between 14 and 18 weeks gestation to prolong the pregnancy. This reduces pressure of the presenting part on the cervix which in turn reduces the irritability of the uterus due to the relaxation of the smooth muscle

Intramuscular administration of 2 doses of steroids antenatally:

Report antenatal steroids only if **2 doses** were given **24 hours apart** at **<34 weeks gestation**.

Other (specify)

Select all interventions used for the diagnostic and/or treatment of the mother during the current pregnancy, the labour, birth and the puerperium.

If a procedure and/or operation was performed other than those listed record this in the space provided.

For example; cholecystectomy, which may be open or via laparoscope, report as either open cholecystectomy or laparoscopic cholecystectomy.

Procedures that **do not need** to be reported in this field include:

- anaesthesia or analgesia relating to the birth
- augmentation or induction agents
- caesarean section, forceps or vacuum extraction
- suture/repair of tears
- blood product transfusion
- allied health procedures.

Examples of **included** procedures and operations are:

- colposcopy
- X-ray pelvimetry
- maternal serum screening (MSST) for Down syndrome or neural tube defect
- chorionic villous sampling
- amniocentesis
- ligation of vessels for twin-to-twin transfusion
- amnioscopy
- CAT scan
- cholecystectomy
- external cephalic version (ECV)
- curette (D and C) post partum
- evacuation of vulval haematoma
- hysterectomy
- tubal ligation.

Occasional data

Definition

This section allows for data to be collected for periodic research projects.

*Valid
response/s*

Occasional data:										
●	<table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>									
●										
●										

Section 5: labour, birth and postnatal

Date and time of onset of labour

Definition The date and time of onset of labour.

Valid response/s

Onset labour:	Date	Time
	2,0	
Onset 2nd stage:	Date	Time
	2,0	
Rupture of membranes:	Date	Time
	2,0	

- A valid date (ddmmyyyy)
- A valid time (hhmm)
- 0000 and 2400 are not valid.
- If date and/or time are not stated, fill with 9s.
- If no labour occurred, fill date and time with 8s.

Reporting guide

Labour begins with the onset of regular uterine contractions and is complete when the cervix is fully dilated (10cm).

If the mother has a **caesarean section** and no labour occurred fill both date and time with 8s.

Report hours and minutes using a 24-hour clock.

This field computes length of labour and is used in analysis of morbidity, for example neonatal conditions, haemorrhage and operative birth.

Date and time of onset of second stage of labour

Definition

The date and time of the start of the Second Stage of labour.

Valid response/s

Onset labour:		Date	Time
		2,0	
Onset 2nd stage:		Date	Time
		2,0	
Rupture of membranes:		Date	Time
		2,0	

- A valid date (ddmmyyyy)
- A valid time (hhmm)
- 0000 and 2400 are not valid.
- If date and/or time are not stated, fill with 9s.
- If no second stage of labour occurred, fill date and time with 8s.

Reporting guide

Begins when the cervix is fully dilated (10cm) and is complete with the birth of the baby.

If the mother has a **caesarean section** and no second stage of labour occurred, fill both date and time with 8s or write no second stage.

Report hours and minutes using a 24-hour clock.

This field computes length of labour and is used in analysis of morbidity, for example neonatal conditions, haemorrhage and operative birth.

Date and time of rupture of membranes

Definition

The date and time on which the mother's membranes ruptured (spontaneously or artificially).

Valid response/s

Onset labour:	Date	Time
	2,0	
Onset 2nd stage:	Date	Time
	2,0	
Rupture of membranes:	Date	Time
	2,0	

- A valid date (ddmmyyyy)
- A valid time (hhmm)
- 0000 and 2400 are not valid.
- If date and/or time are not stated, fill with 9s.
- If membranes were ruptured at caesarean, fill date and time with 8s.

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.

If membranes were ruptured at *caesarean section* fill both date and time with 8s.

Report hours and minutes using a 24-hour clock.

This field computes length of labour and is used in analysis of morbidity, for example neonatal conditions, haemorrhage and operative birth.

Labour type

Definition

The manner in which labour starts in a birth event.

Valid response/s

Labour:			
Spontaneous	<input checked="" type="checkbox"/>	Augmented	<input checked="" type="checkbox"/>
Induced – medical	<input checked="" type="checkbox"/>	No labour	<input checked="" type="checkbox"/>
surgical	<input checked="" type="checkbox"/>		
If labour induced or augmented: (circle one or more)			
Oxytocin	<input checked="" type="checkbox"/>	ARM	<input checked="" type="checkbox"/>
Prostaglandins	<input checked="" type="checkbox"/>	Other (specify)	<input checked="" type="checkbox"/>
.....			
Specify indication for induction:			
.....			

Reporting guide

Circle **all** that apply.

Spontaneous:

Labour occurs naturally without any intervention

Induction of labour:

Is a procedure performed for the purpose of initiating and establishing labour either medically and /or surgically

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 either by hindwater or forewater rupture (ARM).

If labour was augmented select and record both spontaneous and augmented in Labour Type.

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.

A combination of **three** valid labour types can be used.

If an induction has occurred record the reason in Indication of induction.

If labour induced or augmented

Definition Agents used to induce or assist in the progress of labour.

Valid response/s

Labour:			
Spontaneous	<input checked="" type="checkbox"/>	Augmented	<input checked="" type="checkbox"/>
Induced – medical	<input checked="" type="checkbox"/>	No labour	<input checked="" type="checkbox"/>
surgical	<input checked="" type="checkbox"/>		
If labour induced or augmented: (circle one or more)			
Oxytocin	<input checked="" type="checkbox"/>	ARM	<input checked="" type="checkbox"/>
Prostaglandins	<input checked="" type="checkbox"/>	Other (specify)	<input checked="" type="checkbox"/>
Specify indication for induction:			

Reporting guide

Circle **all** that apply.

Oxytocin:

Stimulates the uterus to contract and should not be administered unless the membranes are ruptured.

Prostaglandins:

Naturally occurring substances in semen, decidua and many other body tissues. The E1, E8 and F2 compounds stimulate the uterine muscle activity and also cause oxytocin release from the posterior pituitary. Prostaglandin E2 gel is widely used for induction of labour in post date pregnancies. Misoprostol (Cytotec) is a prostaglandin E1 analogue widely used for off label indications such as induction of termination of pregnancy and FDIU.

Ref: Obstetrics and the Newborn third edition N.A.Beisher, E.V. Makay, P.B.Colditz, p10 and p456

If other is recorded specify the type of agent in the space provided, for example Foley's catheter.

The following table outlines what should be recorded in If labour induced or augmented, when one of the following labour types is recorded.

Labour type	If labour induced or augmented
Induced – medical	Oxytocin and/or Prostaglandin
Induced – surgical	ARM
Induced – medical and surgical	Oxytocin and/or Prostaglandin and ARM
Spontaneous and augmented	Oxytocin and/or ARM

Specify indication for induction

Definition

The primary reason given for an induction of labour.

Valid response/s

Labour:			
Spontaneous	<input checked="" type="checkbox"/>	Augmented	<input checked="" type="checkbox"/>
Induced – medical	<input checked="" type="checkbox"/>	No labour	<input checked="" type="checkbox"/>
surgical	<input checked="" type="checkbox"/>		
If labour induced or augmented: (circle one or more)			
Oxytocin	<input checked="" type="checkbox"/>	ARM	<input checked="" type="checkbox"/>
Prostaglandins	<input checked="" type="checkbox"/>	Other (specify)	<input checked="" type="checkbox"/>
Specify indication for induction:			

Reporting guide

If labour was induced, specify the reason for induction.

Examples of reason for induction include:

- pre-labour ruptured membranes (PROM)
- postdates ≥ 41 completed weeks
- oligohydramnios
- suspected fetal compromise.

Conditions that pertain to labour, for example failure to progress, are not valid reasons for induction.

Augmentation is not a valid reason for induction as augmentation is any medical or surgical intervention that assists with the continuation of a labour that has had a spontaneous or induced onset.

All indications for induction should also be recorded in Obstetric complications **except** for the following;

- postdates < 41 completed weeks
- postdates ≥ 41 completed weeks
- spurious labour
- social, Dr preference or no medical indication.

Scenario

Data items involved

Labour type, labour induction/augmentation agent and indication for induction

Scenario 1

Where the woman is induced for post dates with an **ARM** but requires a syntocinon infusion in the latter part of the labour or in second stage this management is still considered to be part of the induction. There is occasional confusion that this is augmentation, however syntocinon would only be considered as augmentation if the labour was **spontaneous**.

Fetal monitoring in labour

Definition Methods used to monitor the well being of the fetus during labour.

Valid response/s

Fetal monitoring in labour: (circle one or more)			
Intermittent Ausc	<input checked="" type="checkbox"/>	Internal CTG	<input checked="" type="checkbox"/>
Admission CTG	<input checked="" type="checkbox"/>	Fetal blood sampling	<input checked="" type="checkbox"/>
Intermittent CTG	<input checked="" type="checkbox"/>	None	<input checked="" type="checkbox"/>
Cont. external CTG	<input checked="" type="checkbox"/>		

Reporting guide Circle **all** methods used to monitor the well being of the baby during labour.

Admission cardiotocography:

A routine cardiotocography (CTG) of limited duration (for example, 30 minutes) on admission

Intermittent cardiotocography:

Fetal heart monitoring by CTG on a number of occasions in labour, but not continuously.

Continuous cardiotocography:

Fetal heart monitoring by CTG more or less continuously from some point in labour until around the time of birth.

It is assumed that all women who birth at a hospital will have intermittent auscultation. This may be performed by using Pinards, or Sonicaid.

Collection of this item enables reporting of the appropriateness of fetal monitoring in various circumstances, its associations with pregnancy outcomes, and management of labour and birth.

Birth presentation

Definition Presenting part of the fetus (at the cervix) at birth.

Valid response/s

Presentation:					
Vertex	<input checked="" type="checkbox"/>	Brow	<input checked="" type="checkbox"/>	Shoulder	<input checked="" type="checkbox"/>
Breech	<input checked="" type="checkbox"/>	Compound	<input checked="" type="checkbox"/>	Unknown	<input checked="" type="checkbox"/>
Face	<input checked="" type="checkbox"/>	Cord	<input checked="" type="checkbox"/>	Other (<i>specify</i>)	<input checked="" type="checkbox"/>

Reporting guide

Breech:

Includes breech with extended legs, breech with flexed legs, footling and knee presentations.

Compound:

Refers to more than one presenting part. 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.

Ref: Obstetrics and the Newborn third edition N.A.Beisher, E.V. Makay, P.B.Colditz, p451 and 452.1986

This does not include hand beside the face. A compound presentation would be the hand appearing before the vertex.

Other – specify:

Further information regarding what other refers to, should be recorded in the space provided.

For a multiple pregnancy with differing presentations, record the presentation of the fetus for which the Birth Report is being completed.

Method of birth

Definition The method of complete expulsion or extraction from its mother of a product of conception in a birth event.

Valid response/s

Method of birth:		
Unassisted vaginal <input checked="" type="checkbox"/>	Forceps <input checked="" type="checkbox"/>	Vacuum <input checked="" type="checkbox"/>
Planned C/S - No labour <input checked="" type="checkbox"/>	Labour <input checked="" type="checkbox"/>	
Unplanned C/S - No labour <input checked="" type="checkbox"/>	Labour <input checked="" type="checkbox"/>	

Reporting guide

Forceps:
Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the after coming head for breech presentations.

Planned caesarean – no labour:
Procedure takes place as a planned procedure, before the onset of labour.

Unplanned caesarean – labour:
Procedure is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced.

Planned caesarean – labour:
Procedure was a planned procedure, but occurs after spontaneous onset of labour.

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 CS, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) which becomes the immediate indication for the caesarean, record as unplanned, either in labour or not in labour as appropriate.

For a multiple pregnancy with differing methods of birth, record the method of birth of the fetus for which the Birth Report is being completed.

Scenario

Data item involved

The method of birth.

Scenario 1

If a women is planning to have a caesarean for a non-urgent indication (for example, repeat CS, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) which becomes the immediate indication for the caesarean, record as unplanned, either in labour or not in labour as appropriate.

For a multiple pregnancy with differing methods of birth, record the method of birth of the fetus for which the Birth Report is being completed.

Indications for operative birth

Definition The reason(s) given for an operative birth.

Valid response/s

Indications for operative birth:

Reporting guide

A reason must be recorded for all births where the method of birth is via forceps, vacuum or caesarean section.

Record up to **four** reasons for operative birth, from the most to least influential in making the decision.

These may include:

- delayed second stage
- abnormal CTG
- maternal exhaustion
- cardiac condition – cardiomyopathy, mitral stenosis.

Where a caesarean occurs as a result of a failed forceps or vacuum, then the indication for operative delivery should be failed forceps/vacuum as well as the original indication for the forceps or vacuum (for example, prolonged second stage).

This field monitors the trends in operative birth in planned or unplanned caesarean sections, forceps or vacuum extraction (Ventouse) deliveries.

Scenario

Data items involved

Labour type, method of birth and indication for operative birth

Scenario 1

Failed induction of labour

There has been some confusion about the definition of '**failed induction of labour**'. We ask that you report this when there has been an attempt to induce labour (including the use of prostaglandin gel), but the woman does not establish into labour.

In this situation there would have been no analgesia during labour (because there was no established labour), although analgesia might have been given for other pain, for example, abruption, back pain.

Any caesarean in these circumstances would be an unplanned one before labour. It seems that a few midwives report '**failed induction of labour**' when labour has been successfully established, but '**failure to progress**' leads to caesarean section.

Perhaps the thinking is along the lines that induction of labour is intended to result in vaginal birth, so if the birth is not vaginal, the induction has 'failed'. However the focus is in fact on inducing **labour (not inducing vaginal birth)**. Please contact the liaison midwife if you have any questions about this, or you think there is a situation that should be an exception.

Analgesia for labour - indicator

Definition Whether analgesia was administered to the woman to relieve pain during labour.

Valid response/s

Analgesia for labour: (specify)	<input type="checkbox"/> Y	<input type="checkbox"/> N
---	----------------------------	----------------------------

Reporting guide

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.

If analgesia is administered specify the type/s used.

Analgesia for labour - type

Definition The type of analgesia administered to the woman to relieve pain during labour.

Valid response/s

Analgesia for labour: (specify)	<input type="checkbox"/> Y	<input type="checkbox"/> N
---	----------------------------	----------------------------

- Nitrous oxide
- Systemic opioids
- Epidural or caudal
- Spinal
- Combined spinal – epidural
- TENS
- Sterile water injections

Reporting guide

If analgesia was received specify the agents used.

Analgesia will usually be administered by injection or inhalation.

This item is to be reported 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.

Combined spinal-epidural:

Combined spinal-epidural analgesia (CSE) most commonly involves insertion of an epidural needle into the lumbar epidural space, passage of the tip of a spinal needle through this epidural 'introducer', spinal injection, and withdrawal of the needle, and then the insertion of an epidural catheter through the epidural needle for use after the spinal analgesia wanes.

Anaesthesiology: Volume 91(1) July 1999 pp 299-302

A combination of up to **four** types of analgesia can be recorded.

This data monitors the effect of analgesia use: it may influence the duration of labour, in addition to affecting the health status of the baby at birth and is an indicator of obstetric intervention.

Anaesthesia for operative birth - indicator

Definition Whether anaesthesia was administered to the woman for, or associated with, the operative birth of the baby (forceps, vacuum/ventouse or caesarean section).

Valid response/s

Anaesthesia for operative delivery:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specify	[REDACTED]	

Reporting guide Operative delivery includes caesarean section, forceps and vacuum/ventouse extraction.

If anaesthesia is administered specify the type/s used.

Anaesthesia for operative birth - type

Definition The type of anaesthesia administered to the woman for, or associated with, the operative birth of the baby (forceps, vacuum/ventouse or caesarean section).

Valid response/s

Anaesthesia for operative delivery:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specify	[REDACTED]	

- Local anaesthetic to perineum
- Pudendal
- Epidural or caudal
- Spinal
- Combined spinal – epidural

Reporting guide If anaesthesia was used for an operative delivery specify the agents used. Operative delivery includes caesarean section, forceps and vacuum/ventouse extraction.

Combined spinal-epidural:

Combined spinal-epidural analgesia (CSE) most commonly involves insertion of an epidural needle into the lumbar epidural space, passage of the tip of a spinal needle through this epidural 'introducer', spinal injection, and withdrawal of the needle, and then the insertion of an epidural catheter through the epidural needle for use after the spinal analgesia wanes.

Anaesthesiology: Volume 91(1) July 1999 pp 299-302

A combination of up to **four** types of anaesthesia can be recorded.

This field monitors obstetric intervention and the effect anaesthetic use may have on the health status of the baby and/or mother.

Complications/events of labour and birth

Definition Medical and obstetric complications arising *after the onset of labour* and before the completed delivery of the baby and placenta, as represented by a code.

Valid response/s

Complications/events of labour and birth:					
Antibiotics	<input checked="" type="checkbox"/>	Shoulder dystocia	<input checked="" type="checkbox"/>	Water birth	<input checked="" type="checkbox"/>
Specify.....					
.....					
.....					
.....					

Reporting guide

This field includes complications/events that occur during labour and birth including preparation for caesarean section, that may cause ongoing maternal morbidity and affect the health status of the baby at birth.

The list of *pre-coded* conditions include;

- antibiotic therapy in labour
- shoulder dystocia
- water birth.

Antibiotic therapy in labour:

The mother received one or more doses of either prophylactic or therapeutic antibiotics during labour and birth.

Shoulder dystocia:

Present when there is obstruction to the passage of the shoulders through the bony pelvis (wedged behind the pubic bone), the head having already been born and the chin burrows into the perineum (turtle sign)

Ref: Obstetrics and the Newborn third edition N.A.Beisher, E.V. Makay, P.B.Colditz, 1986, p459.

True shoulder dystocia has also been defined as any birth in which external and internal manoeuvres in addition to lateral traction and episiotomy are required to birth the shoulders

Water birth: Is an event

The baby is born under/through water.

Pre-coded conditions do not exclude other complications/event of labour and birth from being reported.

A few examples of complications/events of labour and birth that should be recorded in the space provided include:

- cord presentation
- intrapartum haemorrhage
- meconium liquor.

Complications an events often influence the course, management and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the mother, the baby and perinatal morbidity.

Lead intrapartum care provider

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.

Valid response/s

Lead intrapartum care provider:			
Obstetrician	<input checked="" type="checkbox"/>	Midwife	<input checked="" type="checkbox"/>
GP	<input checked="" type="checkbox"/>	None	<input checked="" type="checkbox"/>

Reporting guide

Circle 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 e.g rapid, uncomplicated labour. Please note, this may change during labor with transfer from midwifery to GP/Obstetric care, or from GP to Obstetrician care

It is recognised that midwives provide the majority of intrapartum care regardless of the model of care.

Obstetrician:

Includes public and private obstetric care together with care provided by medical staff in hospitals under the supervision of an obstetrician.

Midwife:

Includes public and private midwifery care including care provided by midwife-led units and caseload midwives in hospitals with limited medical input.

General practitioner:

Includes public and private care by general practitioners (including those with a diploma of obstetrics) including care provided by medical staff in hospitals under the supervision of a general practitioner.

Scenarios

Data item involved

Discipline of lead intrapartum care provider

Scenario 1

In the private setting, the lead intrapartum care provider will always be the obstetrician or the GP.

Scenario 2

When a woman in labour is admitted under one of the models below, record 'midwife' as the lead intrapartum care provider even if she later transfers to medical care.

Midwifery models include:

- midwives clinic*
- team midwifery*
- caseload*
- know your midwife.*

Prophylactic oxytocic third stage

Definition Whether an oxytocic was given prophylactically in the third stage of labour.

Valid response/s

Prophylactic oxytocic 3rd stage:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Manual removal of placenta: (excl c/s)	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

The rate of postpartum haemorrhage varies between institutions. The extent of use of prophylactic oxytocics also varies. Collection of this item allows analysis and reporting of the association between routine use of oxytocics and postpartum haemorrhage, as well as the inter-hospital variation in practice.

Oxytocic given prophylactically:

Record when an oxytocic is used in order to *prevent* heavy blood loss, for example, with the birth of the anterior shoulder, or very soon after the birth.

Oxytocic not given prophylactically:

Record if no oxytocic was given on a routine prophylactic basis. This includes cases where a decision was made to administer an oxytocic only after heavy blood loss was observed.

Manual removal of placenta

Definition Whether the placenta was manually removed.

Valid response/s

Prophylactic oxytocic 3rd stage:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Manual removal of placenta: (excl c/s)	<input type="checkbox"/> Y	<input type="checkbox"/> N

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.

Manual removal of the placenta is an invasive procedure that is associated with an increased risk of infection and other maternal morbidity. Collection enables surveillance and analysis of morbidity.

This field should be left blank if Method of birth is via caesarean section.

Episiotomy

Definition

Whether an incision of the perineum and vagina was made.

Valid response/s

Perineal status: Episiotomy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Laceration:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Degree/type: (specify).....		
Repaired:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

For episiotomies extended by laceration or laceration extended by episiotomy circle Y for the following:

- episiotomy
- perineal laceration
- repaired.

Specify the degree or type of tear in Degree/type: (specify).

Perineal laceration

Definition

The state of the perineum following birth.

Valid response/s

Perineal status: Episiotomy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Laceration:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Degree/type: (specify).....		
Repaired:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

Only refers to lacerations of the perineum which does not include vaginal wall, labial or clitoral lacerations.

The degree of the laceration should be reported in Degree/type: (specify).

If a **laceration occurs which does not involve the perineum**, N should be circled and the type of laceration recorded in Degree/type: (specify).

For episiotomies extended by laceration or laceration extended by episiotomy circle Y for the following;

- episiotomy
- perineal laceration
- repaired.

Specify the degree or type of tear in Degree/type: (specify).

Perineal/genital laceration – degree/type

Definition The degree or type of laceration to the perineum and/or genital tract following birth.

Valid response/s

Perineal status: Episiotomy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Laceration:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Degree/type: (specify).....	[REDACTED]	
Repaired:	<input type="checkbox"/> Y	<input type="checkbox"/> N

- 1st
- 2nd
- 3rd
- 4th
- Labial/clitoral
- Vaginal wall

Reporting guide

Record the degree or type of laceration to the perineum and/or genital tract whether or not it is repaired

If a **laceration occurs which does not involve the perineum**, N should be circled for Laceration and the type of laceration recorded in Degree/type: (specify).

Up to **two** valid degree/types can be recorded.

For episiotomies extended by laceration or laceration extended by episiotomy circle Y for the following:

- episiotomy
- perineal laceration
- repaired.

Specify the degree or type of tear in Degree/type: (specify).

Perineal laceration – repair

Definition Whether a repair to a laceration or incision to the perineum during birth was undertaken.

Valid response/s

Perineal status: Episiotomy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Laceration:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Degree/type: (specify).....	[REDACTED]	
Repaired:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

Record the suturing of any injury to the perineum. Include repair to perineal and/or episiotomy.

For episiotomies extended by laceration or laceration extended by episiotomy circle Y for the following:

- episiotomy
- perineal laceration
- repaired.

Specify the degree or type of tear in Degree/type: (specify).

Blood loss (millilitres)

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).

Valid response/s

Blood loss: (mls)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion:					<input type="checkbox"/> Y <input type="checkbox"/> N

- If not stated record, 99999
- Valid range: 00000-12000, 99999

Reporting guide

This is usually reported to the nearest 50 ml, but may be more accurate than this if desired, for example when there is very small amount of bleeding.

Excessive blood loss following birth continues to be an important factor in maternal mortality and severe maternal morbidity. As the definition of postpartum haemorrhage varies between institutions, queries on PPH will now cease. The estimated blood loss is reported in mls in the medical report at all hospitals, hence collecting the volume of blood lost enables analysis of the predictors and sequelae of excessive blood loss, however defined.

If the mother received a transfusion record this in Transfusion.

Transfusion - mother

Definition Whether the mother was given a transfusion of whole blood or any blood product (excluding anti-D) during her postpartum stay.

Valid response/s

Blood loss: (mls)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfusion:					<input type="checkbox"/> Y <input type="checkbox"/> N

Reporting guide

Blood products may include:

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

Postpartum complications

Definition Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation/discharge from care.

Valid response/s

Postpartum complications: Specify.....
--

Reporting guide

Record any postpartum complications arising after the delivery of the placenta up until the time of discharge from care in the space provided.

A few examples of postpartum complications include:

- anaemia following PPH
- puerperal sepsis
- retention of urine.

If more space is required, record in Complications/events of labour and indicate with an arrow to Postpartum complications.

This field analyses complications in the postpartum period that may cause ongoing maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth and/or for subsequent pregnancies.

Admitted to high dependency unit (HDU) / intensive care unit (ICU) - mother

Definition Whether the mother was admitted into a High Dependency Unit (HDU)/Intensive Care Unit (ICU).

Valid response/s

Admitted to HDU/ICU: (Mother)	<input type="checkbox"/> Y	<input type="checkbox"/> N
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Reporting guide

HDU **does not** include extra time spent with breastfeeding mothers who require supervision and education

Depending on the facilities, and policies of the hospital, this high dependency care may take place in:

- the birthing suite
- high dependency units
- intensive care unit
- coronary care unit
- any other specialist unit.

The mother may spend time in this type of care for days either before and/or after the birth.

If the mother is admitted to HDU/ICU provide the reason in Complications/events of labour and birth and/or Postpartum complications.

Monitoring maternal morbidity that necessitated the high dependency care assists in evaluating and improving outcomes for both mother and baby.

Section 6: baby

Baby UR number (patient identifier – baby)

Definition An identifier, unique to the baby within the hospital or campus (patient's record number/unit record number).

Valid response/s

BABY UR:								
-----------------	--	--	--	--	--	--	--	--

- If the Baby's UR number is not stated, leave blank.

Reporting guide

The UR number is an identifier, unique to the baby within the hospital or campus (patient's report number/unit report number). In hospitals this will usually be either a six or seven digit number. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.

For planned births occurring outside the hospital system enter the birth number or an equivalent number used to identify the mother.

This is an optional field as it is understood that in private facilities the baby is not always admitted and does not receive a UR number.

A baby identifier will:

- enable data linkage purposes
- allow for verification of completeness and accuracy of data, as it is used to identify the patient when there is a need to query the data provided in other fields.

Date and time of birth - baby

Definition The date and time of birth.

Valid response/s

Birthdate:				Date	Time
		2	0		
Estimated gestation at birth: (weeks)					

- A valid date (ddmmyyyy).
- A valid time (hhmm).
- 0000 and 2400 are not valid.
- If date and/or time are not stated, fill with 9s.

Reporting guide

Report hours and minutes using a 24-hour clock.

This field enables calculation of maternal age (difference between Mother's DOB and Baby's DOB) used in the analysis of service utilisation, need for services and epidemiological studies and to enable calculation of length of stay.

Estimated gestation at birth

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.

Valid response/s

Birthdate:	Date	Time
	20	
Estimated gestation at birth: (weeks)		

- If not stated, record 99.
- Valid range: 20-45, 99

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 6 days, this should be recorded as 37 weeks).

Determination of gestational age is an important factor in planning appropriate care for the baby. It provides important information regarding expected or potential problems and directly affects the medical plan for the baby.

Sex - baby

Definition The biological distinction between male and female of the baby.

Valid response/s

Sex:	Male <input checked="" type="checkbox"/>	Female <input checked="" type="checkbox"/>	Indeterminate <input checked="" type="checkbox"/>
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Reporting guide

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).

Plurality

Definition The total number of babies resulting from a single pregnancy.

Valid response/s

Plurality: (eg. Single <input type="checkbox"/> 1, Twins <input type="checkbox"/> 2)	<input type="checkbox"/>
(this record refers to <input type="checkbox"/> born)	

Reporting guide

Plurality of a birth is determined by the number of livebirths or by the number of fetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. Include all livebirths and stillbirths.

Fetuses aborted before 20 completed weeks are excluded. Fetuses compressed in the placenta (*fetus papyraceous*) at 20 or more weeks and expelled at time of delivery are included.

Birth order

Definition

The sequential birth order of the baby, including that in a multiple birth for the current pregnancy.

Valid response/s

Plurality: (eg. Single <input type="checkbox"/> 1, Twins <input type="checkbox"/> 2) <input type="checkbox"/>
(this record refers to <input type="checkbox"/> born)

Reporting guide

For multiple pregnancies, record the birth order of the baby for which the Birth Report is being completed in (this record refers to ___ born).

For a singleton birth, record 1 for plurality and this record refers to **first** born.

For a twin birth, record 2 for plurality and this record refers to **first** born when completing the Birth Report for twin 1, and **second** born when completing for twin 2.

Condition

Definition

Condition of the baby at birth.

Valid response/s

Condition: Liveborn <input checked="" type="checkbox"/>
Stillborn (before labour) <input checked="" type="checkbox"/> (during labour) <input checked="" type="checkbox"/>

Reporting guide

Circle the appropriate box indicating the condition of the baby at birth.

Liveborn:

A livebirth is defined by the World Health Organization to be the complete expulsion or extraction from the mother, of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Stillborn (occurring before or during labour):

A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birth weight.

The death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Scenario

Data item involved

Plurality, Birth status, time and date of birth, procedures and operations, gestation and obstetric complications.

Scenario 1

In the instance of the women initially pregnant with twins but one twin is terminated at 23/40 gestation and births with the live twin at term, please record as follows: twin 2 is a stillbirth at the same gestation as the liveborn twin 1 with time of birth recorded as the time of third stage if it is a 'fetus papyraceous'. Investigations would include amniocentesis. A separate birth report is also completed for twin 2. Fetus papyraceous is recorded in obstetric complications.

Birth weight

Definition The first weight (in grams) of the live-born or stillborn baby obtained after birth.

Valid response/s

Birthweight: (grams)					
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- If not stated, record 9999.
- Valid range: 100-7000, 9999

Reporting guide

Unit of measure is in grams.

For livebirths, birth weight should preferably be measured within the first few hours after birth before significant postnatal weight loss has occurred. 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.

The actual weight should be recorded to the degree of accuracy to which it is measured.

Birth weight is an important indicator of pregnancy outcome. Low birth weight is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.

Apgar scores

Definition

Numerical score used to indicate the baby's condition at one minute and five minutes after birth.

Valid response/s

Apgar: 1 minute	<input type="text"/>	<input type="text"/>	5 minutes	<input type="text"/>	<input type="text"/>
Time to established respiration: (mins.)			<input type="text"/>	<input type="text"/>	<input type="text"/>

- If not stated, record 99 or unknown.
- Valid range: 00-10, 99

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.

Sign	Score		
	0	1	2
Heart rate	Absent	Slow (below 100 per minute)	100 or more per minute
Respiratory effort	Absent	Slow, irregular	Good, crying
Muscle tone	Flaccid	Some flexion of extremities	Active movement
Reflex irritability	No response	Grimace	Vigorous cry
Colour	Blue, pale	Body pink, extremities blue	Completely pink

If the Apgar score is unknown/not stated, for example, for babies born before arrival, it should be reported as 99.

Time to established respiration (TER)

Definition Time in minutes taken to establish regular, spontaneous breathing. This is not the same as the time of first breath.

Valid response/s

Apgar: 1 minute	<input type="text"/>	<input type="text"/>	5 minutes	<input type="text"/>	<input type="text"/>
Time to established respiration: (mins.)					
<input type="text"/>		<input type="text"/>			

- If newborn is intubated and ventilated, and accurate assessment of time is not possible, record 98
- If not stated, record 99.
- Valid range: 00-30, 98, 99

Reporting guide

Most newborns establish spontaneous respirations within 1-2 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 reported.

If **Birth Status is Stillborn**, Time to Established Respiration must equal 00.

If the **baby breathes immediately** and continues to have regular spontaneous breathing after birth the TER is 01 minute.

In the case of baby's born before arrival, where the time to established respiration is not stated report 99.

Resuscitation - mechanical

Definition Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Valid response/s

Resuscitation - mechanical:			
None	<input checked="" type="checkbox"/>	ETT with air	<input checked="" type="checkbox"/>
Suction	<input checked="" type="checkbox"/>	ETT with O ₂	<input checked="" type="checkbox"/>
O ₂ therapy	<input checked="" type="checkbox"/>	CPAP with air	<input checked="" type="checkbox"/>
IPPR with air	<input checked="" type="checkbox"/>	CPAP with O ₂	<input checked="" type="checkbox"/>
IPPR with O ₂	<input checked="" type="checkbox"/>	Cardiac massage	<input checked="" type="checkbox"/>
Other (specify).....			<input checked="" type="checkbox"/>
Resuscitation - drugs: (specify)			
.....			

Reporting guide

If during resuscitation both air and oxygen are given, report both codes.

None:

Includes such strategies as tactile stimulation.

A combination of up to **ten** valid types of mechanical resuscitation methods can be used.

Congenital anomalies – free text

Definition Structural or anatomical abnormalities that are present at birth, in either a live born or stillborn baby. They may be detected during the pregnancy, at the birth or days after. They may be multiple or isolated.

Valid response/s

Congenital anomalies:	<input type="checkbox"/> Y	<input type="checkbox"/> N
CVS / CNS / MS / GI / UG / Resp / Skin / Other		
Circle & Specify.....		
.....		
.....		
.....		
.....		
Paediatrician:		

Reporting guide

Circle the body system that the congenital anomalies refer to.

Specify the defect/s or congenital anomaly with as much detail as possible, for example:

- cleft lip and palate – unilateral / left or right
- congenital dislocation hip (CDH) – bilateral / left or right
- neural tube defect, anencephaly
- spina bifida – lumbar.

If a baby is diagnosed with a syndrome, then it should be specified with **ALL** other associated conditions, for example, down syndrome with associated ventricular septal defect (VSD), and/or duodenal atresia.

It would be preferable for abbreviations not be used however, if they are recorded ensure that the body system is circled above or clearly indicated, for example;

- TOF can stand for Tracheoesophageal Fistula or Tetralogy of Fallot therefore report:
 - TOF – gastrointestinal (GI)
 - TOF – cardiovascular (CVS).

Note: birth injuries or trauma such as a fractured clavicle are recorded in the neonatal morbidity section.

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 all reported congenital anomalies, record the full name of the consulting/treating paediatrician.

Collection of congenital anomalies is important to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

When a congenital anomaly or malformation is reported it provides a source of notification to the Birth Defects Register (BDR) which is maintained by the VPDCU.

Paediatrician's name

Definition The first and surname of the consulting/treating paediatrician.

Valid response/s

Congenital anomalies: <input type="checkbox"/> Y <input type="checkbox"/> N
CVS / CNS / MS / GI / UG / Resp / Skin / Other
Circle & Specify.....
.....
.....
.....
Paediatrician:

- Paediatrician's name
- No paediatrician

Reporting guide

For all reported congenital anomalies, record the full name of the consulting/treating paediatrician.

If the baby is not referred to a paediatrician, record no paediatrician.

Neonatal morbidity - indicator

Definition Whether there were any neonatal morbidities identified.

Valid response/s

Neonatal morbidity: <input type="checkbox"/> Y <input type="checkbox"/> N
Specify.....
.....
.....
.....
Admitted: <input checked="" type="checkbox"/> SCN <input checked="" type="checkbox"/> NICU

Reporting guide

Circle Y, yes if there were any neonatal morbidities identified and record these in the space below. If no neonatal morbidity circle N.

Neonatal morbidity

Definition Illness and/or birth trauma experienced by the baby up to the time of discharge.

Valid response/s

Neonatal morbidity:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Specify.....		
.....		
.....		
.....		
Admitted:	<input checked="" type="checkbox"/> SCN	<input checked="" type="checkbox"/> NICU

Reporting guide

Report the morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU.

Examples of such morbidity include:

- jaundice that required phototherapy
- respiratory distress
- excessive weight loss
- hypoglycaemia
- birth asphyxia
- hypoxic ischaemic encephalopathy
- intraventricular haemorrhage
- eye infections.

Occasionally admissions are for 'observation only' and should be recorded as this.

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. If blank, a query will be generated.

For extremely premature and premature neonates report all associated morbidity.

Note: except for phototherapy, no treatments need to be recorded, just the illness that necessitates them.

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

Definition Whether the neonate was admitted into a special care nursery (SCN) or neonatal intensive care unit (NICU).

Valid response/s

Neonatal morbidity:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Specify.....	
.....	
.....	
Admitted:	<input checked="" type="checkbox"/> SCN	<input checked="" type="checkbox"/> NICU

Reporting guide

The criteria for admissions to SCN may vary depending on facilities available and level of care provided within a particular hospital.

This item is a flag for neonatal morbidity and/or congenital anomalies. If the neonate is admitted to SCN or NICU, then morbidity and/or congenital anomalies must be documented.

If the neonate was admitted to both SCN and NICU, circle NICU.

SCN or NICU can only be recorded if the facility is approved for this.

Hepatitis B vaccine received

Definition Whether the baby received an immunisation vaccine for Hepatitis B during the birth admission.

Valid response/s

Hepatitis B vaccine received:
≤ 7 days <input checked="" type="checkbox"/> > 7 days <input checked="" type="checkbox"/> Not given <input checked="" type="checkbox"/>

Reporting guide

Report the administration of a dose of paediatric hepatitis B vaccine. Do not report immunoglobulin.

Breastfeeding attempted

Definition Whether the mother attempted to breastfeed the baby or express breast milk at least once.

Valid response/s

Breastfeeding attempted:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Formula given in hospital:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Last feed taken exclusively from breast:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

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.

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.

Formula given in hospital

Definition Whether any infant formula was given to this baby in hospital, whether by bottle, cup, gavage or other means.

Valid response/s

Breastfeeding attempted:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Formula given in hospital:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Last feed taken exclusively from breast:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

Circle yes or no to the feeding questions asked.

Last feed taken exclusively from breast

Definition Whether the last feed prior to discharge was taken directly from the breast with no complementary feeding of any kind.

Valid response/s

Breastfeeding attempted:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Formula given in hospital:	<input type="checkbox"/> Y	<input type="checkbox"/> N
Last feed taken exclusively from breast:	<input type="checkbox"/> Y	<input type="checkbox"/> N

Reporting guide

Last feed before discharge taken entirely from breast:

Includes if the baby took the entire last feed prior to discharge directly from the breast. Does not preclude the use of a nipple shield.

Last feed before discharge not taken entirely from breast:

Includes if any expressed breast milk or formula was given at the last feed before discharge from hospital, whether by cup, spoon, and gavage or by any other means.

Section 7: discharge

Date of discharge from place of birth – baby and mother

Definition The date on which the baby and mother is separated/discharged, transferred or died from the place of birth.

Valid response/s

Date of discharge from place of birth:		
Mother date	2 0	
Baby date	2 0	
Discharged status:	Mother	Baby
Discharge	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Died	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transferred to (<i>specify</i>)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mother	[REDACTED]	
Baby	[REDACTED]	

- A valid date (ddmmyyyy).
- If discharge/separation date is not stated, fill with 9s.

Reporting guide

The relocation of the baby and/or mother within the hospital of birth does not constitute a separation (or transfer), unless there was a Care Type change (such as to Hospital in the Home (HITH)). **For babies and/or mother who go to HITH**, record the date on which the baby was transferred. Separation Status should be recorded as *Transferred* and Transfer Destination as HITH.

If the baby and/or mother are transferred to the hospital of birth mother/baby unit, without having left the hospital, the separation/discharge date(s) should be when the baby and/or mother leave the hospital to go home or are transferred.

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

If the baby's discharge date differs from the mother's discharge date ensure that an explanation for this is recorded in the appropriate fields.

In the case of planned homebirths, occurring at home, the baby's date of birth is the same date that is entered in the date of discharge from place of birth for the mother and baby.

Discharge/separation status – baby

Definition Status at separation/discharge of baby (discharge/transfer/death).

Valid response/s

Date of discharge from place of birth:		
Mother date		2 0
Baby date		2 0
Discharged status:	Mother	Baby
Discharge	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Died	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transferred to (<i>specify</i>)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mother	[REDACTED]	
Baby	[REDACTED]	

Reporting guide

Stillborn:
Field should be left blank.

Discharged:
When the baby leaves the hospital premises to go home.

Died:
Refers to the discharge from the hospital premises due to the death of a live born baby. Record the reason for the neonatal death in Congenital anomalies and/or Neonatal morbidity.

Transferred:
Refers to the discharge from the place of birth premises to another hospital or other health care facility. Includes the following:

- higher level of specialist care facility
- private or local facility for post natal care
- hospital in the home (HITH).

For transfers record the name of the facility the baby was transferred to in the space provided.

To maintain accurate and complete data the VPDCU will follow up some transfers, particularly those transferred to a larger medical institution.

Discharge/separation status – mother

Definition Status at separation/discharge of mother (discharge/transfer/death).

Valid response/s

Date of discharge from place of birth:		
Mother date		2 0
Baby date		2 0
Discharged status:	Mother	Baby
Discharge	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Died	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transferred to (specify)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mother	[REDACTED]	
Baby	[REDACTED]	

Reporting guide

Discharged:

Is when the mother leaves the hospital premises to go home.

Died:

Refers to the discharge from the hospital premises due to the death of a mother. Record the reason for maternal death in 'Complications/events of labour and birth and/or Postpartum complications'.

Transferred:

Refers to the discharge from the place of birth premises to another hospital or other health care facility. Includes the following:

- higher level of specialist care facility
- private or local facility for post natal care
- hospital in the home (HITH)
- mother/baby unit within the hospital.

For transfers record the name of the facility the mother was transferred to in the space provided.

To maintain accurate and complete data the VPDCU will follow up some transfers, particularly those transferred to a larger medical institution.