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| Specifications for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 July 2023 |
| December 2022 |
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# Executive Summary

The changes to be made to the Victorian Perinatal Data Collection (VPDC) for births on and from 1 July 2023 are summarised below:

**Changes to existing data definition** (Section 2, VPDC manual):

* Diabetes mellitus
* Gestational diabetes
* Hypertensive disorder during pregnancy
* Induction
* Labour type
* Operative delivery
* Primary postpartum haemorrhage

**New data elements** (Section 3, VPDC manual):

* Administration of Hepatitis B Immunoglobulin (HBIG) – baby
* Indications for induction (other) – ICD-10-AM code
* Indications for operative delivery (other) – ICD-10-AM code

**Deleted data elements** (Section 3, VPDC manual):

* Labour induction/augmentation agent – other specified description

**Changes to existing data elements** (Section 3, VPDC manual):

* Anaesthesia for operative delivery – type
* Analgesia for labour – type
* Birth plurality
* Birth presentation
* Diabetes mellitus therapy during pregnancy
* Estimated gestational age
* Hospital code (agency identifier)
* Indication for induction (main reason) – ICD-10-AM code
* Indications for induction (other) – free text
* Indication for operative delivery (main reason) – ICD-10-AM code
* Indications for operative delivery (other) – free text
* Labour induction/augmentation agent
* Labour type
* Last feed before discharge taken exclusively from the breast – baby
* Maternity model of care – antenatal
* Maternity model of care – at onset of labour or non-labour caesarean section
* Method of birth
* Setting of birth – actual
* Setting of birth – intended
* Spoken English Proficiency
* Version identifier

**New business rules/validations** (Section 4, VPDC manual):

### Administration of Hepatitis B Immunoglobulin (HBIG) – baby, Birth status and Hepatitis B antenatal screening – mother conditionally mandatory data item

### Estimated gestational age warning validation

### Future date warning validation for multiple data elements

### Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – ICD-10-AM code valid combinations

### Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – ICD-10-AM code valid combinations

### Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation

### Maternity model of care – antenatal and Maternity model of care – at onset of labour or non-labour caesarean section valid codes

**Deleted business rules/validations** (Section 4, VPDC manual):

Labour induction/augmentation agent and Labour induction/ augmentation agent – other specified description conditionally mandatory data item

Maternity model of care code is invalid

**Changes to existing business rules/validations** (Section 4, VPDC manual):

\*\*\*Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations

\*\*\*Birth status, Breastfeeding attempted and Last feed before discharge – baby ~~taken exclusively from the breast~~ valid combinations

\*\*\*Birth status ‘Live born’ and associated conditionally mandatory data items

\*\*\*Birth status ‘Stillborn’ and associated data items valid combinations

\*\*\*Blood loss assessment – indicator, Episiotomy – indicator, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code, Indications for operative delivery (other) – free text, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting

\*\*\*Gravidity and related data items

\*\*\*Estimated gestational age conditionally mandatory data items for Birth status code 1 Liveborn

\*\*\*Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations

\*\*\*Labour type and Labour induction/augmentation agent valid combinations

\*\*\*Labour type ‘Failed induction’ conditionally mandatory data items

\*\*\*Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – ICD-10-AM code and Indications for induction (other) – free text valid combinations

\*\*\*Labour type ‘Woman in labour’ and associated data items valid combinations

\*\*\*Labour type ‘Woman not in labour’ and associated data items valid combinations

\*\*\*Method of birth and Labour type valid combinations

\*\*\*Method of birth and Setting of birth – actual valid combinations

\*\*\*Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations

\*\*\*Parity and associated data items valid combinations

\*\*\*Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations

**Changes to VPDC submission file structure and internet browser update** (Section 5 and 5a, VPDC manual)

Data submission timelines

Table of Episode record data elements

Logging into the MFT portal

Logging into the HealthCollect Portal

**These revisions are presented in this document in order of the section of the VPDC manual where they will appear.**

# Introduction

Each year the Department of Health (the department) reviews the Victorian Perinatal Data Collection (VPDC) on behalf of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM). This review seeks to ensure that the VPDC supports the CCOPMM’s objectives and the department’s planning, policy development and state and national reporting obligations, and incorporates appropriate feedback from data providers on improvements.

Proposals for changes to the VPDC for 1/7/2023 were invited from stakeholders in July 2022. Those Proposals were reviewed by the CCOPMM, which prioritised those to be distributed for feedback from health services, software vendors, and stakeholders in Safer Care Victoria and the department. Feedback was reviewed and where possible, accommodated by CCOPMM in deciding to alter or withdraw some proposals.

The criteria against which proposals were evaluated are listed in this document.

All proposals received are included in this document for transparency purposes. Those proposals not proceeding to implementation for 1/7/2023 are listed on page 14 and are not commented on further in this specifications document.

The revisions set out in this document are final and complete at the date of publication. Any further changes required during the year, for example to reference files such as the postcode locality file, business rules/validations, or supporting documentation, will be advised as they occur.

An updated VPDC manual will be published in early 2023. Until then, the current VPDC manual v10.0 and this document form the data submission specifications for births on and from 1/7/2023.

Victorian health services must ensure their software can capture all necessary data, create a VPDC submission file in accordance with these revised specifications, and ensure reporting capability is achieved to maintain compliance with reporting timeframes set out in the VPDC manual and comply with the *Public Health and Wellbeing Act 2008* and *Public Health and Wellbeing Regulations 2019*.

Submission of test files in 2023-24 file format is strongly recommended before submitting July 2023 data. Please contact the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au> to arrange test file submission prior to July 2023.

Test files must include the filename extension ‘\_TEST’ and be submitted to the [NonProd MFT](https://prs2np-mft.prod.services/) <https://prs2np-mft.prod.services/> as set out in section 5 of the VPDC manual.

## Orientation to symbols and highlighting in this document

New data elements are marked as (new).

Changes to existing entries are highlighted in green

Redundant values and definitions relating to existing entries are ~~struck through~~.

Comments relating only to the specifications document appear in *[square brackets and italics]*

New business rules (validations) are marked ###

Business rules/validations to be changed are marked \*\*\* when listed as part of a data item or below a business rule table

Changes appear in this document in the sequence in which they will appear in the VPDC manual, and under the relevant VPDC manual section headings.

# Summary of changes

|  |  |  |
| --- | --- | --- |
| **New data item / Amend existing** | **Proposal title** | **VPDC manual section changed** |
| **2** | **3** | **4** | **5** |
| New | Administration of Hepatitis B Immunoglobulin (HBIG) – baby |  | Checkmark | Checkmark | Checkmark |
| New | Administration of Hepatitis B Immunoglobulin (HBIG) – baby, Birth status and Hepatitis B antenatal screening – mother conditionally mandatory data item |  |  | Checkmark |  |
| Amend | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations |  | Checkmark | Checkmark |  |
| Amend | Anaesthesia for operative delivery – type |  | Checkmark |  |  |
| Amend | Analgesia for labour – type |  | Checkmark |  |  |
| Amend | Birth plurality |  | Checkmark |  |  |
| Amend | Birth presentation |  | Checkmark |  |  |
| Amend | Birth status, Breastfeeding attempted and Last feed before discharge – baby valid combinations |  | Checkmark | Checkmark |  |
| Amend | Birth status ‘Live born’ and associated conditionally mandatory data items |  |  | Checkmark |  |
| Amend | Birth status ‘Stillborn’ and associated data items valid combinations |  |  | Checkmark |  |
| Amend | Blood loss assessment – indicator, Episiotomy – indicator, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code, Indications for operative delivery (other) – free text, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting |  | Checkmark | Checkmark | Checkmark |
| Amend | Diabetes mellitus | Checkmark |  |  |  |
| Amend | Diabetes mellitus therapy during pregnancy |  | Checkmark |  |  |
| Amend | Estimated gestational age |  | Checkmark | Checkmark |  |
| Amend | Estimated gestational age conditionally mandatory data items for Birth status code 1 Liveborn |  |  | Checkmark |  |
| New | Estimated gestational age warning validation |  |  | Checkmark |  |
| New | Future date warning validation for multiple data elements |  |  | Checkmark |  |
| Amend | Gestational diabetes | Checkmark |  |  |  |
| Amend | Gravidity and related data items |  |  | Checkmark |  |
| Amend | Hospital code (agency identifier) |  | Checkmark |  |  |
| Amend | Hypertensive disorder during pregnancy | Checkmark |  |  |  |
| Amend | Indication for induction (main reason) – ICD-10-AM code |  | Checkmark | Checkmark |  |
| New | Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – ICD-10-AM code valid combinations |  |  | Checkmark |  |
| Amend | Indications for induction (other) – free text |  | Checkmark |  |  |
| New | Indications for induction (other) – ICD-10-AM code |  | Checkmark | Checkmark | Checkmark |
| Amend | Indication for operative delivery (main reason) – ICD-10-AM code |  | Checkmark | Checkmark |  |
| Amend | Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations |  |  | Checkmark |  |
| New | Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – ICD-10-AM code valid combinations |  |  | Checkmark |  |
| New | Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation |  |  | Checkmark |  |
| Amend | Indications for operative delivery (other) – free text |  | Checkmark |  |  |
| New | Indications for operative delivery (other) – ICD-10-AM code |  | Checkmark | Checkmark | Checkmark |
| Amend | Induction | Checkmark |  |  |  |
| Amend | Labour induction/augmentation agent |  | Checkmark | Checkmark |  |
| Remove | Labour induction/augmentation agent – other specified description |  | Checkmark | Checkmark | Checkmark |
| Remove | Labour induction/augmentation agent and Labour induction/ augmentation agent – other specified description conditionally mandatory data item |  |  | Checkmark |  |
| Amend | Labour Type | Checkmark | Checkmark | Checkmark |  |
| Amend | Labour type and Labour induction/augmentation agent valid combinations | Checkmark | Checkmark | Checkmark |  |
| Amend | Labour type ‘Failed induction’ conditionally mandatory data items | Checkmark | Checkmark | Checkmark |  |
| Amend | Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – ICD-10-AM code and Indications for induction (other) – free text valid combinations |  | Checkmark | Checkmark |  |
| Amend | Labour type ‘Woman in labour’ and associated data items valid combinations |  |  | Checkmark |  |
| Amend | Labour type ‘Woman not in labour’ and associated data items valid combinations |  |  | Checkmark |  |
| Amend | Last feed before discharge taken exclusively from the breast – baby |  | Checkmark | Checkmark |  |
| Amend | Maternity model of care – antenatal |  | Checkmark | Checkmark |  |
| New | Maternity model of care – antenatal and Maternity model of care – at onset of labour or non-labour caesarean section valid codes |  |  | Checkmark |  |
| Amend | Maternity model of care – at onset of labour or non-labour caesarean section |  | Checkmark | Checkmark |  |
| Remove | Maternity model of care code is invalid |  |  | Checkmark |  |
| Amend | Method of birth |  | Checkmark | Checkmark |  |
| Amend | Method of birth and Labour type valid combinations |  | Checkmark | Checkmark |  |
| Amend | Method of birth and Setting of birth – actual valid combinations |  | Checkmark | Checkmark |  |
| Amend | Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations |  | Checkmark | Checkmark |  |
| Amend | Operative delivery | Checkmark |  |  |  |
| Amend | Parity and associated data items valid combinations |  |  | Checkmark |  |
| Amend | Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations |  |  | Checkmark |  |
| Amend | Primary postpartum haemorrhage | Checkmark |  |  |  |
| Amend | Setting of birth – actual |  | Checkmark | Checkmark |  |
| Amend | Setting of birth – intended |  | Checkmark | Checkmark |  |
| Amend | Spoken English Proficiency |  | Checkmark |  |  |
| Amend | Version identifier |  | Checkmark |  |  |

## End of financial year reporting – 30/6/2023

Data submissions must include all relevant data elements and code sets valid as at the Date of birth – baby reported in the record:

* Date of birth – baby is prior to 1/7/2023 – report all data elements in 2022-23 format
* Date of birth – baby is on or after 1/7/2023 – report all data elements in 2023-24 format

A single submission file must contain records of a single format, in which the Version identifier in each episode record is consistent with the Version identifier in the Header record.

This is described under File structure specifications in Section 5 of the VPDC manual, accessible at the [VPDC website](https://www.health.vic.gov.au/publications/victorian-perinatal-data-collection-vpdc-manual-2022-23) < https://www.health.vic.gov.au/publications/victorian-perinatal-data-collection-vpdc-manual-2022-23 >.

An updated list of all data items in the submission file sequence applicable from 1/7/2023 is included in this specifications document.

## Proposals that are not proceeding for 1/7/2023

The following proposals were received and were considered by the CCOPMM, however it was determined that they will not be implemented for 1/7/2023:

* **Add new data item**: Hepatitis B viral load (HBV DNA) test – mother
* **Add new data item**: Hepatitis B treatment – mother
* **Add new data items**: Two new data items to report timing of administration of a pertussis containing vaccine during pregnancy
* **Add new data items**: At least two new data items to report timing of administration of influenza vaccine(s) during pregnancy
* **Add new data item**: Oral health assessment
* **Add new data item**: Dental health referral
* **Amend existing data item**: Labour type – amend definition
* **Amend existing data item**: Remove the term ‘delivery’ and replace with ‘birth’ throughout the VPDC manual
* **Amend existing data item**: Last birth – caesarean section indicator
* **Amend existing data item**: Parity
* **Other**: Do not add anything else

# Section 2 Concept and derived item definitions

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| Diabetes mellitus |
| **Definition/guide for use** | Diabetes is a chronic condition in which the levels of glucose (sugar) in the blood are too high. Blood glucose levels are normally regulated by the hormone insulin, which is made by the pancreas. Diabetes occurs when there is a problem with this hormone and how it works in the body.The main types of diabetes are Type 1 and Type 2. Other varieties include gestational diabetes, diabetes insipidus and pre-diabetes. Gestational diabetes is diabetes that occurs during pregnancy. After the baby is born, the mother’s glucose levels usually return to normal. Women are at greater risk of developing Type 2 diabetes after experiencing gestational diabetes. Pre-diabetes is a condition in which blood glucose levels are higher than normal, although not high enough to cause diabetes. (Source: Better Health Channel)Intermediate hyperglycaemia is not within the scope of diabetes for the purposes of VPDC diabetes reporting.Four data elements report details about diabetes to the VPDC: * Diabetes mellitus during pregnancy – type
* Diabetes mellitus – gestational – diagnosis timing
* Diabetes mellitus – pre-existing – diagnosis timing
* Diabetes mellitus therapy during pregnancy

The following sequence of questions may assist in capturing relevant information.Refer also to the Reporting guides for these data elements in Section 3 of the VPDC manual. |
| **Related data items (Section 3):** | Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus – pre-existing – diagnosis timing; Diabetes mellitus therapy during pregnancy; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for induction (other) – ICD-10-AM code; Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications – ICD-10-AM code. |

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| Gestational diabetes |
| **Definition/guide for use** | Gestational diabetes mellitus (GDM) is a carbohydrate intolerance resulting in hyperglycaemia with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment, or the condition persists after pregnancy. |

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| **Related data items (Section 3):** | Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus – pre-existing – diagnosis timing; Diabetes mellitus therapy during pregnancy; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for induction (other) – ICD-10-AM code; Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications – ICD-10-AM code. |

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| Hypertensive disorder during pregnancy |
| **Definition/guide for use** | Hypertensive disorder during pregnancy includes pre-existing hypertensive disorders, hypertension arising in pregnancy and associated disorders such as eclampsia and preeclampsia.Hypertension in pregnancy is defined as:* Systolic blood pressure greater than or equal to 140 mmHg and/or
* Diastolic blood pressure greater than or equal to 90 mmHg.

Measurements should be confirmed by repeated readings over several hours. Elevations of both systolic and diastolic blood pressures have been associated with adverse fetal outcome and therefore both are important.Disorders associated with hypertension such as eclampsia and preeclampsia are further characterised by symptoms such as proteinuria, oedema or high body temperature.There are several reasons to support the blood pressure readings defined above as diagnostic of hypertension in pregnancy:1. perinatal mortality rises with diastolic blood pressures above 90 mmHg
2. readings above this level were beyond two standard deviations of mean blood pressure in a New Zealand cohort of normal pregnant women
3. the chosen levels are consistent with international guidelines and correspond with the current diagnoisis of hypertension outside of pregnancy.

This definition of hypertensive disorder in pregnancy from the Society of Obstetric Medicine in Australia and New Zealand (SOMANZ) aligns with the definition of the International Society for the Study of Hypertension in Pregnancy (ISSHP).(Source: METeOR #655620, Australian Institute of Health and Welfare) |
| **Related data items (Section 3):** | Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for induction (other) – ICD-10-AM code; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free tex~~s~~t; Postpartum complications – ICD-10-AM code |
| Induction |
| **Definition/guide for use** | Procedure performed to stimulate and establish labour in a woman who has not started labour spontaneously.More than one method of induction can be recorded. The use of medications or forewater ARM to initiate labour following pre-labour rupture of the membranes (PROM) is considered an induction (but not an augmentation as augmentation is possible only after labour has started spontaneously). If labour begins spontaneously following PROM, the use of these techniques should be reported as augmentation. |
| **Related data items (Section 3):** | Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indication for induction (other) – ICD-10-AM code |
| Labour type |
| **Definition/guide for use** | The manner in which labour started in a birth event.Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes (PROM). If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours have passed, then a later onset of labour without further induction techniques should be coded as a spontaneous onset.  |
| **Related data items (Section 3):** | Labour induction / augmentation agent; ~~Labour induction / augmentation agent – other specified description;~~ Labour type |

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| Operative delivery |
| **Definition/guide for use** | The birth of an infant either by operative vaginal birth or caesarean section.Operative vaginal birth refers to a forceps or vacuumassisted birth. Operative intervention in the second stage of labour may be indicated by conditions of the fetus or the mother. Maternal indication includes inadequate progress in labour, congestive heart failure and cerebral vascular malformations. Caesarean section is the surgical alternative to operative vaginal birth. This may be an elective or emergency procedure. |
| **Related data items (Section 3):** | Anaesthesia for operative delivery – indicator; Anaesthesia for operative delivery – type; Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (main (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Last birth – caesarean section indicator; Method of birth; Plan for vaginal birth after caesarean; Procedure – ACHI code; Procedure – free text; Total number of previous caesareans |
| Primary postpartum haemorrhage |
| **Definition** | Primary postpartum haemorrhage, a form of obstetric haemorrhage, is excessive bleeding from the genital tract after childbirth, occurring within 24 hours of birth.A blood loss of 500mls is the usual minimum amount for identification of postpartum haemorrhage however a woman’s haemodynamic instability is also taken into account, meaning that a smaller blood loss may be significant in a severely compromised woman.Secondary postpartum haemorrhage is excessive bleeding from the genital tract after childbirth occurring between 24 hours and 6 weeks postpartum. |
| **Related data items (Section 3):** | Blood loss assessment~~accuracy~~ – indicator; Blood loss (ml); Main reason for excessive blood loss following childbirth; Prophylactic oxytocin in third stage |

# Section 3 Data definitions

## Administration of Hepatitis B Immunoglobulin (HBIG) – baby (new)

**Specification**

|  |  |
| --- | --- |
| Definition | Report whether Hepatitis B immunoglobulin (HBIG) was administered to the baby, and if so, the timing of that administration |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 168 |
| Permissible values | **Code Descriptor**1 HBIG not administered to the infant2 HBIG administered <12 hours after birth3 HBIG administered ≥ 12 hours after birth 9 Not stated / inadequately described |
| Reporting guide | Report the interventions to prevent mother-to-child transmission (MTCT) of hepatitis B for women who are HBsAg positive.Report only for liveborns when mother reports code 2 Hepatitis serology (HBsAg) positive in Hepatitis B antenatal screening – mother Otherwise, leave blank. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All births where Birth status is code 1 liveborn and Hepatitis B antenatal screening - mother is code 2 Hepatitis serology (HBsAg) was positive |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Birth status; Hepatitis B antenatal screening – mother |
| Related business rules (Section 4): | ### Administration of Hepatitis B Immunoglobulin (HBIG) – baby, Birth status and Hepatitis B antenatal screening – mother conditionally mandatory data item |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. July 2023 |
| Codeset source | DH | Collection start date | July 2023 |

## Anaesthesia for operative delivery – type

**Specification**

|  |  |
| --- | --- |
| Definition | The type of anaesthesia administered to a woman during a birth event |
|  |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 (x4) |
|  |
| Location | Episode record | Position | 80 |
|  |
| Permissible values | **Code Descriptor**2 Local anaesthetic to perineum3 Pudendal block4 Epidural or caudal block5 Spinal block6 General anaesthetic7 Combined spinal-epidural block8 Other anaesthesia9 Not stated / inadequately described |
|  |
| Reporting guide | This item should be recorded for operative or instrumental delivery of the baby only. It does not include the removal of the placenta.Report in this data item only agent/s administered to provide anaesthesia for an operative delivery, not where the agent was administered solely for pain relief during labour. If given only during labour, report the agent in the data item Analgesia for labour – type. If given for pain relief during labour, and as anaesthesia for operative delivery, report in both Anaesthesia for operative delivery – type and Analgesia for labour – type data items. 2 Local anaesthetic to perineumA local anaesthetic to the perineum was administered to the mother for the operative/instrumental birth of the baby. Local anaesthetic to perineum is the infiltration of the perineum with a local anaesthetic.3 Pudendal blockA pudendal block was administered to the mother for the operative/ instrumental birth of the baby. A pudendal block is an injection of a local anaesthetic to the pudendal nerves.4 Epidural or caudal blockAn epidural or caudal block was administered to the mother for the operative/ instrumental birth of the baby. An epidural block is an injection of a local anaesthetic into the epidural space of the spinal column. A caudal block is an injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.5 Spinal blockA spinal block was administered to the mother for the operative/ instrumental birth of the baby. A spinal block is an injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord. Spinal block is also called Subarachnoid Block Anaesthesia.6 General anaestheticGeneral anaesthesia was administered to the mother for the operative/ instrumental birth of the baby. General anaesthesia includes various anaesthetic agents given primarily by inhalation or intravenous injection.7 Combined spinal-epidural blockA combined spinal-epidural block was administered to the mother for the operative/ instrumental birth of the baby. A combined spinal-epidural block is a needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column. The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.8 Other anaesthesia:Other anaesthesia (not indicated above) was administered to the mother for the operative/instrumental birth of the baby. This may include parenteral opioids and nitrous oxide.Code 9 Not stated / inadequately described:May not be reported with any other code.More than one permissible value may be recorded. However no permissible value can be reported more than once. Code 7 Combined spinal-epidural block may not be recorded with both Code 4 and Code 5. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Birth episodes with an operative delivery |
| Related concepts (Section 2): | Anaesthesia; Operative delivery |
| Related data items (this section): | Anaesthesia for operative delivery – indicator; Analgesia for labour – type |
| Related business rules (Section 4): | Anaesthesia for operative delivery – indicator and Anaesthesia for operative delivery – type valid combinations;  |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | NHDD AIHW | Version | 1. January 19992. July 20153. July 2023 |
| Codeset source | ~~NHDD~~ AIHW (DH modified) | Collection start date | 1999 |

## Analgesia for labour – type

**Specification**

|  |  |
| --- | --- |
| Definition | The type of analgesia administered to the woman during a birth event. |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 (x4) |
|  |
| Location | Episode record | Position | 78 |
|  |
| Permissible values | **Code Descriptor**2 Nitrous oxide3 Systemic opioids4 Epidural or caudal block5 Spinal block7 Combined spinal-epidural block8 Other analgesia9 Not stated / inadequately described |
|  |
| Reporting guide | This item is to be recorded for first and second stage labour, but not for third stage labour, e.g., removal of placenta.Report in this data item only agent/s administered to provide pain relief during labour, not where the agent was administered solely as anaesthesia for an operative delivery. If given only to facilitate an operative delivery, report the agent in the data item Anaesthesia for operative delivery. If given for pain relief during labour, and as anaesthesia for operative delivery, report in both anaesthesia and analgesia data items.Code 2 Nitrous oxide: Nitrous oxide was administered to a female for pain relief during the labour and/or birth. Nitrous oxide is a gas providing light anaesthesia delivered in various concentrations with oxygen.Code 3 Systemic opioids:Systemic opioids were administered to a female for pain relief during the labour and/or birth. This includes intramuscular and intravenous opioids.Code 4 Epidural or caudal blockAn epidural or caudal block was administered to a female for pain relief during the labour and/or birth. An epidural block is an injection of a local anaesthetic into the epidural space of the spinal column. A caudal block is an injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.Code 5 Spinal blockA spinal block was administered to a female for pain relief during the labour and/or birth. A spinal block is an injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord, also called the Subarachnoid Block Anaesthesia.Code 7 Combined spinal-epidural block:A combined spinal-epidural block was administered to a female for pain relief during the labour and/or birth. A combined spinal-epidural block is a needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column. The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.Code 8 Other analgesia:Other analgesia (not indicated above) was administered to a female for pain relief during the labour and/or birth. This includes all non-narcotic oral analgesia and nonpharmacological methods such as hypnosis, acupuncture, massage, relaxation techniques, temperature regulation and aromatherapy and other.Code 9 Not stated / inadequately described:May not be reported with any other code.More than one permissible value may be recorded. However no permissible value can be reported more than once. Code 7 Combined spinal-epidural block may not be recorded with both Code 4 and Code 5. |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | Birth episodes where there is a labour |
|  |
| Related concepts (Section 2): | Analgesia |
|  |
| Related data items (this section): | Analgesia for labour – indicator; Anaesthesia for operative delivery – type |
|  |
| Related business rules (Section 4): | Analgesia for labour – indicator and Analgesia for labour – type valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | ~~NHDD~~ AIHW | Version | 1. January 19992. July 20153. July 2023 |
|  |
| Codeset source | ~~NHDD~~ AIHW (DH modified) | Collection start date | 1999 |

## Birth plurality

**Specification**

|  |  |
| --- | --- |
| Definition | The total number of babies resulting from a single pregnancy |
|  |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 |
|  |
| Location | Episode record | Position | 98 |
|  |
| Permissible values | **Code Descriptor**1 Singleton2 Twins3 Triplets4 Quadruplets5 Quintuplets6 Sextuplets8 Other9 Not stated / inadequately described |
|  |
| Reporting guide | Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus is likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included they should be recognisable as a fetus and have been expelled or extracted with other products of conception when pregnancy ended at 20 or more weeks gestation.Fetus papyraceous and fetus compressus are products of conception recognisable as a deceased fetus. These fetal deaths are likely to have occurred before 20 weeks gestation but should be included as stillbirths in perinatal collections if they are recognisable as a fetus and have been expelled or extracted with other products of conception at 20 or more weeks gestational age. |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | All birth episodes |
|  |
| Related concepts (Section 2): | Stillbirth (fetal death) |
|  |
| Related data items (this section): | Birth order |
|  |
| Related business rules (Section 4): | Birth plurality and Birth order valid combinations; Birth plurality and Chorionicity of multiples valid combinations; Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | ~~NHDD~~ AIHW METeOR 732874 | Version | 1. January 19822. July 20153. July 2023 |
|  |
| Codeset source | ~~NHDD~~ AIHW METeOR 732874 | Collection start date | 1982 |

## Birth presentation

**Specification**

|  |  |
| --- | --- |
| Definition | Presenting part of the fetus (at the cervix) at birth |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 |
|  |
| Location | Episode record | Position | 73 |
|  |
| Permissible values | **Code Descriptor**1 Vertex2 Breech3 Face4 Brow5 Compound6 Cord7 Shoulder8 Other9 Not stated / inadequately described |
|  |
| Reporting guide | For a multiple pregnancy with differing presentations, report the presentation of the fetus for each birth. Code 1 Vertex:Presentation at birth is the upper back part of the fetal head. That is, the occiput is the point of reference.Includes incomplete rotation of fetal headCode 2 Breech: Presentation at birth is the buttocks or legs. Includes breech with extended legs, breech with flexed legs, footling and knee presentations.Code 3 Face:Presentation at birth is the face. That is, the fetal head is hyper-extended and the area of the head below the root of the nose and the orbital ridge is at the cervical os.Code 4 Brow:Presentation at birth is the brow. That is, the fetal head is partly extended and the area of the head between the anterior fontanelle and the root of the nose is at the cervical os.Code 5 Compound: Refers to more than one presenting part. It is the situation where there is an associated prolapse of hand and/or foot in a cephalic presentation or hand(s) in a breech presentation. Code 8 Other – specify: When Other – specify is reported, further details must be reported in Events of labour and birth – free text or Events of labour and birth – ICD-10-AM code. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | ~~None specified~~ Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code |
|  |
| Related business rules (Section 4): | Birth presentation conditionally mandatory data items; Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | ~~NHDD~~ AIHW METeOR 749924 | Version | 1. January 19822. January 19993. January 20094. July 20225. July 2023 |
| Codeset source | ~~NHDD~~ AIHW (DH modified) | Collection start date | 1982 |

## Diabetes mellitus therapy during pregnancy

**Specification**

|  |  |
| --- | --- |
| Definition | The type/s of therapy prescribed during the pregnancy for diabetes mellitus |
| Representation class | Code | Data type | String |
| Format | N | Field size | 1(x3) |
| Location | Episode record | Position | 145 |
| Permissible values | **Code** | **Descriptor** |
|  | 2 | Insulin |
|  | 3 | Oral hypoglycaemics  |
|  | 4 | Diet and exercise |
|  | 9 | Not stated / inadequately described |
| Reporting guide | Report all therapies prescribed during the pregnancy, up to 3 codes.Report any single code once only.Code 2 Insulin: Equivalent to 5th digit 2 (insulin treated) on ICD-10-AM codes in therange O24.1- to O24.9-.Code 3 Oral hypoglycaemics: Includes sulphonylurea, biguanide (e.g., metformin), alpha-glucosidaseinhibitor, thiazolidinedione, meglitinide, combination (e.g., biguanide andsulphonylurea) or other. Equivalent to 5th digit 3 (oral hypoglycaemictherapy) on ICD-10-AM codes O24.1- to O24.9-.Code 4 Diet and exercise: Includes generalised prescribed diet; avoidance of added sugar/simplecarbohydrates (CHOs); low joule diet; portion exchange diet and usesglycaemic index and a recommendation for increased exercise. Equivalent to 5th digit 4 (other; diet; exercise; lifestyle management) onICD‑10‑AM codes O24.1- to O24.9-.Code 9 Not stated / inadequately described:This code is not to be used with any other code.Leave blank for mothers with Type 1 diabetes mellitus diagnosed before the current pregnancy (reported as code 2 in Diabetes mellitus during pregnancy – type) as insulin therapy is assumed. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes reporting Diabetes mellitus during pregnancy – type codes 3, 4, 8 or 9. |
| Related concepts (Section 2): | Diabetes mellitus; Gestational diabetes mellitus |
| Related data items (this section): | Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus – pre-existing – diagnosis timing; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for induction (other) – ICD-10-AM code; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications- ICD-10-AM code |
| Related business rules (Section 4): | Diabetes mellitus during pregnancy – type, Diabetes mellitus – gestational – diagnosis timing, Diabetes mellitus – pre-existing – diagnosis timing and Diabetes mellitus therapy during pregnancy valid combinations; Diabetes mellitus therapy during pregnancy valid combinations. |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity |
| Definition source | AIHW | Version | 1. January 20202. July 2023 |
| Codeset source | AIHW | Collection start date | 2020 |

## Estimated gestational age

**Specification**

|  |  |
| --- | --- |
| Definition | The number of completed weeks of the period of gestation as measured from the first day of the last normal menstrual period to the date of birth |
|  |
| Representation class | Total | Data type | Number |
|  |
| Format | NN | Field size | 2 |
|  |
| Location | Episode record | Position | 48 |
|  |
| Permissible values | Range: ~~16~~ 15 to 45 (inclusive)**Code Descriptor**99 Not stated / inadequately described |
|  |
| Reporting guide | The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed weeks (for example, if a baby is 37 weeks and six days, this should be recorded as 37 weeks). |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Estimated date of confinement |
| Related business rules (Section 4): | \*\*\*Estimated gestational age and Gestational age at first antenatal visit valid combinations; \*\*\*Estimated gestational age conditionally mandatory data items for Birth status; ###Estimated gestational age warning validation; Mandatory to report data items; Scope ‘Stillborn’ |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | AIHW METeOR (DH modified) ~~NHDD~~  | Version | 1. January 19822. July 2023 |
|  |
| Codeset source | AIHW METeOR ~~NHDD~~ | Collection start date | 1982 |

## Hospital code (agency identifier)

**Specification**

|  |  |
| --- | --- |
| Definition | Numeric code for the hospital campus reporting to the VPDC |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record, Header record, File name | Position | 4 |
| Permissible values | Please refer to the 'Campus Code Table’ available at the [HDSS website](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files>  |
| Reporting guide | Software-system generated. Report the campus code for your maternity hospital ~~(includes birth centres).~~ |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Each VPDC electronic submission file and in each birth record. |
| Related concepts (Section 2): | Hospital; Transfer |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 20092. July 2023 |
| Codeset source | DH | Collection start date | 2009 |

## Indication for induction (main reason) – ICD-10-AM code

**Specification**

|  |  |
| --- | --- |
| Definition | The main reason given for an induction of labour |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (X1) |
| Location | Episode record | Position | 71 |
| Permissible values | Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**O480 Social induction (when documented as such)Z8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Report where a medical, ~~or~~ surgical or mechanical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously.  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where an induction was performed |
| Related concepts (Section 2): | Induction |
| Related data items (this section): | Indications for induction (other) – free text; Indications for induction (other) – ICD-10-AM code |
| Related business rules (Section 4): | Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; ### Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – ICD-10-AM code valid combinations; \*\*\*Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – free text and Indication for induction (other) – ICD-10-AM code valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 19992. January 20093. July 20154. January 20205. July 20226. July 2023 |
| Codeset source | ICD-10-AM/ACHI 12th edition plus CCOPMM additions | Collection start date | 1999 |

## Indications for induction (other) – free text

**Specification**

|  |  |
| --- | --- |
| Definition | Any other reasons given for an induction of labour, in addition to the main reason reported for the induction |
| Representation class | Text | Data type | String |
| Format | A(50) | Field size | 50 |
| Location | Episode record | Position | 70 |
| Permissible values | Permitted characters: * a–z and A–Z
* special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)
* numeric characters
* blank characters

A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**O480 Social induction (when documented as such)Z8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Report any other indications for induction in this field. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where an induction was performed and there is more than one indication for the induction. |
| Related concepts (Section 2): | Induction |
| Related data items (this section): | Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – ICD-10-AM code |
| Related business rules (Section 4): | Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; \*\*\*Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – free text and Indication for induction (other) – ICD-10-AM code valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 19992. January 20203. July 2023 |
| Codeset source | Not applicable | Collection start date | 1999 |

## Indications for induction (other) – ICD-10-AM code (new)

**Specification**

|  |  |
| --- | --- |
| Definition | Other indications for an induction of labour, reported using ICD-10-AM code(s), in addition to the main reason reported for the induction |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x15) |
| Location | Episode record | Position | 166 |
| Permissible values | Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**O480 Social induction (when documented as such)Z8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Report where a medical, surgical, or mechanical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously and there are other indications for this induction in addition to the one main reason for induction that has been reported .  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where an induction was performed and there is more than one indication for the induction. |
| Related concepts (Section 2): | Induction |
| Related data items (this section): | Indication for induction (main reason) – ICD-10-AM; Indications for induction (other) – free text  |
| Related business rules (Section 4): | Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; \*\*\*Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; ### Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – ICD-10-AM code valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. July 2023 |
| Codeset source | ICD-10-AM/ACHI 12th edition plus CCOPMM additions | Collection start date | 2023 |

## Indication for operative delivery (main reason) – ICD-10-AM code

**Specification**

|  |  |
| --- | --- |
| Definition | The main reason given for an operative birth |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x1) |
| Location | Episode record | Position | 76 |
| Permissible values | Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**O480 Social induction (when documented as such) including maternal choiceZ8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Report the main reason for operative delivery as an ICD-10-AM code.Report the ‘main reason’ for the operative birth by reporting in this field a single ICD-10-AM code for each birth in which Method of birth code is reported as one of:1 Forceps4 Planned caesarean – no labour5 Unplanned caesarean – labour6 Planned caesarean – labour7 Unplanned caesarean – no labour8 Vacuum extraction10 Other operative birthCode O480 includes ‘Maternal choice’Code O480 may not be reported with any other indication for operative delivery |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps, or vacuum extraction (ventouse) or other operative birth |
| Related concepts (Section 2): | Operative delivery; Procedure |
| Related data items (this section): | Indications for operative delivery (other) – free text; Indications for operative delivery (other) – ICD-10-AM code; Method of birth |
| Related business rules (Section 4): | \*\*\*Labour type ‘Failed induction’ conditionally mandatory data items; \*\*\*Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations; \*\*\*Indications for operative delivery (other) – ICD-10-AM code and Indication for operative delivery (main reason) – ICD-10-AM code valid combinations; ### Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 19822. January 19993. January 20094. July 20155. January 20206. July 20227. July 2023 |
| Codeset source | ICD-10-AM/ACHI 12th edition plus CCOPMM additions | Collection start date | 1982 |

## Indications for operative delivery (other) – free text

**Specification**

|  |  |
| --- | --- |
| Definition | Any other reason(s) given for an operative birth, in addition to the one main reason reported |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 75 |
| Permissible values | Permitted characters: * a–z and A–Z
* special characters (a character which has a visual representation and is neither a letter, number or ideogram; for example, full stops, punctuation marks and mathematical symbols)
* numeric characters
* blank characters

A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**Z8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Must report in the data item ‘Indication for operative delivery (main reason) a single ICD-10-AM code to indicate the ‘main reason’ for operative birth when Method of birth code is reported as one of:1. Forceps

4Planned caesarean – no labour5Unplanned caesarean – labour6Planned caesarean – labour7Unplanned caesarean – no labour8Vacuum extraction10 Other operative birthReport any other indications for operative delivery in this field, in order from the most to least influential in making the decision. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps, or vacuum extraction (ventouse) or other operative birth |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Indication for operative delivery (main reason) – ICD-10-AM code; Method of birth; Indications for operative delivery (other) – ICD-10-AM code |
| Related business rules (Section 4): | \*\*\*Labour type ‘Failed induction’ conditionally mandatory data items; \*\*\*Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations; ###Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 19822. January 20203. July 20224. July 2023 |
| Codeset source | Not applicable | Collection start date | 1982 |

## Indications for operative delivery (other) – ICD-10-AM code (new)

**Specification**

|  |  |
| --- | --- |
| Definition | Other reason(s) given for an operative birth, reported using ICD-10-AM code(s), in addition to the one main reason reported |
| Representation class | Code | Data type | String |
| Format | ANN[NN] | Field size | 5 (x15) |
| Location | Episode record | Position | 167 |
| Permissible values | Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.A small number of additional codes have been created solely for VPDC reporting in this data element:**Code Descriptor**Z8751 Past history of shoulder dystociaZ8752 Past history of third or fourth degree perineal tear |
| Reporting guide | Must report in the data item ‘Indication for operative delivery (main reason) – ICD-10-AM code’ a single ICD-10-AM code to indicate the ‘main reason’ for operative birth when Method of birth code is reported as one of:1 Forceps4 Planned caesarean – no labour5 Unplanned caesarean – labour6 Planned caesarean – labour7 Unplanned caesarean – no labour8 Vacuum extraction10 Other operative birthAny indications for operative birth in addition to the main reason can be reported in this data item as an ICD-10-AM code/s. Excludes:Code O480 which cannot be reported in this field as it may not be reported with any other Indication for operative delivery.  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps, or vacuum extraction (ventouse) or other operative birth and there is more than one indication for operative delivery.  |
| Related concepts (Section 2): | Operative delivery; Procedure |
| Related data items (this section): | Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Method of birth |
| Related business rules (Section 4): | ### Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – ICD-10-AM code valid combinations; ### Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation; \*\*\*Labour type ‘Failed induction’ conditionally mandatory data items; \*\*\*Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. July 2023 |
| Codeset source | ICD-10-AM/ACHI 12th edition plus CCOPMM additions | Collection start date | 2023 |

## Labour induction/augmentation agent

|  |  |
| --- | --- |
| Definition | Agents used to induce or assist in the progress of labour |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (~~x4~~x5) |
| Location | Episode record | Position | 68 |
| Permissible values | **Code Descriptor**1 Oxytocin2 Prostaglandins3 Artificial rupture of membranes (ARM)4 ~~Cervical Ripening – balloon catheter~~ Mechanical cervical dilation5 Antiprogestogen8 Other ~~– specify~~9 Not stated/inadequately described |
| Reporting guide | Report up to ~~four~~five (5) codes.Code 2 Prostaglandins: includes misoprostolCode 4 Mechanical cervical dilation includes the use of a cervical ripening balloon catheterCode 5 Antiprogestogen – also known as antiprogesterone or antiprogestin. Code 8 Other ~~– specify: if code 8 is reported, specify the agent of induction or augmentation in Labour induction/augmentation agent – other specified description~~If labour is not induced or augmented do not report a value, leave blank.No code may be reported more than once.Code 9 may not be reported with any other code. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where labour was induced or augmented |
| Related concepts (Section 2): | Augmentation, Labour type |
| Related data items (this section): | Indication for Induction (main reason) – ICD-10-AM code; Indications for induction (other) – ICD-10-AM code; Indications for induction (other) – free text~~; Labour induction / augmentation agent – other specified description~~ |
| Related business rules (Section 4): | ~~Labour induction / augmentation agent and Labour induction / augmentation agent – other specified description – conditionally mandatory data item;~~ \*\*\*Labour type and Labour induction / augmentation agent valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 1999
2. January 2017
3. July 2023
 |
| Codeset source | AIHW METeOR 270037 | Collectionstartdate | 1999 |

## ~~Labour induction/augmentation agent – other specified description~~

**~~Specification~~**

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

**~~Administration~~**

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

## Labour type

**Specification**

|  |  |
| --- | --- |
| Definition | The manner in which labour starts in a birth event |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x~~3~~ 4) |
| Location | Episode record | Position | 67 |
| Permissible values | **Code Descriptor**1 Spontaneous2 Induced - medical3 Induced – surgical4 Augmented5 No labour6 Induced – mechanical9 Not stated / inadequately described |
| Reporting guide | Labour commences at the onset of regular uterine contractions which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.If prost~~o~~aglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.A combination of up to ~~three~~ four valid codes can be reported. * Spontaneous: labour occurs naturally without any intervention.
* Induction of labour: a procedure performed for the purpose of initiating and establishing labour, either medically and/or surgically and/or mechanically.- Medical includes prostaglandins, oxytocins, ~~cervical ripening – balloon catheter~~ or other hormonal derivatives (eg cervidal, misoprostol). - Surgical is the artificial rupture of membranes (ARM) either by hindwater or forewater rupture- Mechanical methods for induction promote cervical ripening and onset of labour by stretching the cervix. They commonly include insertion of balloon catheters or possibly laminaria.
* Augmentation of labour: spontaneous onset of labour complemented with the use of drugs such as oxytocins~~, prostaglandins or their derivatives,~~ and/or artificial rupture of membranes (ARM) either by hindwater or forewater rupture. If labour was augmented, select and record both spontaneous and augmented in Labour type. Code 4 Augmented cannot be reported on its own.
* No labour: indicates the total absence of labour, as in an elective caesarean or a failed induction. If a failed induction occurred, that is, the mother failed to establish labour, select ~~both the~~ all the relevant induction types (medical and/or surgical and/or mechanical~~both~~) and ‘no labour’.

An induction, medical and/or surgical and/or mechanical, cannot be recorded with augmentation. If an induction has occurred, record the reason in Indication for induction (main reason) – ICD-10-AM code. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | Labour type |
| Related data items (this section): | Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – ICD-10-AM code; Indications for induction (other) – free text; Labour induction / augmentation agent; ~~Labour induction / augmentation agent – other specified description;~~ Method of birth |
| Related business rules (Section 4): | \*\*\*Labour type ‘Failed induction’ conditionally mandatory data items; \*\*\*Labour type ‘Woman in labour’ and associated data items valid combinations; \*\*\*Labour type ‘Woman not in labour’ and associated data items valid combinations; \*\*\*Labour type and Labour induction/augmentation agent valid combinations; \*\*\*Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; Mandatory to report data items; \*\*\*Method of birth and Labour type valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | ~~NHDD~~ AIHW METeOR(DH Modified) | Version | 1. January 19822. July 20153. July 2023 |
| Codeset source | ~~NHDD~~ AIHW METeOR (DH Modified) | Collection start date | 1982 |

## Last feed before discharge ~~taken exclusively from the breast~~ – baby

**Specification**

|  |  |
| --- | --- |
| Definition | Whether the last feed prior to discharge was taken exclusively from the breast, or included expressed breastmilk, or any formula.~~with no complementary feeding of any kind~~ |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 117 |
| Permissible values | **Code Descriptor**1 Last feed before discharge taken exclusively from breast~~2 Last feed before discharge not taken exclusively from breast~~ 3 Last feed before discharge is exclusively breastmilk but not taken exclusively from the breast4 Last feed before discharge included both infant formula and breastmilk8 Last feed before discharge did not include any breastmilk9 Not stated / inadequately described |
|  | Discharge in the context of this data element means the end of the birth episode. This encompasses discharge to home, died and transfer to another hospital. Do not report a value for stillbirth episodes, leave blank. Code 1 Last feed before discharge taken exclusively from breast: includes when the baby took the entire last feed prior to discharge directly from the breast. Can include the use of a nipple shield. ~~Code 2 Last feed before discharge not taken exclusively from breast:includes any expressed breast milk or formula given at the last feed before discharge from hospital, whether by cup, spoon, gavage or by any other means.~~ Code 3 Last feed before discharge is exclusively breastmilk but not taken exclusively from the breast:Last feed before discharge from hospital comprised of at least some expressed breast milk given in any way. Includes:- any expressed breastmilk whether given by cup, spoon, syringe, gavage, or any other means;- entirely expressed breastmilk from any source by any method;- donated breastmilk;- may include some breastmilk taken from the breast. Code 4 Last feed before discharge included both infant formula and breastmilk:Last feed before discharge comprised of both infant formula and breastmilk (given by any method). Code 8 Last feed before discharge did not include any breastmilk:Report if the last feed before discharge did not include any breastmilk by any method. Includes if last feed before discharge was only infant formula or parenteral nutrition. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All live birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Breastfeeding attempted, Birth status, Formula given in hospital |
| Related business rules (Section 4): | \*\*\*Birth status ‘Live born’ and associated conditionally mandatory data items; \*\*\*Birth status ‘Stillborn’ and associated data items valid combinations; \*\*\*Birth status, Breastfeeding attempted and Last feed before discharge - baby ~~taken exclusively from the breast~~ valid combinations |

**Administration**

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| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | ~~NHDD~~DH | Version | 1. January 20092. July 2023 |
| Codeset source | ~~NHDD~~DH | Collection start date | 2009 |

## Maternity model of care – antenatal

**Specification**

|  |  |
| --- | --- |
| Definition | The Maternity model of care a woman received for the majority of pregnancy care |
| Representation class | Code | Data type | Number |
| Format | NNNNNN | Field size | 6 |
| Location | Episode record | Position | 164 |
| Permissible values | **Code Description**NNNNNNMaternity model of care for the majority of this pregnancy999994Planned homebirth with care from a registered private homebirth midwife999997No antenatal care received by the woman for this pregnancy988888Majority of antenatal care at a hospital interstate988899Majority of antenatal care at a health service outside Australia999999 Not stated stated/inadequately described |
| Reporting guide | NNNNNNReport the six-digit unique Model of care code from the Maternity Care Classification System (MaCCS) that represents the model of care the woman received for the majority of her pregnancy care, as determined by the number of antenatal visits within that Model of care.Where the number of antenatal visits is equal for more than one Model of care, the referring Model of care should be reported. For example, if the woman was in a low-risk GP shared care model for 6 antenatal visits and then developed hypertension and pre-eclampsia and was referred to a high-risk model for 6 antenatal visits, the GP shared care should be reported.Report this data item after the birth, to ensure all antenatal care is represented.Where the majority of the woman’s antenatal care was provided at a health service other than the one where the birth occurred, report the relevant code of the model of care for the health service that provided the antenatal care. Maternity models of care for all health services in Australia are listed on the MaCCS DCT website. Where that other hospital was interstate, and no further details are available, report the supplementary code 988888.Report only a code that has been valid for the duration of the care it represents, and is listed for that period for the health service campus where that antenatal care was provided, as found at the MaCCS DCT website.Maternity model of care codes can be found at the [AIHW’s MaCCS DCT website](https://maccs.aihw.gov.au/) <https://maccs.aihw.gov.au> 999994 Planned homebirth with care from a registered private homebirth midwife. If this care is provided by a registered homebirth midwife through a public hospital, report the code for the relevant Maternity model of care for that public hospital. Refer to the MaCCS DCT website.999997Report if no antenatal care was received by the woman for this pregnancy, or where an informal plan was in place with a carer who is not a registered private homebirth midwife988888Report where the majority of antenatal care was provided by a health service interstate, and no further details of the Maternity model of care at that hospital are available988899Report where the majority of antenatal care was provided by a health service outside Australia999999Not stated stated/inadequately described. Should be used only in exceptional circumstances, such as where the woman is unconscious and cannot provide any details of her antenatal care or plan |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternity model of care – at onset of labour or non-labour caesarean section |
| Related business rules (Section 4): | Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations; Mandatory to report data items; ~~Model of care code is invalid;~~ ### Maternity model of care – antenatal and Maternity model of care – at onset of labour or non-labour caesarean section valid codes |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | AIHW | Version | 1. July 20222. July 2023 |
| Codeset source | AIHW (DH modified) | Collection start date | 2022 |

## Maternity model of care – at onset of labour or non-labour caesarean section

**Specification**

|  |  |
| --- | --- |
| Definition | The Maternity model of care a woman is under at the onset of labour or at the time of non-labour caesarean section |
| Representation class | Code | Data type | Number |
| Format | NNNNNN | Field size | 6 |
| Location | Episode record | Position | 165 |
| Permissible values | Code DescriptionNNNNNN Maternity model of care at the time of onset of labour or non-labour caesarean section999994Planned homebirth with care from a registered private homebirth midwife999997No antenatal care received by the woman for this pregnancy988888Majority of antenatal care at a hospital interstate988899Majority of antenatal care at a health service outside Australia999999 Not stated stated/inadequately described |
| Reporting guide | NNNNNNReport the six-digit unique Model of care code from the Maternity Care Classification System (MaCCS) that represents the model of care the woman is under at the onset of labour or at the time of non-labour caesarean section.This may or may not be the same Model of care as reported in the Maternity model of care – antenatal. For example, if the woman was in a low-risk GP shared care model for most of this pregnancy, but towards the end of this pregnancy developed hypertension and pre-eclampsia and was referred to a high-risk model, the high-risk model should be reported as it is current at the time of onset of labour or non-labour caesarean section.Report this data item after the birth.Where antenatal care was provided at a health service other than the one where the birth occurred, report the relevant code of the model of care for the health service that provided the antenatal care. Maternity models of care for all health services in Australia are listed on the MaCCS DCT website.If the birth occurred at a location that was not planned, whether at a health service, in transit or born elsewhere before arrival at a health service, and the woman had a Maternity model of care at the time of the onset of labour or non-labour caesarean section, report the code for that model of care, including if it is for another health service.Report only a code that is valid at the time of the birth, as found at the MaCCS DCT website.Maternity models of care can be found at the [AIHW’s MaCCS DCT website](https://maccs.aihw.gov.au/) <https://maccs.aihw.gov.au>.999994 Planned homebirth with care from a registered private homebirth midwife. If this care is provided by a registered homebirth midwife through a public hospital, report the code for the relevant Maternity model of care for that public hospital. Refer to the MaCCS DCT website.999997Report if no antenatal care was received by the woman at the onset of labour or non-labour caesarean section, or where an informal plan was in place with a carer who is not a registered private homebirth midwife988888Report where the majority of antenatal care was provided by a health service interstate, and no further details of the Maternity model of care at that hospital are available988899Report where the plan at onset of labour or non-labour caesarean section had been provided by a health service outside Australia999999Not stated stated/inadequately described. Should be used only in exceptional circumstances, such as where the woman is unconscious and cannot provide any details of Maternity model of care at onset of labour or non-labour caesarean section. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Maternity model of care – antenatal  |
| Related business rules (Section 4): | Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations; Mandatory to report data items; ~~Model of care code is invalid;~~ ### Maternity model of care – antenatal and Maternity model of care – at onset of labour or non-labour caesarean section valid codes |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | AIHW | Version | 1. July 20222. July 2023 |
| Codeset source | AIHW (DH modified) | Collection start date | 2022 |

## Method of birth

**Specification**

|  |  |
| --- | --- |
| Definition | The method of complete expulsion or extraction from the woman of a product of conception in a birth event |
| Representation class | Code | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 74 |
| Permissible values | **Code Descriptor**1 Forceps3 Vaginal birth – non-instrumental4 Planned caesarean – no labour5 Unplanned caesarean – labour6 Planned caesarean – labour7 Unplanned caesarean – no labour8 Vacuum extraction9 Not stated / inadequately described10 Other operative birth |
| Reporting guide | In the case of multiple births, the method of birth is reported in each baby’s episode record. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.Code 1 Forceps:Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the head during breech presentations. Includes vaginal breech with forceps to the aftercoming headCode 3 Vaginal birth – non-instrumental:Includes manual assistance for example, a vaginal breech that has been manually rotatedCode 4 Planned caesarean – no labour:Caesarean takes place as a planned procedure before the onset of labour Code 5 Unplanned caesarean – labour\*:Caesarean is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced.Code 6 Planned caesarean – labour:Caesarean was a planned procedure, but occurs after spontaneous onset of labourCode 7 Unplanned caesarean – no labour\*:Procedure is undertaken for an urgent indication before the onset of labour.Code 8 Vacuum extraction:Vaginal birth with vacuum extraction assistance. Code 10 Other operative birthIncludes D&C, D&E, hysterotomy and laparotomy;Excludes operative methods of birth for which a specific code exists.\*Note: for Unplanned caesarean (codes 5 or 7): if a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate. In this situation also report:- Category of unplanned caesarean section urgency AND- Date of decision for unplanned caesarean section AND- Time of decision for unplanned caesarean section. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Anaesthesia for operative delivery – indicator, Anaesthesia for operative delivery – type, Analgesia for labour – indicator, Analgesia for labour – type; Category of unplanned caesarean section urgency; Date of decision for unplanned caesarean section; Time of decision for unplanned caesarean section; Labour type |
| Related business rules (Section 4): | Anaesthesia for operative delivery – indicator and Method of birth valid combinations; \*\*\*Blood loss assessment – indicator, Episiotomy – indicator, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code, Indications for operative delivery (other) – free text, ~~Indications for operative delivery – ICD-10-AM code,~~ Method of birth, Perineal/genital laceration – degree/type and Perineal laceration – indicator conditional reporting; Episiotomy – indicator and Method of birth valid combinations; \*\*\*Labour type ‘Woman in labour’ and associated data items valid combinations; \*\*\*Labour type ‘Woman not in labour’ and associated data items valid combinations; Mandatory to report data items; Manual removal of placenta and Method of birth conditionally mandatory data items; Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data item; \*\*\*Method of birth and Labour type valid combinations; Method of birth and Manual removal of placenta conditionally mandatory data item; \*\*\*Method of birth and Setting of birth – actual valid combinations; \*\*\*Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code, Indications for operative delivery (other) – free text valid combinations; Perineal laceration – indicator and Method of birth valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | ~~NHDD~~ AHIW (DH modified) | Version | 1. January 19822. January 19993. January 20094. June 20155. July 20216. July 2023 |
| Codeset source | ~~NHDD~~ AHIW (DH Modified) | Collection start date | 1982 |

## Setting of birth – actual

**Specification**

|  |  |
| --- | --- |
| Definition | The actual place where the birth occurred |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 27 |
| Permissible values | Please refer to the ‘Campus Code Table’ available at the [HDSS website](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files>**Code Descriptor** 0003 Home (other) 0005 In transit 0006 Home – Private midwife care 0007 Home – Public homebirth program 0008 Other - specify0009 Not stated / inadequately described0010 Community, non-medical, freebirth |
| Reporting guide | The 4-digit Hospital code (agency identifier) of the hospital/health service where the birth occurred must be reported for this data element. The code for this data element may be the same as or different from that reported in Setting of birth – intended. The supplementary codes listed above are only to be used to report the location of births that do not occur within a health service/hospital campus. Code 0003 Home (other): includes a birth not intended to occur at home. Home in the context of this data element means the home of the woman or a relative or a friend.Excludes homebirth with a private midwife (use code 0006) and homebirth under the public homebirth program (use code 0007)Code 0005 In transit: includes births occurring on the way to the intended place of birth or the car park of a hospitalCode 0006 Home: private midwife care:reported when a birth is attended by a private midwife practitioner in the mother’s own home or a home environmentCode 0007 Home: Public homebirth program:reported when a birth is attended by a public midwife in the mother’s home under the Public homebirth programCode 0008 Other – specify: used when birth occurs at any location outside a hospital or health service other than at the locations listed above. May also include a community health centre. Report the Other location in Setting of birth – actual – other specified descriptionCode 0010 Community, non-medical, freebirth:Record for births that occur in the community, that are planned outside of a medical setting and without a midwife or other medical professional in attendance, for example, free births. This may include a home or other location in the community. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Setting of birth – actual – other specified description; Setting of birth – change of intent; Setting of birth – change of intent -reason; Setting of birth – intended; Setting of birth – intended – other specified description |
| Related business rules (Section 4): | Date of birth – baby, Date of admission – mother and Setting of birth – actual valid combinations; Mandatory to report data items; \*\*\*Method of birth and Setting of birth – actual valid combinations; Setting of birth – actual and Admitted patient election status – mother valid combinations; Setting of birth – actual and Setting of birth – actual – other specified description conditionally mandatory data item; Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | ~~NHDD~~ AHIW (DH modified) | Version | 1. January 19822. July 20153. January 20204. July 2023 |
| Codeset source | ~~NHDD~~ AHIW (DH modified) | Collection start date | 1982 |

## Setting of birth – intended

**Specification**

|  |  |
| --- | --- |
| Definition | The intended place of birth |
| Representation class | Code | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record | Position | 25 |
| Permissible values | Please refer to the ‘Campus Code Table’ available at the [HDSS website](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files>**Code Descriptor** 0003 Home (other) 0006 Home – Private midwife care 0007 Home – Public homebirth program 0008 Other - specify 0009 Not stated / inadequately described0010 Community, non-medical, freebirth |
| Reporting guide | The 4-digit Hospital code (agency identifier) of the hospital/health service where the birth was intended to occur must be reported for this data element, whether the birth actually occurred there or not. The code for this data element may be the same as or different from that reported in Setting of birth – actual. The supplementary codes listed above are only to be used to report when the location where the birth was intended to occur was not a health service/hospital campus. If the birth was intended to occur interstate or overseas, report code 0008 Other – specify and report the details in ‘Setting of birth – intended – other specified description).~~Home in the context of this data element means the home of the woman or a relative or a friend.~~ Code 0003 Home (other): excludes homebirth with a private midwife (use code 0006) and homebirth in a public homebirth program (use code 0007) Home in the context of this data element means the home of the woman or a relative or a friend.Code 0006 Home: private midwife care:reported when a birth is attended by a private midwife practitioner in the mother’s own home or a home environmentCode 0007 Home: Public homebirth program:reported when a birth is attended by a public midwife in the mother’s home under the Public homebirth programCode 0008 Other – specify: includes when the birth is planned to occur at any location outside a hospital or health service other than at the locations listed above, including at locations such as community (health) centres, interstate or overseas hospitals or health services. ~~Record~~ Report the location in Setting of birth – intended – other specified descriptionCode 0009 Not stated / inadequately described: includes unbooked or unplannedCode 0010 Community, non-medical, freebirth:Record for births that occur in the community, that are planned outside of a medical setting and without a midwife or other medical professional in attendance, for example, free births. This may include a home or other location in the community. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Setting of birth – actual; Setting of birth – actual – other specified description; Setting of birth – change of intent, Setting of birth – change of intent – reason, Setting of birth – intended – other specified description |
| Related business rules (Section 4): | Mandatory to report data items; Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items; Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | ~~NHDD~~ AHIW (DH modified) | Version | 1. January 19992. July 20153. January 20204. July 2023 |
| Codeset source | ~~NHDD~~ AHIW (DH modified) | Collection start date | 1999 |

## Spoken English Proficiency

**Specification**

|  |  |
| --- | --- |
| Definition | Self assessment by a mother~~,~~ ~~born in a country other than Australia,~~ of her own spoken English language fluency. |
|  |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 |
|  |
| Location | Episode record | Position | 127 |
|  |
| Permissible values | **Code Descriptor** |  |  |
| 1 Very well2 Well3 Not well4 Not at all9 Not stated / inadequately described |  |  |
| Reporting guide | Each woman should be asked “How well do you speak English”? Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes~~, where the Country of Birth is not Australia~~ |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | ~~Country of Birth~~ None specified |
|  |
| Related business rules (Section 4): | None specified |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | AIHW METeOR ~~ID~~ 270203 | Version | 1. January 20172. July 2023 |
| Codeset source | ~~NHDD~~ AIHW METeOR | Collection start date | 2017 |

## Version identifier

**Specification**

|  |  |
| --- | --- |
| Definition | Version of the data collection |
| Representation class | Identifier | Data type | Number |
| Format | NNNN | Field size | 4 |
| Location | Episode record, Header record | Position | 2 |
| Permissible values | **Code**~~2020 (for births in the period 1 January 2020 to 30 June 2021 inclusive)~~2021 (for births in the period 1 July 2021 to 30 June 2022 inclusive)2022 (for births in the period 1 July 2022 to 30 June 2023 inclusive)2023 (for births in the period 1 July 2023 to 30 June 2024 inclusive) |
| Reporting guide | Software-system generated. A VPDC electronic submission file with a missing or invalid Version identifier will be rejected and the submission file will not be processed.The Version identifier in each Episode record in a submission file must be the same as the Version identifier in the Header record of that submission file.All Episode records in a submission file must have the same Version identifier. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Each VPDC electronic submission file (Header record); Each VPDC electronic birth record (Episode record) |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified  |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DH | Version | 1. January 20092. July 20153. January 20174. January 20185. January 20196. January 20207. July 20218. July 20229. July 2023 |
| Codeset source | DH | Collection start date | 2009 |

# Section 4 Business rules

## ### Administration of Hepatitis B Immunoglobulin (HBIG) – baby, Birth status and Hepatitis B antenatal screening – mother conditionally mandatory data item

|  |
| --- |
| **If Administration of Hepatitis B Immunoglobulin (HBIG) – baby is:**  |
| Not blank |
| **Birth status must be:** | **Hepatitis B antenatal screening – mother must be:** |
| 1 Live born | 2 Hepatitis serology (HBsAg) was positive |

## Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations

|  |
| --- |
| **If admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby is:** |
| 1 Admitted to SCN **or** |
| 2 Admitted to NICU |
| **Hospital code (agency identifier) must be:** | **Setting of birth – actual must be:** |
| A health service from the list below with SCN and/or NICU services | Equal to Hospital code (agency identifier) **or**0003 Home (other) **or**0005 In transit **or**0006 Home – Private midwife care **or**0007 Home – Public home birth program **or**0008 Other – Specify **or**0010 Community, non-medical, freebirth |

Campuses with a SCN and/or NICU

|  |  |  |  |
| --- | --- | --- | --- |
| **Campus Code** | **Campus Name** | **SCN** | **NICU** |
| 1660 | Albury Wodonga Health - Wodonga | Yes | No |
| 1590 | Angliss Hospital | Yes | No |
| 3020 | Bacchus Marsh campus of Western Health (formerly Djerriwarrh) | Yes | No |
| 2010 | Ballarat Health Services [Base Campus] | Yes | No |
| 6291 | Bays Hospital, The [Mornington] | Yes | No |
| 1021 | Bendigo Hospital, The | Yes | No |
| 1050 | Box Hill Hospital | Yes | No |
| 6511 | Cabrini Malvern | Yes | No |
| 3660 | Casey Hospital | Yes | No |
| 2060 | Central Gippsland Health Service [Sale] | Yes | No |
| 2111 | Dandenong Campus | Yes | No |
| 6470 | Epworth Freemasons | Yes | No |
| 6480 | Epworth Geelong | Yes | No |
| 7720 | Frances Perry House  | Yes | No |
| 2220 | Frankston Hospital | Yes | No |
| 1121 | Goulburn Valley Health [Shepparton] | Yes | No |
| 8890 | Jessie McPherson Private Hospital [Clayton] | Yes | No |
| 2440 | Latrobe Regional Hospital [Traralgon] | Yes | No |
| 1160 | Mercy Hospital for Women | Yes | Yes |
| 1320 | Mercy Public Hospitals Inc [Werribee] | Yes | No |
| 8440 | Mitcham Private Hospital | Yes | No |
| 1170 | Monash Medical Centre [Clayton] | Yes | Yes |
| 2320 | New Mildura Base Hospital | Yes | No |
| 1150 | Northeast Health Wangaratta | Yes | No |
| 1280 | Northern Hospital, The [Epping] | Yes | No |
| 7390 | Northpark Private Hospital [Bundoora] | Yes | No |
| 6790 | Peninsula Private Hospital [Frankston] | Yes | No |
| 1230 | Royal Women’s Hospital [Carlton] | Yes | Yes |
| ~~1232~~ | ~~Sandringham & District Memorial Hospital (Women’s at Sandringham)~~  | ~~Yes~~ | ~~No~~ |
| 4330 | Sandringham at Monash | Yes | No |
| 2160 | South West Healthcare [Warrnambool] | Yes | No |
| 6520 | St John of God Ballarat Hospital | Yes | No |
| 6030 | St John of God Bendigo Hospital | Yes | No |
| 6080 | St John of God Berwick Hospital | Yes | No |
| 6550 | St John of God Geelong Hospital | Yes | No |
| 6620 | St Vincent’s Private Hospital Fitzroy | Yes | No |
| 1390 | Sunshine Hospital | Yes | Yes |
| 2050 | University Hospital, Geelong | Yes | No |
| 6600 | Waverley Private Hospital [Mt Waverley] | Yes | No |
| 1580 | West Gippsland Healthcare Group [Warragul] | Yes | No |
| 2170 | Wimmera Base Hospital [Horsham] | Yes | No |

## Birth status, Breastfeeding attempted and Last feed before discharge – baby ~~taken exclusively from the breast~~ valid combinations

This business rule only applies when birth status is reported as **code 1 – Live born**.

|  |  |
| --- | --- |
| **If Breastfeeding attempted is:** | **Last feed before discharge – baby ~~taken exclusively from the breast~~ must not be:** |
| ~~1 Attempted to breastfeed / express breast milk~~ | ~~1 Last feed before discharge taken exclusively from breast~~ **~~or~~** ~~2 Last feed before discharge not taken exclusively from breast~~ |
| 2 Did not attempt to breastfeed / express breast milk | ~~2 Last feed before discharge not taken exclusively from breast~~1 Last feed before discharge taken exclusively from breast |

## Birth status ‘Live born’ and associated conditionally mandatory data items

|  |  |
| --- | --- |
| **If Birth status is:** | **then the following elements cannot be blank:** |
| 1 Live born | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – BabyAntenatal corticosteroid exposureBreastfeeding attemptedFormula given in hospitalHead circumference - babyHepatitis B vaccine receivedLast feed before discharge – baby ~~taken exclusively from the breast~~Separation date – babySeparation status – baby |

## Birth status ‘Stillborn’ and associated data items valid combinations

|  |
| --- |
| **If the birth status is:** |
| 2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) |
| **the data elements listed below must be:** |
| **Data element:**Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – babyApgar score at one minuteApgar score at five minutesBreastfeeding attemptedFormula given in hospitalHepatitis B vaccine receivedLast feed before discharge – baby ~~taken exclusively from the breast~~Separation date – babySeparation status – babyTime to established respiration (TER) | **Value:**Blank0000Blank Blank Blank Blank Blank Blank00 |
|  |  |

## Blood loss assessment – indicator, Episiotomy – indicator, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – free text, Indications for operative delivery (other) – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting

**Blood loss assessment – indicator may not be reported as code 9 with**:

|  |  |
| --- | --- |
| **the following codes** | **in the following data elements** |
| 1 Incision of the perineum and vagina made | Episiotomy – indicator |
| Any entry  | Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – free text **or**Indications for operative delivery (other) – ICD-10-AM code |
| 4 Planned caesarean – no labour **or**5 Unplanned caesarean – labour **or**6 Planned caesarean – labour **or**7 Unplanned caesarean – no labour **or**10 Other operative birth | Method of birth |
| 2 Second degree laceration/tear **or**3 Third degree laceration/tear **or**4 Fourth degree laceration/tear **or**5 Labial/clitoral laceration/tear **or**6 Vaginal wall laceration/tear **or**7 Cervical laceration/tear **or**8 Other perineal laceration, rupture or tear | Perineal/genital laceration – degree/type |
| 1 Laceration/tear of the perineum following birth | Perineal laceration – indicator |

## Estimated gestational age conditionally mandatory data items for Birth status code 1 Liveborn

**When Birth status reported as code 1 Liveborn:**

|  |  |
| --- | --- |
| **and Estimated gestational age is:** | **values must be reported in at least one of the following data items:** |
| Between ~~16~~ 15 and 36 | Neonatal morbidity – free text Neonatal morbidity – ICD-10-AM code |

## ### Estimated gestational age – in scope validation

|  |  |  |
| --- | --- | --- |
| **Birth status** | **Estimated gestational age** | **Validation** |
| 1 Liveborn | Less than 15 completed weeks | Rejection |
| 1 Liveborn | 15 to 19 completed weeks | Warning: confirm Estimated gestational age |
| 1 Liveborn | 20 to 45 completed weeks | Accepted |
| 2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) | Less than 15 completed weeks | Rejection |
| 2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) | 15 to 19 completed weeks | Rejection if Plurality = 1 Singleton**Or**Warning if Plurality is other than 1: confirm Estimated gestational age and that at least one other sibling was liveborn |
| 2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) | 20 to 45 completed weeks | Accepted |
| 1 Liveborn **or**2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) | 46 or more completed weeks | Rejection |
| 9 Not stated / inadequately described | Any | Rejection |

## ****### Future date warning validation for multiple data elements****

When a valid date is later than the date component of the Data Submission Identifier, in the Filename and/or the Header record, for any of the following data elements, a warning validation message will be produced:

* Date of admission – mother
* Date of birth – baby
* Date of birth – mother
* Date of completion of last pregnancy
* Date of decision for unplanned caesarean section
* Date of onset of labour
* Date of onset of second stage of labour
* Date of rupture of membranes
* Separation date – baby
* Separation date – mother

## Gravidity and related data items

|  |
| --- |
| **Gravidity must be less than or equal to the sum of:** |
| Total number of previous abortions – inducedTotal number of previous abortions – spontaneousTotal number of previous ectopic pregnanciesTotal number of previous live birthsTotal number of previous neonatal deathsTotal number of previous stillbirths (fetal deaths)Total number of previous unknown outcomes of pregnancyPlus one (for example, the current pregnancy) |

## ### Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – ICD-10-AM code valid combinations

|  |  |
| --- | --- |
| **Where an entry is reported for Indications for induction (other) – ICD-10-AM code** | **then there must be a valid code reported in Indication for induction (main reason) – ICD-10-AM code** |
| **If there is no Indication for induction (main reason) – ICD-10-AM code reported** | **then there may be no entry reported for Indications for induction (other) – ICD-10-AM code** |

## Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations

|  |  |
| --- | --- |
| **Where an entry is reported for Indications for operative delivery (other) – free text** | **then there must be a valid code reported in Indication for operative delivery (main reason) – ICD-10-AM code** |
| **If there is no Indication for operative delivery (main reason) – ICD-10-AM code reported** | **then there may be no entry reported for Indications for operative delivery ~~induction~~ (other) – free text** |

## ### Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – ICD-10-AM code valid combinations

|  |  |
| --- | --- |
| **Where an entry is reported for Indications for operative delivery (other) – ICD-10-AM code** | **then there must be a valid code reported in Indication for operative delivery (main reason) – ICD-10-AM code** |
| **If there is no Indication for operative delivery (main reason) – ICD-10-AM code reported** | **then there may be no entry reported for Indications for operative delivery (other) – ICD-10-AM code** |

## ### Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text validation

|  |  |
| --- | --- |
| Where **Indication for operative delivery (main reason) – ICD-10-AM code** is reported as Code **O480** **Social induction (when documented as such) including maternal choice;** | then**Indication for operative delivery (other) – ICD‑10‑AM code** and**Indication for operative delivery (other) – free text** must both be **(blank)** |

## ~~Labour induction/augmentation agent and Labour induction/ augmentation agent – other specified description conditionally mandatory data item~~

|  |  |
| --- | --- |
| **~~If Labour induction/augmentation agent is:~~** | **~~the following item cannot be blank:~~** |
| ~~8 Other – specify~~ | ~~Labour induction/augmentation agent – other specified description~~ |

## Labour type and Labour induction/augmentation agent valid combinations

|  |  |
| --- | --- |
| **When Labour type is:** | **Labour induction/augmentation agent:** |
| 2 Induced – medical **or**3 Induced – surgical **or**4 Augmented **or**6 Induced mechanical | Cannot be blank |

## Labour type ‘Failed induction’ conditionally mandatory data items

|  |  |
| --- | --- |
| **If Labour type is:** | **Failed induction must be reported by submitting the following ICD-10-AM code/s in at least one of the following data items:** |
| 2 Induced medical **and** 5 No labour | Code O610 Failed medical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 3 Induced surgical **and** 5 No labour | Code O611 Failed surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 2 Induced medical **and** 3 Induced surgical **and** 5 No labour | Code O610 Failed medical induction of labour **and** Code O611 Failed surgical induction of labour **or** Code O612 Failed medical and surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 6 Induced mechanical **and** 5 No labour | Code O611 Failed surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 2 Induced medical **and**6 Induced mechanical **and** 5 No labour | Code O610 Failed medical induction of labour **and** Code O611 Failed surgical induction of labour **or** Code O612 Failed medical and surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 3 Induced surgical **and**6 Induced mechanical **and** 5 No labour | Code O611 Failed surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |
| 2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour | Code O610 Failed medical induction of labour **and** Code O611 Failed surgical induction of labour **or** Code O612 Failed medical and surgical induction of labour – in Indication for operative delivery (main reason) – ICD-10-AM code **or**Indications for operative delivery (other) – ICD-10-AM code **or**Indications for operative delivery (other) – free text |

\*Code O611 Failed surgical induction also includes Failed mechanical induction

## Labour type, Indication for induction (main reason) – ICD-10-AM code, Indications for induction (other) – ICD-10-AM code and Indications for induction (other) – free text valid combinations

|  |  |
| --- | --- |
| **If Labour type is:** |  |
| 2 Induced medical **or**3 Induced surgical **or**6 Induced mechanical **or**2 Induced medical **and** 3 Induced surgical **or**2 Induced medical **and** 6 Induced mechanical **or**3 Induced surgical **and** 6 Induced mechanical **or** 2 Induced medical **and** 3 Induced surgical **and** 6 induced mechanical  | A valid code must be reported in Indication for induction (main reason) – ICD-10-AM code.An entry may also be reported for Indications for induction (other) – ICD-10-AM code and/or Indications for induction (other) – free text, if appropriate. |

## Labour type ‘Woman in labour’ and associated data items valid combinations

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 6 Induced mechanical **or**1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical **or**2 Induced medical **and** 6 Induced mechanical **or**3 Induced surgical **and** 6 Induced mechanical **or** 2 Induced medical **and** 3 Induced surgical **and** 6 induced mechanical | 1 Forceps **or** 3 Vaginal birth – non-instrumental **or**8 Vacuum extraction  |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | BlankBlankDDMMCCYYDDMMCCYYDDMMCCYY **or** 77777777BlankBlankHHMM or 7777HHMMHHMM **or** 7777 |

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 6 Induced mechanical **or**1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical **or**2 Induced medical **and** 6 Induced mechanical **or**3 Induced surgical **and** 6 Induced mechanical **or** 2 Induced medical **and** 3 Induced surgical **and** 6 induced mechanical | 6 Planned caesarean – labour  |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | BlankBlankDDMMCCYYDDMMCCYY **or** 88888888DDMMCCYY **or** 77777777 **or** 88888888BlankBlankHHMM or 7777HHMM **or** 8888HHMM **or** 7777 or 8888 |

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 6 Induced mechanical **or**1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical **or**2 Induced medical **and** 6 Induced mechanical **or**3 Induced surgical **and** 6 Induced mechanical **or** 2 Induced medical **and** 3 Induced surgical **and** 6 induced mechanical | 5 Unplanned caesarean – labour |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | 1 **or** 2 **or** 3 **or** 9DDMMCCYYDDMMCCYYDDMMCCYY **or** 88888888DDMMCCYY **or** 77777777 **or** 88888888BlankHHMMHHMM or 7777HHMM **or** 8888HHMM **or** 7777 or 8888 |

## Labour type ‘Woman not in labour’ and associated data items valid combinations

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 5 No labour **or**2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 6 Induced mechanical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 5 No labour **or** 2 Induced medical **and** 6 Induced mechanical **and** 5 No labour **or**3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour | 4 Planned caesarean – no labour **or** 10 Other operative birth |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | BlankBlank8888888888888888DDMMYYYY **or** 77777777 **or** 88888888BlankBlank88888888HHMM **or** 7777 **or** 8888 |

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 5 No labour **or**2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 6 Induced mechanical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 5 No labour **or** 2 Induced medical **and** 6 Induced mechanical **and** 5 No labour **or**6 Induced mechanical **and** 3 Induced surgical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour | 7 Unplanned caesarean – no labour |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | 1 **or** 2 **or** 3 **or** 9DDMMCCYY8888888888888888DDMMYYYY **or** 77777777 **or** 88888888BlankHHMM88888888HHMM **or** 7777 **or** 8888 |

## ### Maternity model of care – antenatal and Maternity model of care – at onset of labour or non-labour caesarean section valid codes

|  |  |  |
| --- | --- | --- |
| **Where the following is reported in either Maternity model of care data item:** | **And the value reported is** | **Validation result will be:** |
| Invalid format (i.e., not six digits, NNNNNN) | Not six digits [NNNNNN] | Rejection |
| Code with first digit 9 | Not one of: 999994 **or**999997 **or**988888 **or**988899 **or**999999 | Rejection |
| 6 digit Code with first digit in range 1 to 8 (both inclusive) | A code not in the VPDC reference table for these data items (accumulated from AIHW’s DCT code sets)  | Warning |
| 6 digit Code with first digit in range 1 to 8 (both inclusive) | A code in the VPDC reference table for these data items (accumulated from AIHW’s DCT code sets)  | Accepted |

## ~~Maternity model of care code is invalid~~

~~The code submitted in Maternity model of care – antenatal and/or Maternity model of care – at onset of labour or non-labour caesarean section is not valid, ie is not one of the supplementary codes listed in Section 3 of the VPDC manual, nor is it a code listed on the MaCCS website as being valid in the past year (Warning error).~~

## Method of birth and Labour type valid combinations

| **If Method of birth is:** | **Labour type must be:** |
| --- | --- |
| 1 Forceps **or**3 Vaginal birth – non-instrumental **or**5 Unplanned caesarean – labour **or**6 Planned caesarean – labour **or**8 Vacuum extraction | 1 Spontaneous **or**2 Induced medical **or**3 Induced surgical **or**6 Induced mechanical **or**1 Spontaneous **and** 4 Augmented **or**2 Induced medical **and** 3 Induced surgical **or**2 Induced medical **and** 6 Induced mechanical **or**6 Induced mechanical **and** 3 Induced surgical **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical |
| 4 Planned caesarean – no labour **or**7 Unplanned caesarean – no labour | 5 No labour **or**2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 6 Induced mechanical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical  **and** 5 No labour **or** 2 Induced medical **and** 6 Induced mechanical **and** 5 No labour **or**6 Induced mechanical **and** 3 Induced surgical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour |

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| **If Method of birth is:** | **Labour type must be:** |
| --- | --- |
| 10 Other operative birth | 1 Spontaneous **or**2 Induced medical **or**3 Induced surgical **or**6 Induced mechanical **or**1 Spontaneous **and** 4 Augmented **or**2 Induced medical **and** 3 Induced surgical **or** 2 Induced medical **and** 6 Induced mechanical **or**6 Induced mechanical **and** 3 Induced surgical **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical5 No labour **or**2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 6 Induced mechanical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical  **and** 5 No labour2 Induced medical **and** 6 Induced mechanical **and** 5 No labour **or**6 Induced mechanical **and** 3 Induced surgical **and** 5 No labour **or**2 Induced medical **and** 3 Induced surgical **and** 6 Induced mechanical **and** 5 No labour |

## Method of birth and Setting of birth – actual valid combinations

|  |  |
| --- | --- |
| **If Method of birth is:** | **then Setting of birth – actual must not be:** |
| 4 Planned caesarean – no labour **or**5 Unplanned caesarean – labour **or**6 Planned caesarean – labour **or**7 Unplanned caesarean – no labour **or**10 Other operative birth | 0003 Home (other) **or**0005 In transit **or**0006 Home – Private midwife care **or**0007 Home – Public homebirth program **or**0008 Other – specify **or**0009 Not stated / inadequately described **or**0010 Community, non-medical, freebirth |

## Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – ICD-10-AM code and Indications for operative delivery (other) – free text code valid combinations

|  |  |
| --- | --- |
| **If Method of birth is:** | **the Indication for operative delivery must be reported in at least one of the following data items:** |
| 1 Forceps **or**4 Planned caesarean – no labour **or**5 Unplanned caesarean – labour **or**6 Planned caesarean – labour **or**7 Unplanned caesarean – no labour **or**8 Vacuum extraction **or**10 Other operative birth | Indication for operative delivery (main reason) – ICD-10-AM codeIndications for operative delivery (other) – ICD-10-AM codeIndications for operative delivery (other) – free text |

## Parity and associated data items valid combinations

|  |  |
| --- | --- |
| **If Parity is:** | **then the following item cannot be blank:** |
| Greater than 00 | Date of completion of last pregnancy |
| **and Outcome of last pregnancy must be:** |
| 1 Live birth2 Spontaneous abortion3 Not stated / inadequately described4 Stillbirth5 Induced abortion6 Neonatal death7 Ectopic pregnancy |

## Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations

When Perineal laceration indicator is **code 1 – Laceration/tear of the perineum following birth**, at least one code must be reported in **Perineal/genital Laceration – degree/type**. This can be either a **single code from the following list**:

|  |
| --- |
| **Single codes:** |
| 1 first degree laceration/tear |
| 2 second degree laceration/tear |
| 3 third degree laceration/tear |
| 4 fourth degree laceration/tear |
| 8 Other perineal laceration, rupture or tear |

**or up to three (3) codes from the following combinations of two, or three, codes:**

|  |
| --- |
| **Two-code combinations:** |
| 1 First degree laceration/tear | * 5 Labial/clitoral laceration/tear
 |
| 1 First degree laceration/tear | * 6 Vaginal wall laceration/tear
 |
| 1 First degree laceration/tear | * 7 Cervical laceration/tear
 |

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|  |
| --- |
| **Two-code combinations (continued):** |
| ~~1 First degree laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| 1 First degree laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| 2 Second degree laceration/tear | * 5 Labial/clitoral laceration/tear
 |
| 2 Second degree laceration/tear | * 6 Vaginal wall laceration/tear
 |
| 2 Second degree laceration/tear | * 7 Cervical laceration/tear
 |
| ~~2 Second degree laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| 2 Second degree laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| 3 Third degree laceration/tear | * 5 Labial/clitoral laceration/tear
 |
| 3 Third degree laceration/tear | * 6 Vaginal wall laceration/tear
 |
| 3 Third degree laceration/tear | * 7 Cervical laceration/tear
 |
| ~~3 Third degree laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| 3 Third degree laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| 4 Fourth degree laceration/tear | * 5 Labial/clitoral laceration/tear
 |
| 4 Fourth degree laceration/tear | * 6 Vaginal wall laceration/tear
 |
| 4 Fourth degree laceration/tear | * 7 Cervical laceration/tear
 |
| ~~4 Fourth degree laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| 4 Fourth degree laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| ~~5 Labial/clitoral laceration/tear~~ | * ~~6 Vaginal wall laceration/tear~~
 |
| ~~5 Labial/clitoral laceration/tear~~ | * ~~7 Cervical laceration/tear~~
 |
| ~~5 Labial/clitoral laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| ~~5 Labial/clitoral laceration/tear~~ | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| ~~6 Vaginal wall laceration/tear~~ | * ~~7 Cervical laceration/tear~~
 |
| ~~6 Vaginal wall laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| ~~6 Vaginal wall laceration/tear~~ | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| ~~7 Cervical laceration/tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 |
| ~~7 Cervical laceration/tear~~ | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| 8 Other perineal laceration, rupture or tear | * 5 Labial/clitoral laceration/tear
 |
| 8 Other perineal laceration, rupture or tear | * 6 Vaginal wall laceration/tear
 |
| 8 Other perineal laceration, rupture or tear | * 7 Cervical laceration/tear
 |

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|  |
| --- |
| **Two-code combinations (continued):** |
| 8 Other perineal laceration, rupture or tear | * 0 Laceration, rupture or tear of other genital tract location
 |

|  |
| --- |
| **Three-code combinations:** |
| 1 First degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 6 Vaginal wall laceration/tear
 |
| 1 First degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 1 First degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 1 First degree laceration/ tear | * 6 Vaginal wall laceration/tear
 | * 7 Cervical laceration/tear
 |
| 1 First degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 1 First degree laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| ~~1 First degree laceration/ tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| 2 Second degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 6 Vaginal wall laceration/tear
 |
| 2 Second degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 2 Second degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 2 Second degree laceration/ tear | * 6 Vaginal wall laceration/tear
 | * 7 Cervical laceration/tear
 |
| 2 Second degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 2 Second degree laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| ~~2 Second degree laceration/ tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| 3 Third degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 6 Vaginal wall laceration/tear
 |
| 3 Third degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 7 Cervical laceration/tear
 |

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|  |
| --- |
| **Three-code combinations (continued):** |
| 3 Third degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 3 Third degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 3 Third degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 3 Third degree laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| ~~3 Third degree laceration/ tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| 4 Fourth degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 6 Vaginal wall laceration/tear
 |
| 4 Fourth degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 4 Fourth degree laceration/ tear | * 5 Labial/clitoral laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 4 Fourth degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 4 Fourth degree laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 4 Fourth degree laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| ~~4 Fourth degree laceration/ tear~~ | * ~~8 Other perineal laceration, rupture or tear~~
 | * ~~0 Laceration, rupture or tear of other genital tract location~~
 |
| 5 Labial/clitoral laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 8 Other perineal laceration, rupture or tear
 |
| 5 Labial/clitoral laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 5 Labial/clitoral laceration/ tear | * 7 Cervical laceration/tear
 | * 8 Other perineal laceration, rupture or tear
 |
| 5 Labial/clitoral laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 5 Labial/clitoral laceration/ tear | * 8 Other perineal laceration, rupture or tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 6 Vaginal wall laceration/ tear | * 7 Cervical laceration/tear
 | * 8 Other perineal laceration, rupture or tear
 |

(business rule table continues over page)

|  |
| --- |
| **Three-code combinations (continued):** |
| 6 Vaginal wall laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 6 Vaginal wall laceration/ tear | * 8 Other perineal laceration, rupture or tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 7 Cervical laceration/ tear | * 8 Other perineal laceration, rupture or tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |

When Perineal laceration indicator is **code 2 No laceration/tear of the perineum following birth,** valid **Perineal/genital laceration – degree/type** **codes** and combinations of up to three (3) codes are:

|  |
| --- |
| **Single codes:** |
| blank |
| 5 Labial/clitoral laceration/tear |
| 6 Vaginal wall laceration/tear |
| 7 Cervical laceration/tear |
| 0 Laceration, rupture or tear of other genital tract location |

|  |
| --- |
| **Two-code combinations:** |
| 5 Labial/clitoral laceration/tear | * 6 Vaginal wall laceration/tear
 |
| 5 Labial/clitoral laceration/tear | * 7 Cervical laceration/tear
 |
| 5 Labial/clitoral laceration/tear | * 8 Other perineal laceration, rupture or tear
 |
| 5 Labial/clitoral laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| 6 Vaginal wall laceration/tear | * 7 Cervical laceration/tear
 |
| 6 Vaginal wall laceration/tear | * 8 Other perineal laceration, rupture or tear
 |
| 6 Vaginal wall laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| 7 Cervical laceration/tear | * 8 Other perineal laceration, rupture or tear
 |
| 7 Cervical laceration/tear | * 0 Laceration, rupture or tear of other genital tract location
 |
| **Three-code combinations:** |
| 5 Labial/clitoral laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 7 Cervical laceration/tear
 |
| 5 Labial/clitoral laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 8 Other perineal laceration, rupture or tear
 |
| 5 Labial/clitoral laceration/ tear | * 6 Vaginal wall laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |

(business rule table continues over page)

|  |
| --- |
| **Three-code combinations (continued):** |
| 5 Labial/clitoral laceration/ tear | * 7 Cervical laceration/ tear
 | * 8 Other perineal laceration, rupture or tear
 |
| 5 Labial/clitoral laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |
| 6 Vaginal wall laceration/ tear | * 7 Cervical laceration/ tear
 | * 8 Other perineal laceration, rupture or tear
 |
| 6 Vaginal wall laceration/ tear | * 7 Cervical laceration/ tear
 | * 0 Laceration, rupture or tear of other genital tract location
 |

# Section 5 Compilation and submission

## Data submission timelines

The Public Health and Wellbeing Regulations 2019 require VPDC data to be reported within 30 days of the birth. This includes correction of any rejections caused by non-compliance with business rules.

Where mother and/or baby remain in hospital at the submission deadline, report all data items known at the time of submission, and resubmit the Episode record when the episode ends, and data are complete.

Exceptions to reporting timelines are only permissible when negotiated on a case by case basis.

The minimum frequency for reporting is one submission file to report the births for an entire calendar month. Most health services report births for a shorter period, often weekly.

Births can be reported individually if that suits the health service.

More than one submission file can be lodged in a day.

Health services with high birth counts will benefit from more frequent submissions so the volume of data in each submission file, and the prompt correction of any rejections in that file, is more manageable.

Experience has shown that review, correction and resubmission of errors is easiest close to the clinical event.

The table below sets out the timeframes for reporting a single submission file for each calendar month, and represents the latest date for submission of data for that period:

|  |  |  |
| --- | --- | --- |
| **Birth period (from)** | **Birth period (to)** | **Latest submission date** |
| 01/07/202~~2~~3 | 31/07/202~~2~~3 | 30/08/202~~2~~3 |
| 01/08/202~~2~~3 | 31/08/202~~2~~3 | 30/09/202~~2~~3 |
| 01/09/202~~2~~3 | 30/09/202~~2~~3 | 30/10/202~~2~~3 |
| 01/10/202~~2~~3 | 31/10/202~~2~~3 | 30/11/202~~2~~3 |
| 01/11/202~~2~~3 | 30/11/202~~2~~3 | 30/12/202~~2~~3 |
| 01/12/202~~2~~3 | 31/12/202~~2~~3 | 30/01/202~~3~~4 |
| 01/01/202~~3~~4 | 31/01/202~~3~~4 | 02/03/202~~3~~4 |
| 01/02/202~~3~~4 | 28/02/202~~3~~4 | 30/03/202~~3~~4 |
| 01/03/202~~3~~4 | 31/03/202~~3~~4 | 30/04/202~~3~~4 |
| 01/04/202~~3~~4 | 30/04/202~~3~~4 | 30/05/202~~3~~4 |
| 01/05/202~~3~~4 | 31/05/202~~3~~4 | 30/06/202~~3~~4 |
| 01/06/202~~3~~4 | 30/06/202~~3~~4 | 30/07/202~~3~~4 |

## Table of Episode record data elements

| Position number | Data item name  | Data type | Format | Field size |
| --- | --- | --- | --- | --- |
| 1 | Collection identifier | String | AAAA | 4 |
| 2 | Version identifier | Number | NNNN | 4 |
| 3 | Transaction type flag | String | A | 1 |
| 4 | Hospital code (agency identifier) | Number | NNNN | 4 |
| 5 | Patient identifier – mother | String | A(10) | 10 |
| 6 | Patient identifier – baby | String | A(10) | 10 |
| 7 | Date of admission – mother | Date/time | DDMMCCYY | 8 |
| 8 | Surname / family name – mother | String | A(40) | 40 |
| 9 | First given name – mother | String | A(40) | 40 |
| 10 | Middle name – mother | String | A(40) | 40 |
| 11 | Residential locality | String | A(46) | 46 |
| 12 | Residential postcode | Number | NNNN | 4 |
| 13 | Residential road number – mother | String | A(12) | 12 |
| 14 | Residential road name – mother | String | A(45) | 45 |
| 15 | Residential road suffix code – mother | String | AA | 2 |
| 16 | Residential road type – mother | String | AAAA | 4 |
| 17 | Admitted patient election status – mother | Number | N | 1 |
| 18 | Country of birth | Number | NNNN | 4 |
| 19 | Indigenous status – mother | Number | N | 1 |
| 20 | Indigenous status – baby | Number | N | 1 |
| 21 | Marital status | Number | N | 1 |
| 22 | Date of birth – mother | Date/time | DDMMCCYY | 8 |
| 23 | Height – self-reported – mother | Number | NNN | 3 |
| 24 | Weight – self-reported – mother | Number | NN[N] | 3 |
| 25 | Setting of birth – intended | Number | NNNN | 4 |
| 26 | Setting of birth – intended – other specified description | String | A(20) | 20 |
| 27 | Setting of birth – actual | Number | NNNN | 4 |
| 28 | Setting of birth, actual – other specified description | String | A(20) | 20 |
| 29 | Setting of birth – change of intent | Number | N | 1 |
| 30 | Setting of birth – change of intent – reason | Number | N | 1 |
| 31 | Maternal smoking < 20 weeks | Number | N | 1 |
| 32 | Maternal smoking ≥ 20 weeks | Number | NN | 2 |
| 33 | Gravidity | Number | N[N] | 2 |
| 34 | Total number of previous live births | Number | NN | 2 |
| 35 | Parity | Number | NN | 2 |
| 36 | Total number of previous stillbirths (fetal deaths) | Number | NN | 2 |
| 37 | Total number of previous neonatal deaths | Number | NN | 2 |
| 38 | Total number of previous abortions – spontaneous | Number | NN | 2 |
| 39 | Total number of previous abortions – induced | Number | NN | 2 |
| 40 | Total number of previous ectopic pregnancies | Number | NN | 2 |
| 41 | Total number of previous unknown outcomes of pregnancy | Number | NN | 2 |
| 42 | Date of completion of last pregnancy | Date/time | {DD}MMCCYY | 6 (8) |
| 43 | Outcome of last pregnancy | Number | N | 1 |
| 44 | Last birth – caesarean section indicator | Number | N | 1 |
| 45 | Total number of previous caesareans | Number | NN | 2 |
| 46 | Plan for VBAC | Number | N | 1 |
| 47 | Estimated date of confinement | Date/time | DDMMCCYY | 8 |
| 48 | Estimated gestational age | Number | NN | 2 |
| 49 | Maternal medical conditions – free text | String | A(300) | 300 |
| 50 | Maternal medical conditions – ICD-10-AM code | String | ANN[NN] | 5 (X12) |
| 51 | Obstetric complications – free text | String | A(300) | 300 |
| 52 | Obstetric complications – ICD-10-AM code | String | ANN[NN] | 5 (x15) |
| 53 | Gestational age at first antenatal visit | Number | N[N] | 2 |
| 54 | Discipline of antenatal care provider | Number | N | 1 |
| 55 | Procedure – free text | String | A(300) | 300 |
| 56 | Procedure – ACHI code | Number | NNNNNNN | 7 (x8) |
| 57 | Deleted field |  |  |  |
| 58 | Deleted field |  |  |  |
| 59 | Deleted field |  |  |  |
| 60 | Artificial reproductive technology – indicator | Number | N | 1 |
| 61 | Date of onset of labour | Date/time | DDMMCCYY | 8 |
| 62 | Time of onset of labour | Date/time | HHMM | 4 |
| 63 | Date of onset of second stage of labour | Date/time | DDMMCCYY | 8 |
| 64 | Time of onset of second stage of labour | Date/time | HHMM | 4 |
| 65 | Date of rupture of membranes | Date/time | DDMMCCYY | 8 |
| 66 | Time of rupture of membranes | Date/time | HHMM | 4 |
| 67 | Labour type | Number | N | 1 (x~~3~~ 4) |
| 68 | Labour induction/augmentation agent | Number | N | 1 (~~x4~~x5) |
| 69 | ~~Labour induction/augmentation agent – other specified description~~ | ~~String~~ | ~~A(20)~~ | ~~20~~ |
| 70 | Indications for induction (other) – free text | String | A(50) | 50 |
| 71 | Indication for induction (main reason) – ICD-10-AM code | String | ANN[NN] | 5 (x1) |
| 72 | Fetal monitoring in labour | String | NN | 2 (x7) |
| 73 | Birth presentation | Number | N | 1 |
| 74 | Method of birth | Number | NN | 2 |
| 75 | Indications for operative delivery (other) – free text | String | A(300) | 300 |
| 76 | Indication for operative delivery (main reason) – ICD-10-AM code | String | ANN[NN] | 5 (x~~4~~1) |
| 77 | Analgesia for labour – indicator | Number | N | 1 |
| 78 | Analgesia for labour – type | Number | N | 1 (x4) |
| 79 | Anaesthesia for operative delivery – indicator | Number | N | 1 |
| 80 | Anaesthesia for operative delivery – type | Number | N | 1 (x4) |
| 81 | Events of labour and birth – free text | String | A(300) | 300 |
| 82 | Events of labour and birth – ICD-10-AM code | String | ANN[NN] | 5 (x9) |
| 83 | Prophylactic oxytocin in third stage | Number | N | 1 |
| 84 | Manual removal of placenta | Number | N | 1 |
| 85 | Perineal laceration – indicator | Number | N | 1 |
| 86 | Perineal / genital laceration – degree/type | Number | N | 1 (x3) |
| 87 | Perineal laceration – repair | Number | N | 1 |
| 88 | Episiotomy – indicator | Number | N | 1 |
| 89 | Blood loss (ml) | Number | N[NNNN] | 5 |
| 90 | Blood product transfusion – mother | Number | N | 1 |
| 91 | Postpartum complications – free text | String | A(300) | 300 |
| 92 | Postpartum complications – ICD-10-AM – code | String | ANN[NN] | 5 (x6) |
| 93 | Discipline of lead intra-partum care provider | Number | N | 1 |
| 94 | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother | Number | N | 1 |
| 95 | Date of birth – baby | Date/time | DDMMCCYY | 8 |
| 96 | Time of birth | Date/time | HHMM | 4 |
| 97 | Sex – baby | Number | N | 1 |
| 98 | Birth plurality | Number | N | 1 |
| 99 | Birth order | Number | N | 1 |
| 100 | Birth status | Number | N | 1 |
| 101 | Birth weight | Number | NN[NN] | 4 |
| 102 | Apgar score at one minute | Number | N[N] | 2 |
| 103 | Apgar score at five minutes | Number | N[N] | 2 |
| 104 | Time to established respiration (TER) | Number | NN | 2 |
| 105 | Resuscitation method – mechanical | String | NN | 2 (x10) |
| 106 | Resuscitation method – drugs | Number | N | 1 (x5) |
| 107 | Congenital anomalies – indicator | Number | N | 1 |
| 108 | Deleted field |  |  |  |
| 109 | Deleted field |  |  |  |
| 110 | Deleted field |  |  |  |
| 111 | Neonatal morbidity – free text | String | A(300) | 300 |
| 112 | Neonatal morbidity – ICD-10-AM code | String | ANN[NN] | 5 (x10) |
| 113 | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby | Number | N | 1 |
| 114 | Hepatitis B vaccine received | Number | N | 1 |
| 115 | Breastfeeding attempted | Number | N | 1 |
| 116 | Formula given in hospital | Number | N | 1 |
| 117 | Last feed before discharge – baby ~~taken exclusively from the breast~~ | Number | N | 1 |
| 118 | Separation date – mother | Date/time | DDMMCCYY | 8 |
| 119 | Separation date – baby | Date/time | DDMMCCYY | 8 |
| 120 | Separation status – mother | Number | N | 1 |
| 121 | Separation status – baby | Number | N | 1 |
| 122 | Transfer destination – mother | Number | NNNN | 4 |
| 123 | Transfer destination – baby | Number | NNNN | 4 |
| 124 | Number of antenatal care visits | Number | NN | 2 |
| 125 | Influenza vaccination status | Number | N | 1 |
| 126 | Pertussis (whooping cough) vaccination status | Number | N | 1 |
| 127 | Spoken English Proficiency | Numeric | N | 1 |
| 128 | Year of arrival in Australia | Number | NNNN | 4 |
| 129 | Head circumference | Number | NN.N | 4 |
| 130 | Episode identifier | String | A (9) | 9 |
| 131 | Fetal monitoring prior to birth – not in labour | String | NN | 2 (x5) |
| 132 | Reason for transfer out – baby | Number | N | 1 |
| 133 | Reason for transfer out – mother | Number | N | 1 |
| 134 | Congenital anomalies – ICD-10-AM code | String | ANN[NN]  | 5 (x9) |
| 135 | Maternal alcohol use at less than 20 weeks | Number | N | 1 |
| 136 | Maternal alcohol volume intake at less than 20 weeks | Number | N | 1 |
| 137 | Maternal alcohol use at 20 or more weeks | Number | N | 1 |
| 138 | Maternal alcohol volume intake at 20 or more weeks | Number | N | 1 |
| 139 | Antenatal corticosteroid exposure | Number | N | 1 |
| 140 | Chorionicity of multiples | Number | N | 1 |
| 141 | Cord complications | String | ANN[NN] | 5 (x3) |
| 142 | Diabetes mellitus during pregnancy – type  | Number | N | 1 |
| 143 | Diabetes mellitus – gestational – diagnosis timing | Number | NN | 2 |
| 144 | Diabetes mellitus – pre-existing – diagnosis timing | Number | NNNN | 4 |
| 145 | Diabetes mellitus therapy during pregnancy | String | N | 1 (x3) |
| 146 | Main reason for excessive blood loss following childbirth | Number | N | 1 |
| 147 | Blood loss assessment - indicator | Number | N | 1 |
| 148 | Category of unplanned caesarean section urgency | Number | N | 1 |
| 149 | Date of decision for unplanned caesarean section | Date/time | DDMMCCYY | 8 |
| 150 | Time of decision for unplanned caesarean section | Date/time | HHMM | 4 |
| 151 | COVID19 vaccination status | Number | N | 1 |
| 152 | COVID19 vaccination during this pregnancy | Number | N | 1 |
| 153 | Gestation at first COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 154 | Gestation at second COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 155 | Gestation at third COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 156 | Antenatal mental health risk screening status | Number | N | 1 |
| 157 | Edinburgh Postnatal Depression Scale score | Number | N[N] | 2 |
| 158 | Presence or history of mental health condition – indicator  | Number | N | 1 |
| 159 | Family violence screening status | Number | N | 1 |
| 160 | Hepatitis B antenatal screening – mother  | Number | N | 1 |
| 161 | HIV antenatal screening – mother  | Number | N | 1 |
| 162 | Syphilis antenatal screening – mother  | Number | N | 1 |
| 163 | Hypertensive disorder during pregnancy | Number | N | 1 (x3) |
| 164 | Maternity model of care – antenatal | Number | NNNNNN | 6 |
| 165 | Maternity model of care – at onset of labour or non-labour caesarean section  | Number | NNNNNN | 6 |
| 166 | Indications for induction (other) – ICD-10-AM code | String | ANN[NN] | 5 (x15) |
| 167 | Indications for operative delivery (other) – ICD-10-AM code  | String | ANN[NN] | 5 (x15) |
| 168 | Administration of Hepatitis B Immunoglobulin (HBIG) – baby | Number | N | 1 |

## Logging into the MFT Portal

* Open an internet browser, and enter the [MFT portal](https://prs2-mft.prod.services) address <https://prs2-mft.prod.services>
* Bookmark this address to facilitate easy access in future.
* Please note: Internet Explorer is no longer a supported browser for accessing the MFT

# Section 5a: Perinatal Webform and HealthCollect

## Logging into the HealthCollect Portal

* Open an internet browser~~,~~ and enter the [HealthCollect portal](https://www.healthcollect.vic.gov.au/desktopdefault.aspx) address <https://www.healthcollect.vic.gov.au/desktopdefault.aspx>.
* Bookmark this address to facilitate easy access in future.
* Please note: Internet Explorer is no longer a supported browser for accessing HealthCollect