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| Specification for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 January 2020  July 2019 |
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# Executive summary

The Final revisions for the Victorian Perinatal Data Collection (VPDC) effective 1 January 2020 are summarised below:

* **Add seven new data items**:
* Blood loss assessment – indicator
* Cord complications
* Diabetes mellitus during pregnancy – type
* Diabetes mellitus – gestational – diagnosis timing
* Diabetes mellitus – pre-existing – diagnosis timing
* Diabetes mellitus therapy during pregnancy
* Main reason for excessive blood loss following childbirth
* **Change** the title, definition, scope or code set of **fourteen** **existing data items**:
* Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby
* Antenatal corticosteroid exposure
* Congenital anomalies – indicator
* Data submission identifier
* ~~Estimated~~ B~~b~~lood loss (ml)
* Fetal monitoring prior to birth – not in labour
* Indication for induction (main reason) – ICD-10-AM code
* Indications for induction (other) – free text
* Indications for operative delivery – free text
* Indications for operative delivery – ICD-10-AM code
* Setting of birth – actual
* Setting of birth – intended
* Time of onset of labour
* Transaction type flag
* **Add one new Concept and derived item definition**:
  + - * + Diabetes mellitus – with Guide to reporting relevant new data items to the VPDC
* **Amend three existing Concept and derived item definitions**:
  + - * + Congenital anomalies for reporting to, and those not to be reported to, the VPDC
        + Gestational diabetes
        + Induction
* **Remove two redundant Concept and derived item definitions**:
  + - * + Birth centre
        + Postpartum haemorrhage
* **Add VPDC-created codes** applicable in **four data items:**
* Indication for induction (main reason) – ICD-10-AM code
* Indications for operative delivery – ICD-10-AM code
* Maternal medical conditions – ICD-10-AM code
* Procedures – ACHI code
* **Amend to 11th edition ICD-10-AM/ACHI codes** used in **nine data items:**
* Congenital anomalies – ICD-10-AM code
* Events of labour and birth – ICD-10-AM code
* Indication for induction (main reason) – ICD-10-AM code
* Indications for operative delivery – ICD-10-AM code
* Maternal medical conditions – ICD-10-AM code
* Neonatal morbidity – ICD-10-AM code
* Obstetric complications – ICD-10-AM code
* Postpartum complications – ICD-10-AM code
* Procedures – ACHI code
* **Clarify** the definition, reporting guide or business rules for **forty-one existing data items**
* Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother
* Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby
* Anaesthesia for operative delivery – indicator
* Anaesthesia for operative delivery – type
* Analgesia for labour – indicator
* Analgesia for labour – type
* Apgar score at one minute
* Apgar score at five minutes
* Birth plurality
* Birth status
* Blood product transfusion – mother
* Congenital anomalies – ICD-10-AM code
* Country of birth
* Date of onset of labour
* Date of onset of second stage of labour
* Date of rupture of membranes
* Discipline of antenatal care provider
* Episode identifier
* Fetal monitoring in labour
* Gestational age at first antenatal visit
* Head circumference
* Labour induction/augmentation agent
* Last birth – caesarean section indicator
* Maternal alcohol use at less than 20 weeks
* Maternal alcohol use at 20 or more weeks
* Maternal alcohol volume intake at less than 20 weeks
* Maternal alcohol volume intake at 20 or more weeks
* Method of birth
* Number of antenatal care visits
* Obstetric complications – free text
* Obstetric complications – ICD-10-AM code
* Procedure – ACHI code
* Procedure – free text
* Residential road name – mother
* Residential road number – mother
* Residential road suffix code – mother
* Residential road type – mother
* Total number of previous caesareans
* Total number of previous ectopic pregnancies
* Transfer destination – baby
* Transfer destination – mother
* Version identifier
* Year of arrival in Australia
* **Add eighteen new business rules**
* **Amend twenty-four existing business rules**

# Introduction

Each year, the Department of Health and Human Services (DHHS) 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 perinatal data collection supports the state and national reporting obligations of both the CCOPMM and the department, assists DHHS planning and policy development, and incorporates appropriate feedback from data providers on improvements.

An invitation is circulated to health services seeking suggestions for changes. Responses are evaluated against criteria that consider the data collection’s scope, the collectability and intended use of the data, best practice, feasibility and consequential impact of implementation and data quality and cost and collection burden for health services.

The suggested changes that meet these criteria are compiled into the Proposals for revisions to the VPDC document and distributed to health services and software vendors involved in reporting births to the VPDC, and feedback is invited. Comments received are reviewed and where possible, are accommodated, resulting in alteration to or withdrawal of some proposals, on advice from the CCOPMM.

This document sets out the revisions to the VPDC effective 1.1.2020. The changes documented are complete at the date of publication. Where further changes are required during the year, for example to reference files such as the postcode locality file, data validation rules or supporting documentation, these will be advised at the time.

An updated VPDC manual will be published later in 2019. Until then, the current VPDC manual and this document form the data submission specifications for 2020.

Victorian health services must ensure their software can create a VPDC submission file in accordance with the revised specifications and ensure reporting capability is achieved to maintain compliance with reporting timeframes set out in the VPDC manual.

Submission of test files prior to implementation of these changes is recommended. Please contact the HDSS HelpDesk ([hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au)) to make arrangements for test file submission.

## Orientation to symbols and highlighting in this document

New data items are marked as (new).

Changes to existing data items are highlighted in green.

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

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

New validations are marked ###

Validations to be changed are marked \* when listed as part of a data item or below a validation table.

Changes are documented in relation to each specific proposal: the total impact of all changes will be reflected in the VPDC Manual for 1.1.2020, to be released later.

Entries in this document are sequenced by proposal number.

Following the entries relating to proposed changes are entries highlighting clarifications to entries in version 7 of the VPDC manual.

# Outcome of proposals

Proposals proceeding

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Proposal #** | **New data element / Amend existing** | **Proposal title & summary of impact** | **VPDC Manual sections affected** | | | |
| **2** | **3** | **4** | **5** |
| 2 | **Amend** | **Change to 11th edition ICD-10-AM/ACHI codes**: Amend code sets for data elements requiring or accepting ICD-10-AM or ACHI codes;  includes update of VPDC-created codes |  | Checkmark | Checkmark |  |
| 3 | **Amend** | **Extend reporting of Antenatal corticosteroid exposure to stillbirths**:  Amend Reporting guide and validations |  | Checkmark | Checkmark |  |
| 4 | **Amend** | **Remove code for Birthing Centre from Setting of birth – intended and Setting of birth – actual**: Amend code set for these two data elements | Checkmark | Checkmark | Checkmark |  |
| 6 | **New** | **Main reason for excessive blood loss following childbirth**: New data element, code set and validations | Checkmark | Checkmark | Checkmark | Checkmark |
| 10 | **Amend** | **Congenital anomalies – indicator**: Amend code set and validations | Checkmark | Checkmark | Checkmark |  |
| 13 | **Amend x2** | **Primary indication for induction of labour**: Amend definition, scope and field size |  | Checkmark | Checkmark | Checkmark |
| 14 | **New x4** | **Diabetes mellitus status, type, timing of diagnosis, and treatment**: Four new data elements with code sets and validations | Checkmark | Checkmark | Checkmark | Checkmark |
| 17 | **New** | **Cord complications**: New data element, code set and validations |  | Checkmark | Checkmark | Checkmark |
| 23 | **New  Amend** | **Blood loss assessment – indicator**: New data element, code set and validations; Amend existing data element Estimated blood loss (ml) to Blood loss (ml) |  | Checkmark | Checkmark | Checkmark |
| 24 | **Amend** | **Iron infusion**: Add new VPDC-created code in one existing data element |  | Checkmark |  |  |
| 25 | **Amend** | **Past history of shoulder dystocia**: Add new VPDC-created code in two existing data elements |  | Checkmark |  |  |
| 26 | **Amend** | **Past history of 3rd or 4th degree perineal tear**: Add new VPDC-created code in two existing data elements |  | Checkmark |  |  |
| **Proposal #** | **New data element / Amend existing** | **Proposal title & summary of impact** | **VPDC Manual sections affected** | | | |
| **2** | **3** | **4** | **5** |
| 27 | **Amend** | **Past history of bariatric surgery**: Add new VPDC-created code in one existing data element |  | Checkmark |  |  |
| 28 | **Amend** | **Amend reporting guides for Date and Time of onset of labour; and  Amend valid values for Time of onset of labour** |  | Checkmark | Checkmark |  |
| 29 | **Amend** | **Amend reporting guide for Episode identifier**: Include additional wording in Reporting guide for this existing data element |  | Checkmark |  |  |
| 30 | **Amend** | **Add new Transaction Type flag code** |  | Checkmark |  |  |

Proposals deferred

|  |  |
| --- | --- |
| Proposal 1 | Remove ‘Review Required’ validations |
| Proposal 7 | Amend VPDC system validations for mother and/or baby remaining in hospital |

Proposals withdrawn

|  |  |
| --- | --- |
| Proposal 5a | Antibiotic administration – baby |
| Proposal 5b | Antibiotic administration – mother |
| Proposal 5c | Antibiotic timing – baby |
| Proposal 5d | Antibiotic timing – mother |
| Proposal 5e | Antibiotic type and dose – baby |
| Proposal 5f | Antibiotic type and dose – mother |
| Proposal 8 | Prenatal screening for aneuploidy |
| Proposal 9 | Artificial reproductive technology – indicator |
| Proposal 11 | Maternal weight at the 36-week antenatal visit |
| Proposal 12 | Highest level of maternal education |
| Proposal 15 | Therapeutic hypothermia (cooling) |
| Proposal 16 | Transfer for higher level of neonatal care |
| Proposal 18 | Assisted reproduction items |
| Proposal 19 | Introduce CQR elements |
| Proposal 20 | Emergency LUSCS in multiparas |
| Proposal 21 | 3rd and 4th degree tears in multiparas |
| Proposal 22 | Gestational age at first antenatal visit |

# End of year reporting

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 1/1/2020 – report all data elements in 2019 format
* Date of birth – baby is on or after 1/1/2020 – report all data elements in 2020 format

This is described under File structure specifications in Section 5 of the VPDC manual, accessible at <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection>: while this will be updated for 2020, the substance of the information will not change.

# Proposal 2 Change to 11th edition ICD-10-AM/ACHI codes

The full list of 11th edition ICD-10-AM/ACHI codes will be made available to vendors of VPDC software.

To assist health services submitting VPDC data, those data elements relevant to specific segments of the full code set will also be identified, along with VPDC-created codes applicable to relevant data elements from 1.1.2020.

Software vendors should submit their request for access to this file by email to the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).

Researchers and others wanting to compare ICD-10-AM/ACHI codes across years and code set versions should apply to the HDSS HelpDesk for forward and backward code mappings across the different versions of ICD-10-AM/ACHI and prior classifications.

In the past, a limited number of codes were created exclusively for VPDC reporting, in addition to the ICD‑10-AM/ACHI codes in use at the time. Most of these VPDC-created codes are now included in the 11th edition ICD-10-AM/ACHI codes being introduced for VPDC reporting from 1.1.2020. Consequently, most of those VPDC-created codes will be removed from the codes listed for relevant data elements in the VPDC Manual. These VPDC-created codes are ~~crossed through~~ in the table of VPDC-created codes to follow, and in the entries for the respective data elements later in this document.

Where a code is in 11th edition ICD-10-AM/ACHI for a condition/procedure previously assigned a VPDC-created code, but the 11th edition code is not exactly the same as the VPDC-created code it replaces, the relevant codes are listed beneath the following table, to enable comparison with prior years’ data.

A small number of new VPDC-created codes will be added from 1.1.2020. These are listed under the relevant data element/Proposal in this document. These are also listed in the table below in the data element/s for which they can be reported and are highlighted.

With these amendments, the following table lists all VPDC-created codes valid for reporting births on and from 1.1.2020.

Section 3 Data definitions

The following list of data elements require submission of ICD-10-AM or ACHI codes.

From 1.1.2020, the only codes that will be accepted in these data elements will be valid 11th edition ICD‑10-AM/ACHI codes and the few VPDC-created codes, listed in the following table for relevant data elements.

Congenital anomalies – ICD-10-AM code

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

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

Indications for operative delivery – ICD-10-AM code

Maternal medical conditions – ICD-10-AM code

Neonatal morbidity – ICD-10-AM code

Obstetric complications – ICD-10-AM code

Postpartum complications – ICD-10-AM code

Procedure - ACHI

The following data elements accept free text entries. Some health services report ICD-10-AM or ACHI codes in these data elements. Where such codes are reported, they should be valid 11th edition codes, or VPDC-created codes valid for the relevant data element, from the table below.

Events of labour and birth – free text

Indication for induction (other) – free text

Indications for operative delivery – free text

Maternal medical conditions – free text

Neonatal morbidity – free text

Obstetric complications – free text

Postpartum complications – free text

Procedure – free text

## Table of VPDC-created codes and relevant data elements:

|  |  |  |
| --- | --- | --- |
| **VPDC data item:** | **VPDC-created code** | **Code description:** |
| Congenital anomalies | Nil |  |
|  |  |  |
| Events of labour and birth | ~~O660~~ | ~~Shoulder dystocia~~ |
| O839 | Water birth |
| Z292 | Antibiotic therapy in labour |
|  |  |  |
| Indication for induction (main reason) | O480 | Social induction |
| Z8751 | Past history of shoulder dystocia |
| Z8752 | Past history of third or fourth degree perineal tear |
| **VPDC data item:** | **VPDC-created code** | **Code description:** |
| Indications for operative delivery | ~~Nil~~ |  |
| Z8751 | Past history of shoulder dystocia |
| Z8752 | Past history of third or fourth degree perineal tear |
|  |  |  |
| **VPDC data item:** | **VPDC-created code** | **Code description:** |
| Maternal medical conditions | ~~O100~~ 1 | ~~Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium~~ |
| ~~O142~~ | ~~HELLP Syndrome~~ |
| ~~O240~~ | ~~Pre-existing diabetes mellitus, type 1, in pregnancy~~ |
| ~~O2419~~ | ~~Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified~~ |
| ~~O2681~~ | ~~Renal disease, pregnancy related~~ |
| ~~O993~~ 2 | ~~Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium (psychosocial problems) Code O993 Psychosocial problems includes mental illness, violent relationships and alcohol or drug misuse.~~ |
| ~~O994~~ | ~~Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium~~ |
| Z9884 | Bariatric surgery status |
|  |  |  |
| Neonatal morbidity | Nil |  |
|  |  |  |
| Obstetric complications | ~~O142~~ | ~~HELLP Syndrome~~ |
| ~~O149~~ | ~~Pre-eclampsia, unspecified~~ |
| ~~O2442~~ | ~~Diabetes mellitus arising at or after 24 weeks’ gestation, insulin treated~~ |
| ~~O2444~~ | ~~Diabetes mellitus arising at or after 24 weeks’ gestation, diet controlled~~ |
| ~~O365~~ | ~~Suspected fetal growth restriction~~ |
| ~~O440~~ | ~~Placenta praevia without haemorrhage~~ |
| ~~O441~~ | ~~Placenta praevia with haemorrhage~~ |
| ~~O459~~ | ~~Premature separation of placenta (abruptio placentae)~~ |
| ~~O468~~ | ~~Other antepartum haemorrhage~~ |
| Z223 | Carrier of streptococcus group B (GBS+) |
|  |  |  |
| Postpartum complications | ~~O142~~ | ~~HELLP Syndrome~~ |
|  |  |  |
| Procedure | ~~1651100~~ | ~~Cervical suture for cervical shortening~~ |
| ~~1321504~~ 3 | ~~ART - Intracytoplasmic sperm injection (ICSI)~~ |
| 1321505 | ART - Donor Insemination |
| ~~1321506~~ 4 | ~~ART - Other~~ |
| 9619910 | IV iron infusion |
|  |  |  |

1 O100 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium  
 - replaced by code O10 in ICD-10-AM 11th edition

2 O993 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the  
 puerperium  
 - replaced by two codes in ICD-10-AM 11th edition:  
 O9931 Mental disorders in pregnancy, childbirth and the puerperium  
 O9932 Diseases of the nervous system in pregnancy, childbirth and the puerperium

Use of O993 to report alcohol or drug misuse is replaced by use of 11th edition ICD-10-AM code:

O9931 Mental disorders in pregnancy, childbirth and the puerperium  
Use of O993 to report violent relationships is replaced by use of 11th edition ICD-10-AM code:  
 Z630 Problems in relationship with spouse or partner

3 1321504 ART – Intracytoplasmic sperm injection (ICSI)  
 - replaced by code 1325100 Intracytoplasmic sperm injection in ACHI 11th edition

4 1321506 ART – Other   
 - replaced by code 1321503 Other reproductive medicine procedure in ACHI 11th edition

Section 4 Business rules

\*Artificial reproductive technology – indicator conditionally mandatory data items

|  |  |
| --- | --- |
| If Artificial reproductive technology – indicator is: | **~~the~~ anartificial reproductive technology procedure must be reported in at least one of the following data items:** |
| 1 Artificial reproductive technology was used to assist this pregnancy | Procedure – ACHI code OR  Procedure – free text |

Valid 11th edition ACHI codes and descriptors for reporting an artificial reproductive technology in the data item Procedure – ACHI code or Procedure – free text include:

|  |  |
| --- | --- |
| **11th edition ACHI code** | **Descriptor** |
| 1320000 | Assisted reproductive ~~services, using drugs~~ technologies to induce superovulation |
| 1320300 | Ovulation monitoring services~~,~~ for ~~super-ovulation treatment cycles and~~ artificial insemination |
| 1320600 | Assisted reproductive ~~services, using unstimulated ovulation or ovulation stimulated by clomiphene citrate~~ to induce oocyte growth and development |
| 1320900 | Planning and management for assisted reproductive technologies |
| 1321200 | Transvaginal oocyte retrieval |
| 1321201 | Transabdominal oocyte retrieval |
| 1321500 | Gamete intra-fallopian transfer (GIFT) |
| 1321501 | Embryo transfer to uterus |
| 1321502 | Embryo transfer to fallopian tube |
| 1321503 | Other reproductive medicine procedure |
| ~~1321504~~ 1325100 | Intracytoplasmic sperm injection (ICSI) |
| 1321505 | Donor insemination [VPDC-created ACHI code] |
| ~~1321506~~ 1321503 | ~~ART – other~~ Other reproductive medicine procedure |

# Proposal 3 Extend reporting of Antenatal corticosteroid exposure to stillbirths

Section 3 Data definitions

## Antenatal corticosteroid exposure

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | Administration of any antenatal dose of steroids for the purpose of fetal lung maturation | | | |
| Representationclass | Code | | Data type | Number |
| Format | N | | Field size | 1 |
| Location | Episode record | | Position | 139 |
| Permissible values | **Code** | **Descriptor** | | |
|  | 1 | None | | |
|  | 2 | One dose | | |
|  | 3 | Two doses (one course) | | |
|  | 4 | More than two doses | | |
|  | 9 | Not stated/adequately described | | |
| Reporting guide | Report the number of steroid doses given during the pregnancy ~~episode~~ | | | |
| Reported by | All Victorian Hospital where a ~~live~~ birth has occurred and homebirth practitioners | | | |
| Reported for | All ~~live~~ birth episodes | | | |
| Related concepts (Section 2): | None specified | | | |
| Related data items (this section): | ~~The number of steroid doses~~ None specified | | | |
| Related Business rules (Section 4): | Birth status ‘Live born’ and associated conditionally mandatory data items; \*Birth status ‘Stillborn’ and associated data items valid combinations; \*Mandatory to report data items | | | |
|  |  | | | |

#### Administration

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2019 2. January 2020 |
| Codeset source | DHHS | Collection start date | 2019 |

Section 4 Business rules

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \* Birth status ‘Stillborn’ and associated data items valid combinations   |  |  | | --- | --- | | If birth status is: | | | 2 Stillborn (occurring before labour) **or** 3 Stillborn (occurring during labour) **or** 4 Stillborn (timing of occurrence unknown) | | | The data items listed below must be: | | | **Data item:** Admission to special care nursery (SCN)/neonatal intensive care unit (NICU) – baby ~~Antenatal corticosteroid exposure~~ Apgar score at one minute Apgar score at five minutes Breastfeeding attempted Formula given in hospital Hepatitis B vaccine received Last feed before discharge taken exclusively from the breast Separation date – baby Separation status – baby Time to establish respiration (TER) | **Value:** Blank  ~~Blank~~ 00 00 Blank Blank Blank Blank Blank Blank 00 | |

# Proposal 4 Remove code for Birthing Centre from Setting of birth – intended and Setting of birth – actual

Section 2 Concept and derived item definitions

|  |  |
| --- | --- |
| ~~Birth centre~~ | |
| **~~Definition/guide for use~~** | ~~A facility where women are able to give birth in an environment that:~~   * ~~is physically separate from a labour ward but has access to emergency medical facilities for both mother and child, if required~~ * ~~has a home-like atmosphere~~ * ~~focuses on a model of care (for example, midwifery) that ensures continuity of care/caregiver, a family-centred approach and informed client participation in choices related to the management of care.~~ |

Section 3 Data definitions

## Setting of birth – actual

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The actual place where the birth occurred | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | NNNN | Field size | 4 |
|  | | | |
| Location | Episode record | Position | 27 |
|  | | | |
| Permissible values | Please refer to the ‘Hospital Code Table available at <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>  **Code Descriptor**  ~~0002 Birth centre~~  0003 Home (other)  0005 In transit  0006 Home – Private midwife care  0007 Home – Public homebirth program  0008 Other - specify  0009 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | * ~~Code 0002 Birth centre: reported when a birth occurs at the actual hospital’s birth centre~~ * Code 0003 Home (other): includes a birth not intended to occur at home. Excludes homebirth with a private midwife (use code 0006) and homebirth under the public homebirth program (use code 0007) * Code 0005 In transit: includes births occurring on the way to the intended place of birth or the car park of a hospital ~~/birthing centre~~ * Code 0006 Home: private midwife care – reported when a birth is attended by a private midwife practitioner in the mother’s own home or a home environment * Code 0007 Home: Public homebirth program – reported when a birth is attended by a public midwife in the mother’s home under the Public homebirth program * Code 0008 Other – specify: Used when birth occurs at any location other than those listed above. May also include a community health centre. Report the location in Setting of birth – actual – other specified description | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ 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 | Version | 1. January 1982 2. July 2015 3. January 2020 | |
|  | | | | | |
| Codeset source | NHDD (DHHS 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 ‘Hospital Code Table available at <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>  **Code Descriptor**  ~~0002 Birth centre~~  0003 Home (other)  0006 Home – Private midwife care  0007 Home – Public homebirth program  0008 Other – specify  0009 Not stated / inadequately described | | |
|  | | | | |
| Reporting guide | ~~If unable to provide hospital code, record the hospital name in Setting of Birth – intended – other specified description.~~ Home in the context of this data element means the home of the woman or a relative or a friend.   * ~~Code 0002 Birth centre: if the birth was intended at the hospital’s birth centre~~ * Code 0003 Home (other):  excludes homebirth:  - with a private midwife (use code 0006) and  - under the public homebirth program (use code 0007) * Code 0008 Other – specify:  includes community (health) centres. Record the location in Setting of birth – intended – other specified description * Code 0009 Not stated / inadequately described:  includes unbooked or unplanned | | |
|  | | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | | |
| Reported for | All birth episodes | | |
|  | | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | | |
| Related data items (this section): | Setting of birth – 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 | Version | 1. January 1999 2. July 2015 3. January 2020 | |
|  | | | | | |
| Codeset source | NHDD (DHHS modified) | Collection start date | | 1999 |

Section 4 Business rules

\* 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 | |
| **Setting of birth – actual must be:** | **and Hospital code (agency identifier) must be**: |
| A health service from the list of Campuses ~~below~~ with a SCN and/or NICU ~~services~~ | Equal to Setting of birth - actual |
| ~~0002 Birth centre 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 | A health service from the list below with SCN and/or NICU services |

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 |
| 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 Hospital | Yes | No |
| 6470 | Epworth Freemasons | Yes | No |
| 6480 | Epworth Geelong | Yes | No |
| 2220 | Frankston Hospital | Yes | No |
| 2050 | Geelong Hospital [University Hospital, Geelong] | Yes | No |
| **Campus Code** | **Campus Name** | **SCN** | **NICU** |
| 1121 | Goulburn Valley Health [Shepparton] | Yes | No |
| 8890 | Jessie McPherson Private Hospital [Clayton] | Yes | No |
| ~~6400~~ | ~~Knox Private Hospital [Wantirna]~~ | ~~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 |
| 1360 | Sandringham & District Memorial Hospital | 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 | ~~No~~ Yes\* |
| 6600 | Waverley Private Hospital [Mt Waverley] | Yes | No |
| 1580 | West Gippsland Healthcare Group [Warragul] | Yes | No |
| 2170 | Wimmera Base Hospital [Horsham] | Yes | No |

*[\* validation change will be activated when NICU services at this site are operational]*

# Proposal 6 Main reason for excessive blood loss following childbirth

Section 3 Data definitions

## Main reason for excessive blood loss following childbirth (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | Report the main reason for excessive blood loss in the first 24 hours following childbirth. | | | |
| Representationclass | Code | | Data type | Number |
| Format | N | | Field size | 1 |
| Location | Episode record | | Position | 146 |
| Permissible values | **Code** | **Descriptor** | | |
|  | 1 | Uterine atony | | |
|  | 2 | Trauma | | |
|  | 3 | Placental insertion abnormality | | |
|  | 4 | Coagulopathy or haematological disorder | | |
|  | 5 | Other | | |
|  | 9 | Not stated/inadequately described | | |

|  |  |
| --- | --- |
| Reporting guide | Report the statement that best describes the main reason for excessive blood loss in the first 24 hours following childbirth.  Code 2 Trauma includes tear/s to labia, perineum, cervix, uterus; episiotomy; accidental injury during caesarean section eg extension of abdominal incision  Code 3 Placental insertion abnormality includes retained placenta; placenta accrete/increta/percreta; other placental abnormality  Code 4 Coagulopathy or haematological disorder includes disseminated intravascular coagulation (DIC), haematological disorder; retroperitoneal haemorrhage  Conditions indicated by reporting code 1, 2, 3, 4 or 5 should also be reported using appropriate ICD-10-AM code/s or free text entry in one or more of the following data elements, as relevant: Events of labour and birth – ICD-10-AM code;  Events of labour and birth – free text;  Postpartum complications – ICD-10-AM code and/or  Postpartum complications – free text and, where appropriate, using the relevant codes in  Blood loss assessment – indicator Episiotomy – indicator,  Perineal/genital laceration – degree/type,  Perineal laceration – indicator Perineal laceration – repair |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | All birth episodes where Blood loss (ml) is reported as 500 or more |
| Related concepts (Section 2): | ~~Postpartum haemorrhage;~~ Primary postpartum haemorrhage |
| Related data items (this section): | ~~Estimated blood~~ Blood loss (ml); Blood loss assessment – indicator; Episiotomy – indicator; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Perineal/genital laceration – degree/type; Perineal laceration – indicator; Perineal laceration – repair; Postpartum complications – free text; Postpartum complications – ICD-10-AM code |
| Related business rules (Section 4): | ### Blood loss (ml) and Main reason for excessive blood loss following childbirth – valid combinations |
|  |  |

#### Administration

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1 January 2020 |
| Codeset source | DHHS | Collection start date | 2020 |

Section 2 Concept and derived item definitions

|  |  |  |
| --- | --- | --- |
| ~~Postpartum haemorrhage~~ | | |
|  |  |
| **~~Definition/guide for use~~** | ~~Primary: blood loss in excess of 500 ml from the birth canal during the third stage of labour and for 24 hours afterwards.~~  ~~Secondary – bleeding occurring in the interval from 24 hours after birth until the end of the puerperium (six weeks).~~ |
|  |  |
| **~~Related data items (Section 3):~~** | ~~Prophylactic oxytocin in third stage~~ |

Section 4 Business rules

### Blood loss (ml) and Main reason for excessive blood loss following childbirth – valid combinations

|  |  |
| --- | --- |
| **When Blood loss (ml) is reported as:** | **Main reason for excessive blood loss following childbirth:** |
| More than 499 | Must be reported as  Code 1 Uterine atony OR  Code 2 Trauma OR  Code 3 Placental insertion abnormality OR  Code 4 Coagulopathy or haematological   disorders OR  Code 5 Other |
| More than 499 | May not be reported as  Code 9 Not stated / inadequately described |

# Proposal 10 Congenital anomalies – indicator

Section 2 Concept and derived item definitions

## Congenital anomalies

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Definition/guide for use** | The following list contains the most common congenital anomalies for reporting in the field ‘Congenital anomalies – ICD-10-AM code’   |  |  | | --- | --- | | Q069 | ~~All Neural tube defects~~ Congenital malformations of spinal cord | | Q0002 | Anencephaly | | Q421 | Anorectal atresia and/or stenosis | | Q3533 | Cleft ~~lip and~~ soft palate | | Q369 | Cleft Lip ~~Unilateral~~ | | Q359 | Cleft palate | | Q2510 | Coarctation of the aorta | | Q650 | Congenital Dislocation of Hip ~~-Right~~ -Unilateral | | Q619 | Cystic Kidney Disease | | Q790 | Diaphragmatic Hernia | | Q019 | Encephalocele | | Q792 | Exomphalos | | Q793 | Gastroschisis | | Q0389 | Hydrocephalus | | Q234 | Hypoplastic Left Heart | | Q549 | Hypospadius | | Q7380 | Limb reduction defect | | Q02 | Microcephaly | | Q6230 | Obstructive defects of the renal pelvis and ureter | | Q390 | Oesophageal Atresia ~~and/or Stenosis~~ | | Q602 | Renal agenesis | | Q0590 | Spina Bifida | | Q213 | Tetralogy of Fallot | | Q2031 | Transposition of Great Vessels | | Q914 | Trisomy 13 | | Q910 | Trisomy 18 | | Q909 | Trisomy 21 - Downs Syndrome | | Q2100 | Ventricular Septal Defect (VSD) |   The following conditions do not need to be reported as a congenital anomaly:   * Abnormal palmar creases * Accessory nipples * Anal fissure * Balanced autosomal translocation (unless occurring with structural defects) * Birth injuries * Birth marks (smaller than 4cm, not including giant naevus) * Bowing of legs (unless severe) * Blocked tear ducts (dacryostenosis) * Brushfield spots * Cephalhaematoma * Cleft gum * Clicky hips * Clinodactyly * Craniotabes (unless severe) * Dermatog~~p~~lyphic abnormalities * Ear abnormalities (minor) * Epicanthic folds * Gastro-oesophageal reflux * Haemangioma (< 4 cm wide) * Hernia – inguinal, umbilical * High-arched palate * Hydrocele * Hypertelorism * Imperforate hymen * Laryngeal stridor * Laryngomalacia * Low slung/set ears * Macroglossia (large tongue) * Meckel’s diverticulum * Meconium ileus * Mental retardations (unless occurring with a syndrome/structural defect) * Metatarsus varus * Micrognathia (unless severe) * Mongolian spots * Occiput, flat/prominent * Patent ductus arteriosus (< 37 weeks) * Philtrum, long/short * Plagiocephaly * Pre-auricular sinus * Prominent forehead * Protruding tongue * Ptosis * Retrognathia (unless severe) * Rocker-bottom feet (prominent heels) * Sacral pits, dimples, sinuses * Short sternum * Simian creases * Single umbilical artery/two vessels in cord 1 * Skin folds/tags * Slanting eyes * Small mouth * Spina bifida occulta (without evidence of spinal lesion) * Sternomastoid tumour * Subluxating knee joint * Talipes (positional) * Toe anomalies – minor * Tongue tie * Torticollis * Ureteric reflux (ultrasound diagnosed) * Webbing of 2nd and 3rd toes/fingers * Wide suture lines   1 Report two vessels in cord in data element ‘Cord complications’ |

Section 3 Data definitions

## Congenital anomalies – indicator

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether there were any reportable congenital anomalies identified, and if so, whether these were identified antenatally or postnatally or both | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 107 |
|  | | | |
| Permissible values | **Code Descriptor**  ~~1 Reportable congenital anomalies identified~~  2 Reportable congenital anomalies not identified  3 Reportable congenital anomalies identified antenatally  4 Reportable congenital anomalies identified postnatally  5 Reportable congenital anomalies identified both  antenatally and postnatally  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Where reportable congenital abnormalities are identified, please select the most appropriate code in the Congenital anomalies – ICD-10-AM code field. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Congenital anomalies – includes a list of the most common congenital anomalies for reporting in the Congenital anomalies – ICD-10-AM code field, and a list of congenital anomalies that do not need to be reported as a congenital anomaly | | |
|  | | | |
| Related data items (this section): | Congenital anomalies – ICD-10-AM code | | |
|  | | | |
| Related business rules (Section 4): | \*Congenital anomalies – indicator and Congenital anomalies – ICD-10-AM code conditionally mandatory data item; \*Mandatory to report data items; \*Sex – baby and Congenital anomalies – indicator conditionally mandatory data item | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999  2. January 2009  3. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 1999 |

Section 4 Business rules

\*Congenital anomalies – indicator and Congenital anomalies – ~~free text~~ ICD-10-AM code conditionally mandatory data item

|  |  |
| --- | --- |
| **If Congenital anomalies – indicator is:** | **then the following item cannot be blank:** |
| ~~1 Reportable congenital anomalies identified~~  3 Reportable congenital anomalies identified antenatally OR  4 Reportable congenital anomalies identified postnatally OR  5 Reportable congenital anomalies identified both antenatally and postnatally | ~~Reportable congenital~~ Congenital anomalies – ~~code~~ ICD-10-AM code ~~cannot be blank~~ |

\*Sex – baby and Congenital anomalies – indicator conditionally mandatory data item

|  |  |
| --- | --- |
| **If Sex – baby is:** | **Congenital anomalies – indicator must be:** |
| 3 Indeterminate | ~~1 Congenital anomalies identified~~  3 Reportable congenital anomalies identified antenatally **or**  4 Reportable congenital anomalies identified postnatally **or**  5 Reportable congenital anomalies identified both antenatally and postnatally |

# Proposal 13 Primary indication for induction of labour

Section 3 Data definitions

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The main ~~primary~~ reason given for an induction of labour | | |
|  | | | |
| Representation class | Code | Data type | ~~String~~ Number |
|  | | | |
| Format | ANN[NN] | Field size | 5 (X1) |
|  | | | |
| Location | Episode record | Position | 71 |
|  | | | |
| Permissible values | ~~For applicable codes for Indication for induction – ICD-10-AM code refer to the ICD-10-AM/ACHI (8~~~~th~~ ~~edition) available on request, by email to~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@dhhs.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.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  Z8751 Past history of shoulder dystocia  *[see proposal 25]*  Z8752 Past history of third or fourth degree perineal tear  *[see proposal 26]* | | |
|  | | | |
| Reporting guide | Report where a medical or surgical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where an induction was performed | | |
|  | | | |
| Related concepts (Section 2): | Induction | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Indications for induction (other) – free text | | |
|  | | | |
| Related business rules (Section 4): | \*Labour type, 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) – free text valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999  2. January 2009  3. July 2015  4. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | 1999 |

## 

## Indications for induction (other) – free text

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | ~~The primary reason~~ Any other reasons given for an induction of labour | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(50) | Field size | 50 |
|  | | | |
| Location | Episode record | Position | 70 |
|  | | | |
| Permissible values | Permitted characters:   * 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   An additional code has been created solely for VPDC reporting:  **Code Descriptor**  O480 Social induction  Z8751 Past history of shoulder dystocia  *[see proposal 25]*  Z8752 Past history of third or fourth degree perineal tear  *[see proposal 26]* | | |
|  | | | |
| Reporting guide | Report any other indications ~~the indication~~ for induction in this field. ~~when there is no ICD-10-AM code available for selection in the software.~~ | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where an induction was performed 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 | | |
|  | | | |
| Related business rules (Section 4): | \*Labour type, 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) – free text valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999  2. January 2020 |
|  | | | |
| Codeset source | Not applicable | Collection start date | 1999 |

Section 4 Business rules

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

|  |  |
| --- | --- |
| **Where an entry is reported for Indications for induction (other) – free text** | **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 | There may be no entry reported for Indications for induction (other) – free text |

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

|  |  |
| --- | --- |
| **If Labour type is:** | **~~The Indication for induction must be reported in at least one of the following data items:~~** |
| 2 Induced medical **or**  3 Induced surgical **or**  2 Induced medical **and** 3 Induced surgical | ~~Indication for induction – free text~~ **~~or~~**  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) – free text, if appropriate |

# Proposal 14 Diabetes mellitus status, type, timing of diagnosis, and treatment

Section 2 Concept and derived item definitions

## Diabetes mellitus

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 blood 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.

## Guide to reporting Diabetes mellitus and Gestational diabetes mellitus to the VPDC

**Did this woman have diabetes mellitus during this pregnancy?**

***Diabetes mellitus during pregnancy – type***:   
code 1 No diabetes mellitus during this pregnancy

No

Was this diabetes mellitus diagnosed before this pregnancy?

Yes

No

Yes

No

In what year was diabetes mellitus diagnosed?  
***Diabetes mellitus – pre-existing – diagnosis timing****:* Year (yyyy)

At what gestation during this pregnancy was gestational diabetes diagnosed?   
***Diabetes mellitus – gestational – diagnosis timing***(Completed weeks (nn)

***Diabetes mellitus during pregnancy – type***:   
code 4 Gestational diabetes mellitus (GDM)

What type of diabetes mellitus?

Type 1:  
***Diabetes mellitus during pregnancy – type***:   
code 2 Pre-existing Type 1 diabetes mellitus

Other type of diabetes:  
***Diabetes mellitus during pregnancy – type***:   
code 8 Other type of diabetes mellitus

Type 2:  
***Diabetes mellitus during pregnancy – type***:   
code 3 Pre-existing Type 2 diabetes mellitus

***Diabetes mellitus therapy during pregnancy****:*  
 Code 2 Insulin  
 Code 3 Oral hypoglycaemics  
 Code 4 Diet & exercise  
 (*report up to 3 codes*)

Section 3 Data definitions

## Diabetes mellitus during pregnancy – type (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | Report whether the mother has diabetes mellitus during this pregnancy, and if so, the type of diabetes mellitus | | | |
| Representationclass | Code | | Data type | Number |
| Format | N | | Field size | 1 |
| Location | Episode record | | Position | 142 |
| Permissible values | **Code** | **Descriptor** | | |
|  | 1 | No diabetes mellitus during this pregnancy | | |
|  | 2 | Pre-existing Type 1 diabetes mellitus | | |
|  | 3 | Pre-existing Type 2 diabetes mellitus | | |
|  | 4 | Gestational diabetes mellitus (GDM) | | |
|  | 8 | Other type of pre-existing diabetes mellitus | | |
|  | 9 | Not stated / inadequately described | | |
| Reporting guide | Report the statement that best describes whether the mother has diabetes mellitus during this pregnancy, and if so, what type of diabetes mellitus  Code 1 No diabetes mellitus during this pregnancy Includes intermediate hyperglycaemia  Code 2 Pre-existing Type 1 diabetes mellitus (equivalent to ICD-10-AM code O24.0)  Code 3 Pre-existing Type 2 diabetes mellitus Includes mothers with pre-existing Type 2 diabetes mellitus and gestational diabetes mellitus (GDM) during the current pregnancy (equivalent to ICD-10-AM codes O24.12, O24.13, O24.14, O24.19)  Code 4 Gestational diabetes mellitus (GDM) (equivalent to ICD-10-AM codes O24.42, O24.43, O24.44, O24.49)  Code 8 Other type of diabetes mellitus Includes pre-existing other specified type of diabetes mellitus (equivalent to ICD-10-AM codes O24.22, O24.23, O24.24, O24.29);  Where no other information is available, report code 8 for patients with pre-existing diabetes mellitus of unspecified type (equivalent to ICD-10-AM codes O24.32, O24.33, O24.34, O24.39). Excludes impaired glucose regulation.  Code 9 Not stated / inadequately described | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| Reported for | All birth episodes | | | |
| Related concepts (Section 2): | Diabetes mellitus | | | |
| Related data items (this section): | 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 operative delivery – free text; Indications for operative delivery – 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 during pregnancy – type, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indications for operative delivery – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code and Postpartum complications – ICD-10-AM code valid combinations; \*Mandatory to report data items | | | |

#### Administration

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

## Diabetes mellitus – gestational – diagnosis timing (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | The gestation at which gestational diabetes mellitus was diagnosed during this pregnancy | | | |
| Representationclass | Total | | Data type | Number |
| Format | NN | | Field size | 2 |
| Location | Episode record | | Position | 143 |
| Permissible values | Range:  **Code** | 01 to 43 (inclusive)  **Descriptor** | | |
|  | 99 | Not stated / inadequately described | | |
| Reporting guide | For mothers diagnosed with gestational diabetes mellitus during the current pregnancy, report the gestation in completed weeks during this pregnancy when the diagnosis of gestational diabetes mellitus was made.  Leave blank for mothers who were: - not diagnosed with diabetes mellitus,  - diagnosed with type 1 or type 2 diabetes mellitus before the current pregnancy,  - diagnosed with gestational diabetes mellitus only during a previous pregnancy but not the current pregnancy. | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| Reported for | All birth episodes where Diabetes mellitus during pregnancy – type code 4 Gestational diabetes mellitus (GDM) is reported | | | |
| Related concepts (Section 2): | Diabetes mellitus | | | |
| Related data items (this section): | Diabetes mellitus during pregnancy – type; 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 operative delivery – free text; Indications for operative delivery – 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 | | | |

#### Administration

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

## Diabetes mellitus – pre-existing – diagnosis timing (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | The year in which pre-existing diabetes mellitus was diagnosed | | | |
| Representationclass | Date | | Data type | Number |
| Format | NNNN | | Field size | 4 |
| Location | Episode record | | Position | 144 |
| Permissible values | Range:  **Code** | 1960 to current year  **Descriptor** | | |
|  | 9999 | Not stated / inadequately described | | |
| Reporting guide | For mothers diagnosed with diabetes mellitus before the current pregnancy only, report the year in which the mother was diagnosed with diabetes mellitus. Leave blank for mothers where were: - not diagnosed with diabetes mellitus,  - diagnosed with gestational diabetes mellitus only during the current pregnancy. | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| Reported for | All birth episodes where Diabetes mellitus during pregnancy – type code 2 Pre-existing Type 1 diabetes mellitus or code 3 Pre-existing Type 2 diabetes mellitus or code 8 Other type of diabetes mellitus is reported | | | |
| Related concepts (Section 2): | Diabetes mellitus | | | |
| Related data items (this section): | Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – 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 operative delivery – free text; Indications for operative delivery – 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 | | | |

#### Administration

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

## Diabetes mellitus therapy during pregnancy (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | The type/s of therapy prescribed during the pregnancy for diabetes mellitus | | | |
| Representationclass | Code | | Data type | Number |
| 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.  Code 2 Insulin:  (equivalent to 5th digit 2 (insulin treated) on ICD-10-AM codes in the range O24.1- to O24.9-)  Code 3 Oral hypoglycaemics:  includes sulphonylurea, biguanide (eg metformin), alpha-glucosidase inhibitor, thiazolidinedione, meglitinide, combination (eg biguanide and sulphonylurea) or other.  (equivalent to 5th digit 3 (oral hypoglycaemic therapy) on ICD-10-AM codes O24.1- to O24.9-)  Code 4 Diet and exercise: includes generalised prescribed diet; avoidance of added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.  (equivalent to 5th digit 4 (other; diet; exercise; lifestyle management) on ICD-10-AM codes O24.1- to O24.9-)  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 codes 3, 4 or 8. | | | |
| Related concepts (Section 2): | 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 operative delivery – free text; Indications for operative delivery – 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 2020 |
| Codeset source | AIHW | Collection start date | 2020 |

Section 4 Business rules

### 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 during pregnancy – type** | **Diabetes mellitus – gestational -diagnosis timing** | **Diabetes mellitus – pre-existing – diagnosis timing** | **Diabetes mellitus therapy during pregnancy** |
| Code 1 | Blank | Blank | Blank |
| Code 4 | Value in range 1 to 43 inclusive OR 99 | Blank | At least one code in range 2, 3 or 4 OR Code 9 only |
| Code 2 | Blank | Value in range 1960 to current year OR 9999 | Blank |
| Code 3 or 8 | Blank | Value in range 1960 to current year OR 9999 | At least one code in range 2, 3 or 4 OR Code 9 only |
| Code 9 | Blank | Value in range 1960 to current year OR 9999 | At least one code in range 2, 3 or 4 OR Code 9 only |

|  |  |  |  |
| --- | --- | --- | --- |
| **Diabetes mellitus – gestational -diagnosis timing** | **Diabetes mellitus during pregnancy – type** | **Diabetes mellitus – pre-existing – diagnosis timing** | **Diabetes mellitus therapy during pregnancy** |
| Value in range 1 to 43 inclusive OR 99 | Code 4 | Blank | At least one code in range 2, 3 or 4 OR Code 9 only |
| Blank | Code 3 or 8 | Value in range 1960 to current year OR 9999 | At least one code in range 2, 3 or 4 OR Code 9 only |
| Blank | Code 2 | Value in range 1960 to current year OR 9999 | Blank |
| Blank | Code 1 | Blank | Blank |
| Blank | Code 9 | Value in range 1960 to current year OR 9999 | At least one code in range 2, 3 or 4 OR Code 9 only |

|  |  |  |  |
| --- | --- | --- | --- |
| **Diabetes mellitus – pre-existing – diagnosis timing** | **Diabetes mellitus – gestational -diagnosis timing** | **Diabetes mellitus during pregnancy – type** | **Diabetes mellitus therapy during pregnancy** |
| Value in range 1960 to current year OR 9999 | Blank | Code 3 or 8 | At least one code in range 2, 3 or 4 OR Code 9 only |
| Value in range 1960 to current year OR 9999 | Blank | Code 2 | Blank |
| Blank | Blank | Code 1 | Blank |
| Blank | Value in range 1 to 43 inclusive OR 99 | Code 4 | At least one code in range 2, 3 or 4 OR Code 9 only |
| Value in range 1960 to current year OR 9999 | Blank | Code 9 | At least one code in range 2, 3 or 4 OR Code 9 only |

|  |  |  |  |
| --- | --- | --- | --- |
| **Diabetes mellitus therapy during pregnancy** | **Diabetes mellitus – gestational -diagnosis timing** | **Diabetes mellitus – pre-existing – diagnosis timing** | **Diabetes mellitus during pregnancy - type** |
| Blank | Blank | Blank | Code 1 |
| Blank | Blank | Value in range 1960 to current year OR 9999 | Code 2 |
| Code 2 and/or 3 and/or 4 OR Code 9 only | Value in range 1 to 43 inclusive OR 99 | Blank | Code 4 |
| Code 2 and/or 3 and/or 4 OR Code 9 only | Blank | Value in range 1960 to current year OR 9999 | Code 3 or 8 |
| Code 2 and/or 3 and/or 4 OR Code 9 only | Blank | Value in range 1960 to current year OR 9999 | Code 9 |

### Diabetes mellitus during pregnancy – type, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD‑10‑AM code, Indications for operative delivery – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code and Postpartum complications – ICD‑10‑AM code valid combinations

|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 1 | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |
| Code 2 | O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 3 | O240  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |
| Code 4 | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |
| Code 8 | O240  O2412  O2413  O2414  O2419  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 9 | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459 | Events of labour and birth – ICD-10-AM code OR  Indication for induction (main reason) – ICD-10-AM code OR  Indications for operative delivery – ICD-10-AM code OR  Maternal medical conditions – ICD-10-AM code OR  Obstetric complications – ICD‑10‑AM code OR  Postpartum complications – ICD‑10‑AM code |

### Diabetes mellitus therapy during pregnancy valid combinations

|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus therapy during pregnancy** | **May not report any code below:** | **In any of the following data elements:** |
| Code 9 | Code 2 OR  Code 3 OR  Code 4 | Diabetes mellitus therapy during pregnancy |
| Code 2 OR  Code 3 OR  Code 4 | Code 9 | Diabetes mellitus therapy during pregnancy |

# Proposal 17 Cord complications

Section 3 Data definitions

## Cord complications (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | Umbilical cord status, including abnormalities and complications | | | |
| Representationclass | Code | | Data type | String |
| Format | N[NNNN] | | Field size | 5(x3) |
| Location | Episode record | | Position | 141 |
| Permissible values | **Code** | **Descriptor** | | |
|  | 1 | No abnormalities or complication relating to umbilical cord | | |
|  | O691 | Nuchal cord (cord tightly around baby’s neck) | | |
|  | O692 | True knot | | |
|  | O690 | Umbilical cord prolapse | | |
|  | O693 | Short umbilical cord | | |
|  | O694 | Vasa previa | | |
|  | Q2701 | Two vessels in cord | | |
|  | O698 | Other | | |
|  | 9 | Not stated / inadequately described | | |
| Reporting guide | Report the umbilical cord status, including abnormalities and complications detected during the birth episodes.  Cord loosely around the baby’s neck should be reported as code 1.  Report up to 3 codes | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| Reported for | All birth episodes | | | |
| Related concepts (Section 2): | Not specified | | | |
| Related data items (this section): | Birth status; Apgar score at one minute; Apgar score at five minutes; Birth presentation; Congenital anomalies – ICD-10-AM code; Congenital anomalies – indicator; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Fetal monitoring in labour; Fetal monitoring prior to birth – not in labour; Indication for induction (other) – free text; Indication for induction (main reason) – ICD-10-AM code; Indications for operative delivery – free text; Indications for operative delivery – ICD-10-AM code; Neonatal morbidity – free text; Neonatal morbidity – ICD-10-AM code; Procedure – ACHI; Procedure – free text | | | |
| Related business rules (Section 4): | ### Cord complications valid combinations; \*Mandatory to report data items | | | |

#### Administration

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

Section 4 Business rules

### Cord complications valid combinations

|  |  |
| --- | --- |
| **Cord complications code** | **Must not be reported with Cord complications code** |
| 1 | O691 OR  9 |
| 9 | 1 OR  O691 OR  O692 OR  O690 OR  O693 OR  O694 OR  Q2701 OR  O698 |

# Proposal 23 Blood loss assessment – indicator

Section 3 Data definitions

## Blood loss assessment – indicator (new)

#### Specification

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Definition | Indicator of the method of assessing the quantity of blood loss reported in data element Blood loss (ml) | | | |
| Representationclass | Code | | Data type | Number |
| Format | N | | Field size | 1 |
| Location | Episode record | | Position | 147 |
| Permissible values | Code | Descriptor | | |
|  | 1 | All blood loss measured (ml) | | |
|  | 2 | All blood loss estimated (ml) | | |
|  | 3 | Combination of measured and estimated blood loss (ml) | | |
|  | 9 | Not stated/inadequately described | | |
| Reporting guide | Report the method used to determine the amount of blood loss (ml) reported in the data element Blood loss (ml) | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| Reported for | All birth episodes where a value greater than 0 is reported in Blood loss (ml) | | | |
| Related concepts (Section 2): | Primary postpartum haemorrhage | | | |
| Related data items (this section): | ~~Estimated~~ Blood loss (ml) | | | |
| Related business rules (Section 4): | ### Blood loss (ml) and Blood loss assessment – indicator valid combinations; ### Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting | | | |

#### Administration

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

## 

## ~~Estimated~~ Blood loss (ml)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | ~~An estimate of the~~ The amount of blood lost ~~at the time of~~ after the baby’s birth and in the following 24 hours, reported in millilitres (whether the loss is from the vagina, from an abdominal incision, or retained for example, broad ligament haematoma) | | |
| Representation class | Total | Data type | Number |
| Format | N[NNNN] | Field size | 5 |
| Location | Episode record | Position | 89 |
| Permissible values | Range: zero to ~~12000~~ 40000 (inclusive)  **Code Descriptor**  99999 Not stated / inadequately described | | |
| Reporting guide | Report the ~~best estimate of the~~ amount of blood lost in millilitres (ml). ~~This is usually reported to the nearest 50 ml, but may be more accurate than this if desired, for example when there is a very small amount of bleeding.~~ Report only blood loss after the baby’s birth. Include stage 3, eg postpartum haemorrhage. Exclude blood loss during labour, eg abruption, concealed haemorrhage, placenta praevia blood loss. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | ~~None specified~~ Primary postpartum haemorrhage | | |
| Related data items (this section): | ~~None specified~~ Blood loss assessment – indicator | | |
| Related business rules (Section 4): | ### Blood loss (ml) and Blood loss assessment – indicator valid combinations; ### Blood loss (ml) and Main reason for excessive blood loss following childbirth valid combinations; \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| Definition source | DHHS | Version | 1. January 2009 2. January 2020 |
| Codeset source | DHHS | Collection start date | 2009 |

Section 4 Business rules

### Blood loss (ml) and Blood loss assessment – indicator valid combinations

|  |  |
| --- | --- |
| **Where Blood loss (ml) is reported as** | **Must report Blood loss assessment – indicator as** |
| Greater than 0 and less than or equal to 40000 or  99999 | Code 1 All blood loss measured (ml) OR  Code 2 All blood loss estimated (ml) OR  Code 3 Combination of measured and estimated   blood loss (ml) |
| 0 or 99999 | Blank |

### Blood loss (ml) and Main reason for excessive blood loss following childbirth valid combinations

|  |  |
| --- | --- |
| **Where Blood loss (ml) is reported as** | **Main reason for excessive blood loss following childbirth must report** |
| Greater than 499 and less than or equal to 40000 or  99999 | Code 1 Uterine atony OR  Code 2 Trauma OR  Code 3 Placental insertion abnormality OR  Code 4 Coagulopathy or haematological disorders OR  Code 5 Other |

### Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – 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** |
| Code 1 Incision of the perineum and vagina   made | Episiotomy – indicator |
| Any entry | Indications for operative delivery – free text OR  Indications for operative delivery – ICD-10-AM code |
| Code 4 Planned caesarean – no labour OR  Code 5 Unplanned caesarean – labour OR  Code 6 Planned caesarean – labour OR  Code 7 Unplanned caesarean – no labour OR  Code 10 Other operative birth | Method of birth |
| Code 2 Second degree laceration/tear OR  Code 3 Third degree laceration/tear OR  Code 4 Fourth degree laceration/tear OR  Code 5 Labial/clitoral laceration/tear OR  Code 6 Vaginal wall laceration/tear OR  Code 7 Cervical laceration/tear OR  Code 8 Other laceration, rupture or tear | Perineal/genital laceration – degree/type |
| Code 1 Laceration/tear of the perineum   following birth | Perineal laceration – indicator |

# Proposal 24 Iron infusion

Section 3 Data definitions

## Procedure – ACHI code

**Specification**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Definition | | The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium | | | |
|  | | | | | |
| Representation class | | Code | Data type | Number | |
|  | | | | | |
| Format | | NNNNNNN | Field size | 7 (x8) | |
|  | | | | | |
| Location | | Episode record | Position | 56 | |
|  | | | | | |
| Permissible values | | ~~ICD-10-AM library file available on request, please email~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@dhhs.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).  A small number of additional codes have been created solely for VPDC reporting in this data element:  **Code Descriptor**  ~~1651100 Cervical suture for cervical shortening~~  *[same code in ACHI 11th edition, descriptor changes to   Insertion of cervical suture]*  ~~1321504 ART – Intracytoplasmic sperm injection (ICSI)~~   *[replaced in ACHI 11th edition by code   1325100 Intracytoplasmic sperm injection]*  1321505 ART – Donor Insemination  ~~1321506 ART – Other~~   *[replaced in ACHI 11th edition by code   1321503 Other reproductive medicine procedure]*  9619910 IV iron infusion | | | |
|  | | | | | |
| Reporting guide | | A procedure should only be coded once, regardless of how many times it is performed. Procedures that are reported in other data elements do not need to be reported in this field. These include anaesthesia or analgesia relating to the birth, augmentation or induction, caesarean section, forceps or vacuum extraction, suture/repair of tears, and allied health procedures.  The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM/ACHI Australian Coding Standards:   * Procedure performed for treatment of the principal diagnosis * Procedure performed for treatment of an additional diagnosis * Diagnostic/exploratory procedure related to the principal diagnosis * Diagnostic/exploratory procedure related to an additional diagnosis. | | | |
|  | | | | | |
| Reported by | | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
|  | | | | | |
| Reported for | | Birth episodes where a medical procedure and/or operation are performed and/or a procedure related to the pregnancy, including assisted reproductive technology, occurred during the pregnancy | | | |
|  | | | | | |
| Related concepts (Section 2): | | Procedure | | | |
|  | | | | | |
| Related data items (this section): | | Artificial reproductive technology – indicator | | | |
|  | | | | | |
| Related business rules (Section 4): | | \* Artificial reproductive technology – indicator conditionally mandatory data items | | | |
|  | | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1982  2. January 2009  3. July 2015  4. January 2018  5. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM/ACHI eleventh ~~nnnth~~ edition plus CCOPMM additions | Collection start date | 1982 |

# Proposal 25 Past history of shoulder dystocia

# Proposal 26 Past history of third or fourth degree perineal tear

Section 3 Data definitions

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The primary reason given for an induction of labour | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (X1) |
|  | | | |
| Location | Episode record | Position | 71 |
|  | | | |
| Permissible values | ~~For applicable codes for indication for induction refer to the ICD-10-AM/ACHI (8~~~~th~~ ~~edition) available on request, by email to~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@dhhs.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.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  Z8751 Past history of shoulder dystocia  *[Proposal 25]*  Z8752 Past history of third or fourth degree perineal tear  *[Proposal 26]* | | |
|  | | | |
| Reporting guide | Report where a medical or surgical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where an induction was performed | | |
|  | | | |
| Related concepts (Section 2): | Induction | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Indications for induction (other) – free text | | |
|  | | | |
| Related business rules (Section 4): | \*Labour type, Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text ~~and Indication for induction (main reason) – ICD-10-AM code~~ valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999  2. January 2009  3. July 2015  4. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | 1999 |

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The reason(s) given for an operative birth | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (x4) |
|  | | | |
| Location | Episode record | Position | 76 |
|  | | | |
| Permissible values | ~~For applicable codes for indication for induction refer to the ICD-10-AM/ACHI (8~~~~th~~ ~~edition) available on request, by email to~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@dhhs.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.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 dystocia  *[Proposal 25]* Z8752 Past history of third or fourth degree perineal tear  *[Proposal 26]* | | |
| Reporting guide | Report up to four reasons for operative delivery in order from the most to least influential in making the decision. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Operative delivery; Procedure | | |
|  | | | |
| Related data items (this section): | Indications for operative delivery – free text; Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Labour type ‘Failed induction’ conditionally mandatory data items; \*Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1982  2. January 1999  3. January 2009  4. July 2015  5. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | 1982 |

# Proposal 27 Past history of bariatric surgery

Section 3 Data definitions

## Maternal medical conditions – ICD-10-AM code

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (x12) |
|  | | | |
| Location | Episode record | Position | 50 |
|  | | | |
| Permissible values | ~~ICD-10-AM/ACHI (8~~~~th~~ ~~edition) available on request. Please email~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@health.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).  An additional code has been created solely for VPDC reporting in this data element:  **Code Descriptor**  ~~O100 Pre-existing essential hypertension complicating~~  ~~pregnancy, childbirth and the puerperium~~  *[replaced in ICD-10-AM 11th edition by code O10 Pre-existing   hypertension in pregnancy, childbirth and the puerperium]*  ~~O142 HELLP Syndrome~~  *[same code in ICD-10-AM 11th edition]*  ~~O240 Pre-existing diabetes mellitus, type 1, in pregnancy~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Pre-existing Type 1 diabetes mellitus in pregnancy, childbirth   and the puerperium]*  ~~O2419 Pre-existing diabetes mellitus, type 2, in pregnancy,~~  ~~unspecified~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Pre-existing Type 2 diabetes mellitus in pregnancy, childbirth   and the puerperium, unspecified [treatment]]*  ~~O2681 Renal disease, pregnancy related~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Kidney disorders in pregnancy, childbirth and the puerperium]*  ~~O993 Mental disorders and diseases of the nervous system~~  ~~complicating pregnancy, childbirth and the puerperium~~  ~~(psychosocial problems)~~  *[replaced in ICD-10-AM 11th edition by codes:*  *O9931 Mental disorders in pregnancy, childbirth and the   puerperium*  *Includes alcohol and/or drugs misuse*  *O9932 Diseases of the nervous system in pregnancy,   childbirth and the puerperium  Z630 Problems in relationship with spouse or partner]  (for violent relationships)*  ~~O994 Diseases of the circulatory system complicating pregnancy,~~  ~~childbirth and the puerperium~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Diseases of the circulatory system in pregnancy, childbirth and   the puerperium]*  Z9884 Bariatric surgery status | | |
|  | | | |
| Reporting guide | Only record conditions that affected the care or surveillance of this pregnancy.  Examples of maternal medical conditions include past history of a hydatidiform mole, rheumatoid arthritis, asthma, deafness, polycystic ovaries and multiple sclerosis. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded.  Do not report past operations such as appendicectomy, knee reconstruction, which do not affect or have not occurred during this pregnancy. When pregnancy-related renal disease, psychosocial problem or disease of the circulatory system (cardiac condition) is reported, also report the specified condition in this field or in the Maternal ~~M~~medical conditions – free text field.  ~~Code O993 Psychosocial problems includes mental illness, violent relationships and alcohol or drug misuse.~~ | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes where a maternal medical condition is present | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Maternal medical conditions – free text | | |
|  | | | |
| Related business rules (Section 4): | \*Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Date of admission – mother and Date of birth – baby conditionally mandatory data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | NHDD | Version | 1. January 1982  2. January 1999  3. January 2009  4. July 2015  5. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | 1982 |

# Proposal 28 Amend reporting guide for Date and Time of onset of labour

# Add code to report no record of onset of labour

Section 3 Data definitions

## Date of onset of labour

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The date of onset of labour | | |
|  | | | |
| Representation class | Date | Data type | Date/time |
|  | | | |
| Format | DDMMCCYY | Field size | 8 |
|  | | | |
| Location | Episode record | Position | 61 |
|  | | | |
| Permissible values | A valid calendar date  **Code Descriptor**  88888888 No labour  99999999 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Century (CC) can only be reported as 20.  Code 88888888 No labour: this code is only reported when the mother has a planned or unplanned caesarean section with no labour.  There is little consensus regarding definitions of labour onset. Most definitions include the presence of regular, painful contractions accompanied by effacement and/or dilatation of the cervix. Many women find it difficult to state the time labour started.  Where the woman cannot provide a specific time, asking her when she noticed the change that prompted her to seek advice or care (eg backache, a show, SROM, etc), will aid in deciding on the commencement date and time. It will often be necessary to make an ‘educated guess or best estimate’ when given the history (Hanley, G et al. 2016, BMC Pregnancy and Childbirth).  Not all midwives would make the same judgement call about the ‘exact’ commencement time and date of labour. Therefore, it is generally accepted as an ‘educated guess’.  The above points are intended to assist in determining the date and time of onset of labour. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Labour type | | |
|  | | | |
| Related data items (this section): | Date of rupture of membranes, Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Date and time data item relationships; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations; \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 2009  2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 2009 |

## Time of onset of labour

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The time of onset of labour measured as hours and minutes using a 24-hour clock | | |
|  | | | |
| Representation class | Time | Data type | Date/time |
|  | | | |
| Format | HHMM | Field size | 4 |
|  | | | |
| Location | Episode record | Position | 62 |
|  | | | |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400)  **Code Descriptor**  7777 No record of time of onset of labour  8888 No labour  9999 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report hours and minutes using a 24-hour clock.  Code 8888 No labour is to be used when the mother has a planned or unplanned caesarean section with no labour.  There is little consensus regarding definitions of labour onset. Most definitions include the presence of regular, painful contractions accompanied by effacement and/or dilatation of the cervix. Many women find it difficult to state the time labour started.  Where the woman cannot provide a specific time, asking her when she noticed the change that prompted her to seek advice or care (eg backache, a show, SROM, etc), will aid in deciding on the commencement date and time. It will often be necessary to make an ‘educated guess or best estimate’ when given the history (Hanley, G et al. 2016, BMC Pregnancy and Childbirth).  Not all midwives would make the same judgement call about the ‘exact’ commencement time and date of labour. Therefore, it is generally accepted as an ‘educated guess’.  The above points are intended to assist in determining the date and time of onset of labour. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Labour type | | |
|  | | | |
| Related data items (this section): | Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Date and time data item relationships; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations; \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 2009  2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 2009 |

# Proposal 29 Amend reporting guide for Episode identifier

Section 3 Data definitions

## Episode Identifier

**Specification**

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

**Administration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Principal data users | Not applicable | | | |
|  | | | | |
| Definition source | DHHS | Version | 1. January 2017 2. January 2019 3. January 2020 | |
|  | | | | |
| Codeset source | DHHS | Collection start date | | 2017 |

# Proposal 30 Add new Transaction Type flag code

Section 3 Data definitions

## Transaction type flag

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | An indicator that identifies the type of transaction to the VPDC | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | A | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 3 |
|  | | | |
| Permissible values | **Code Descriptor**  C Confirmation of previously accepted record  N New record  U Updated/corrected record  X Record to be ~~deleted~~ deactivated  R Reinstate record that was previously deactivated | | |
|  | | | |
| Reporting guide | Software-system generated.  Code X: report when a record that was previously submitted is   found to be in error and is required to be removed from   the VPDC: resubmitting the record with code X marks   the record for ‘deactivation’ (removal) from the final VPDC  Code R: report only for a record that was previously submitted   (ie Code N), and then later deactivated (ie Code X), and   now needs to be reinstated to the PVDC database | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Each VPDC electronic record ~~submission file~~ | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | None specified | | |
|  | | | |
| Related business rules (Section 4): | \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 2009 2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 2009 |

# Other changes to Section 2: Concept and derived item definitions

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| Gestational diabetes | | |
|  |  | |
| **Definition/guide for use** | Gestational diabetes mellitus (GDM) is a carbohydrate intolerance resulting in hyperglycaemia ~~of variable~~ 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. | |

|  |  |
| --- | --- |
| **Related data items (Section 3):** | Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus therapy during pregnancy; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for operative delivery – free text; Indications for operative delivery – 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 |

|  |  |
| --- | --- |
| 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 |

# Other changes to Section 3 Data definitions

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether the mother is admitted into a high dependency unit (HDU) / intensive care unit (ICU) in this health service during the birth episode | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 94 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Admitted to high dependency unit / intensive care unit  2 Not admitted to high dependency unit / intensive care unit  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Depending on the facilities, and policies of the hospital, this high dependency care may take place in the labour ward, high dependency unit, intensive care unit, coronary care unit, or any other specialist unit. The mother may spend time in this unit for days either before and/or after the birth. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | | |
|  | | | |
| Related concepts (Section 2): | High dependency unit (HDU), intensive care unit (ICU) | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Hospital code (agency identifier); Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other reasons) – free text; Indications for operative delivery – free text; Indications for operative delivery – 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): | \*Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999 2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 1999 |

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether the neonate is admitted into a special care nursery (SCN) or neonatal intensive care unit (NICU) in this health service during the birth episode | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 113 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Admitted to SCN  2 Admitted to NICU  3 Not admitted to SCN or NICU  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | The criteria for admission~~s~~ to SCN may vary depending on the facilities available and level of care provided within a particular hospital. This data element is a flag for neonatal morbidity and/or congenital anomalies.  If code 1, Admitted to SCN or code 2, Admitted to NICU is selected, then a code/condition must be reported in Neonatal morbidity and/or Congenital anomalies ~~must be documented~~.  If the neonate is admitted to both SCN and NICU, report code 2 Admitted to NICU.  Do not report a value for stillbirth episodes, leave blank. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All live birth episodes | | |
|  | | | |
| Related concepts (Section 2): | Intensive care unit (ICU) | | |
|  | | | |
| Related data items (this Section): | Congenital anomalies – ~~free text~~ ICD-10-AM code; Congenital anomalies – indicator; Hospital code (agency identifier), Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code | | |
|  | | | |
| Related business rules (Section 4): | \*Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items; \*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 ‘Live born’ and associated conditionally mandatory data items; \*Birth status ‘Stillborn’ and associated data items valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1999  2. January 2007  3. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 1999 |

## Anaesthesia for operative delivery – indicator

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether anaesthesia is administered to the mother for, or associated with, the operative delivery of the baby (forceps, vacuum/ventouse or caesarean section) | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 79 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Anaesthesia administered  2 Anaesthesia not administered  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Operative delivery includes caesarean section, hysterotomy, forceps and vacuum/ventouse extraction. Do not report a value for birth episodes with no operative delivery, leave blank. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes with an operative delivery | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Anaesthesia | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Anaesthesia for operative delivery – type; Method of birth | | |
|  | | | |
| Related business rules (Section 4): | ~~\*Mandatory to report data items~~ Anaesthesia for operative delivery – indicator and Method of birth valid combinations; \*Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data items; ### Anaesthesia for operative delivery – indicator and Anaesthesia for operative deliver – type valid combinations | | |

**Administration**

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

## Anaesthesia for operative delivery – type

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The type of anaesthesia administered to a woman during a birth event | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 (x4) |
|  | | | |
| Location | Episode record | Position | 80 |
|  | | | |
| Permissible values | **Code Descriptor**  2 Local anaesthetic to perineum  3 Pudendal block  4 Epidural or caudal block  5 Spinal block  6 General anaesthetic  7 Combined spinal-epidural block  8 Other anaesthesia  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | This item should be recorded for operative or instrumental delivery of the baby only. It does not include the removal of the placenta.  Code 7 Combined spinal-epidural block:  The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.  Code 8 Other anaesthesia: May include parenteral opioids, nitrous oxide | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes with an operative delivery | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Anaesthesia | | |
|  | | | |
| Related data items (this section): | Anaesthesia for operative delivery – indicator | | |
|  | | | |
| Related business rules (Section 4): | ~~\*Mandatory to report data items~~ ### Anaesthesia for operative delivery – indicator and Anaesthesia for operative deliver – type valid combinations | | |

**Administration**

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

## Analgesia for labour – indicator

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether analgesia is administered to the woman to relieve pain during labour | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 77 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Analgesia administered  2 Analgesia not administered  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Analgesia will usually be administered by injection or inhalation.  This item is to be recorded for first and second stage labour, but not third stage labour (for example, removal of placenta), and not when it is used primarily to enable operative birth.  Inhalation analgesia such as nitrous oxide (N2O and O2) can be used for manual removal of placenta on occasion.  Do not report a value for birth episodes where the woman does not have labour, leave blank. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes where there is a labour | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Analgesia | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Analgesia for labour – type; Labour type | | |
|  | | | |
| Related business rules (section 4): | ~~\*Mandatory to report data items~~ Analgesia for labour – indicator and Labour type valid combinations; Labour type and Analgesia for labour – indicator conditionally mandatory data item; ### 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 | DHHS | Version | 1. January 1999 |
|  | | | |
| Codeset source | DHHS | Collection start date | 1999 |

## Analgesia for labour – type

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The type of analgesia administered to the woman during a birth event. | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 (x4) |
|  | | | |
| Location | Episode record | Position | 78 |
|  | | | |
| Permissible values | **Code Descriptor**  2 Nitrous oxide  3 Systemic opioids  4 Epidural or caudal block  5 Spinal block  7 Combined spinal / epidural block  8 Other analgesia  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | This item is to be recorded for first and second stage labour, but not for third stage labour, e.g. removal of placenta.  Code 3 Systemic opioids:  Includes intramuscular and intravenous opioids.  Code 7 Combined spinal / epidural block:  The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.  Code 8 Other analgesia:  Includes all non-narcotic oral analgesia. Includes non-pharmacological methods such as hypnosis, acupuncture, massage, relaxation techniques, temperature regulation, aroma therapy and other. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes where there is a labour | | |
|  | | | |
| Related concepts (Section 2): | ~~None specified~~ Analgesia | | |
|  | | | |
| Related data items (this section): | Analgesia for labour – indicator | | |
|  | | | |
| Related business rules (Section 4): | ~~\*Mandatory to report data items;~~ ### 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 | Version | 1. January 1999 2. July 2015 |
|  | | | |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1999 |

## Apgar score at one minute

**Specification**

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

**Administration**

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

## Apgar score at five minutes

**Specification**

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

**Administration**

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

## Birth plurality

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The total number of babies resulting from a single pregnancy | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 98 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Singleton  2 Twins  3 Triplets  4 Quadruplets  5 Quintuplets  6 Sextuplets  8 Other  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus is likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included they should be recognisable as a fetus and have been expelled or extracted with other products of conception when pregnancy ended at 20 or more weeks gestation. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Birth order | | |
|  | | | |
| Related business rules (Section 4): | Birth plurality and Birth order valid combinations; 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 | Version | 1. January 1982 2. July 2015 | |
|  | | | | |
| Codeset source | NHDD | Collection start date | | 1982 |

## Birth status

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Status of the baby at birth | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 100 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Live born  2 Stillborn (occurring before labour)  3 Stillborn (occurring during labour)  4 Stillborn (timing of occurrence unknown)  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Code 1 Liveborn:  CCOPMM defines liveborn as the birth of an infant, regardless of maturity or birth weight, who breathes or shows any other signs of life after being born.  Code 2 Stillborn (occurring before labour)  Code 3 Stillborn (occurring during labour)  Code 4 Stillborn (timing of occurence unknown):  CCOPMM defines a stillbirth as the birth of an infant of at least 20 weeks’ gestation or if gestation is unknown, weighing at least 400 grams, which shows no signs of life after birth. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | Live birth, Stillbirth (fetal death) | | |
|  | | | |
| Related data items (this section): | Apgar score at one minute, Apgar score at five minutes | | |
|  | | | |
| Related business rules (Section 4): | Birth status, Breastfeeding attempted and Last feed before discharge 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; \*Estimated gestational age conditionally mandatory data items for Birth status code 1 Liveborn; \*Mandatory to report data items; Scope ‘Stillborn’ | | |

**Administration**

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

## Blood product transfusion – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Whether the mother was given a transfusion of whole blood, or any blood product (excluding anti-D), during her postpartum stay | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 90 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Transfusion of blood products received  2 Transfusion of blood products not received  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Blood products may include:   * whole blood * packed cells * platelets * fresh frozen plasma (FFP).   Intramuscular administration of Hepatitis B immunoglobulins is not to be reported as a transfusion of blood products. | | |
|  | | | |
| 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 b~~Blood loss (ml); Blood loss assessment – indicator; Main reason for excessive blood loss following childbirth | | |
|  | | | |
| Related business rules (Section 4): | \*Mandatory to report data items | | |

**Administration**

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

## Congenital anomalies – ICD-10-AM code

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Structural, functional, genetic, chromosomal and biochemical abnormalities that can be detected before birth, at birth or days later, in either a live born or stillborn baby. They may be multiple or isolated. | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5(x9) |
|  | | | |
| Location | Episode record | Position | 134 |
|  | | | |
| Permissible values | ~~All ICD-10-AM codes~~   * ~~For applicable codes for congenital anomalies refer to the ICD-10-AM/ACHI library file available on request, by email to~~ [~~hdss.helpdesk@dhhs.vic.gov.au~~](mailto:hdss.helpdesk@dhhs.vic.gov.au)   Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au). | | |
|  | | | |
| Reporting guide | Any congenital abnormality detected before birth, at birth or days later. This includes structural, functional, genetic, chromosomal and biochemical anomalies in either a live born or stillborn baby. These anomalies may be multiple or isolated.  Other anomalies that include neoplasms, metabolic and haematological conditions should also be reported.  The most common congenital anomalies are listed in Section 2. Congenital anomalies not required to be reported are also listed in Section 2. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where a congenital anomaly is present | | |
|  | | | |
| Related concepts (Section 2): | Congenital anomalies | | |
|  | | | |
| Related data items (this section): | Congenital anomalies – indicator | | |
|  | | | |
| Related business rules (Section 4): | \*Congenital anomalies – indicator and congenital anomalies – ~~free text~~ ICD‑10-AM code conditionally mandatory data items; \*Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | NHDD | Version | 1. January 2018 2. January 2020 |
|  | | | |
| Codeset source | ICD-10-AM eleventh edition plus CCOPMM additions | Collection start date | 2018 |

## Country of birth

**Specification**

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

**Administration**

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

## Data submission identifier

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | ~~The date and time the VPDC electronic submission file is generated in 24-hour clock format~~ File name component that identifies this file using a date and time format | | |
|  | | | |
| Representation class | Identifier | Data type | Date/time |
|  | | | |
| Format | YYYYMMDDHHMM | Field size | 12 |
|  | | | |
| Location | Header record, File name | Position | Not applicable |
|  | | | |
| Permissible values | A valid calendar date and time value using a 24-hour clock (not 0000 or 2400) | | |
|  | | | |
| Reporting guide | Software-system generated. Time must be in 24-hour clock format.  May be t~~T~~he date and time the VPDC electronic submission file is generated in 24-hour clock format, or may represent the end date used in selecting records for inclusion in the submission file. Cannot be later than the date and time on which it is submitted for processing. Refer also to Section 5 Compilation and submission, of the VPDC manual. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Each VPDC electronic submission file | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | None specified | | |
|  | | | |
| Related business rules (Section 4): | None specified | | |

**Administration**

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

## Date of onset of second stage of labour

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The date of the start of the second stage of labour | | |
|  | | | |
| Representation class | Date | Data type | Date/time |
|  | | | |
| Format | DDMMCCYY | Field size | 8 |
|  | | | |
| Location | Episode record | Position | 63 |
|  | | | |
| Permissible values | A valid calendar date  **Code Descriptor**  88888888 No labour  99999999 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Code 88888888 No second stage of labour: this code is only reported when the mother has a planned or unplanned caesarean section and did not reach second stage of labour.  Century (CC) can only be reported as 20.  In the instance of the woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:  1. Had she had a show or rupture of membranes (ROM)?  2. Had she vomited at all within the hour prior to giving birth or thought she was going to vomit?  3. Had there been any noticeable urge to push?  4. Did she notice if she had bowel pressure prior to having the baby and how long before?  5. Had any family members noticed any change in her behaviour (restless, agitated) prior to having baby?  If none of these questions can be answered then a reasonable assumption would be that the birth occurred within one to two contractions prior to the birth and second stage may be judged to be two and five minutes prior to the birth. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Date of onset of labour, Date of rupture of membranes, Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Date and time data item relationships, \*Labour type ‘Woman in labour’ and associated data items valid combinations, \*Labour type ‘Woman not in labour’ and associated data items valid combinations; \*Mandatory to report data items | | |

**Administration**

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

## Date of rupture of membranes

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The date on which the mother’s membranes ruptured (spontaneously or artificially) | | |
|  | | | |
| Representation class | Date | Data type | Date/time |
|  | | | |
| Format | DDMMCCYY | Field size | 8 |
|  | | | |
| Location | Episode record | Position | 65 |
|  | | | |
| Permissible values | A valid calendar date  **Code Descriptor**  77777777 No record of date of rupture of membranes  88888888 Membranes ruptured at caesarean  99999999 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report the date on which the membranes were believed to have ruptured, whether spontaneously or artificially. If there is a verified hindwater leak, that is followed by a forewater rupture, record the earlier date.  If there is some vaginal loss that is suspected to be ruptured membranes, but in hindsight seems unlikely, record the time at which the membranes convincingly ruptured. In unusual situations, a brief text description will minimise queries.  In the case of a caul birth, report the date and time of ROM as the date and time of birth. If date of ROM is known but time of ROM is not, report unknown date and time. When an unknown code is reported for ROM, unknown codes must be reported for Date and Time of Onset of Labour and Date and Time of Onset of Second Stage of Labour.  Century (CC) can only be reported as 20.  Code 88888888 Membranes ruptured at caesarean: this code is only reported when the mother has a planned or unplanned caesarean section and membranes were ruptured during caesarean. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Date and time data item relationships, \*Labour type ‘Woman in labour’ and associated data items valid combinations, \*Labour type ‘Woman not in labour’ and associated data items valid combinations; \*Mandatory to report data items | | |

**Administration**

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

## Discipline of antenatal care provider

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The discipline of the clinician who provided most occasions of antenatal care | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 54 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Obstetrician  2 Midwife  3 General practitioner  4 No antenatal care provider  8 Other  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Code 1 Obstetrician:  includes public and private obstetric care including care provided by medical staff in hospitals under the supervision of an obstetrician  Code 2 Midwife:  includes public and private midwifery care including care provided by midwife-led units in hospitals with limited medical input  Code 3 General practitioner:  includes public and private care by general practitioners (including those with a diploma of obstetrics) and care provided by medical staff in hospitals under the supervision of a general practitioner | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | None specified | | |
|  | | | |
| Related business rules (Section 4): | Discipline of antenatal care provider and Number of antenatal care visites valid combinations; \*Mandatory to report data items | | |

**Administration**

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

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (x9) |
|  | | | |
| Location | Episode record | Position | 82 |
|  | | | |
| Permissible values | Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).  A small number of additional codes have been created solely for VPDC reporting in this data element:  **Code Descriptor**  ~~O660 Shoulder dystocia~~  *[same code in ICD-10-AM 11th edition]*  O839 Water birth  Z292 Antibiotic therapy in labour  ~~For other applicable codes for indications for Events of labour and birth refer to the ICD-10-AM/ACHI (8~~~~th~~ ~~edition) library file available on request, by email to~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@dhhs.vic.gov.au) | | |
|  | | | |
| Reporting guide | Complications arising after the onset of labour and before the completed birth of the baby and placenta. Report c~~C~~onditions related to the neonate, and classifiable to code range P00–P96~~.~~ Certain conditions originating in the perinatal period, ~~must be~~ ~~reported~~ in data element Neonatal morbidity – ICD-10-AM code. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Births where events occurred during the labour and/or birth | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Birth presentation; Events of labour and birth – free text | | |
|  | | | |
| Related business rules (Section 4): | \*Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Birth presentation conditionally mandatory data items | | |

**Administration**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Principal data users | | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | | | | |
|  | | | | | |
| Definition source | NHDD | | Version | 1. January 2009 2. January 2015 3. January 2020 | | |
|  | | | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | | Collection start date | | 2009 |

## Fetal monitoring in labour

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Methods used to monitor the wellbeing of the fetus during labour | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | NN | Field size | 2 (x7) |
|  | | | |
| Location | Episode record | Position | 72 |
|  | | | |
| Permissible values | **Code Descriptor**  01 None  02 Intermittent auscultation  03 Admission cardiotocography  04 Intermittent cardiotocography  05 Continuous external cardiotocography  06 Internal cardiotocography (scalp electrode)  07 Fetal blood sampling  88 Other  99 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | More than one method of monitoring can be recorded.   * Code 02 Intermittent auscultation:  performed by Pinnards or sonicaid * Code 03 Admission cardiotocography:  a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission * Code 04 Intermittent cardiotocography:  fetal heart monitoring by CTG on a number of occasions in labour, but not continuously * Code 05 Continuous cardiotocography:  fetal heart monitoring by CTG more or less continuously from some point in labour until about the time of birth * Code 07 Fetal blood sampling: includes scalp lactate * If there was no labour, ~~report 01 None or~~ leave blank. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where there is a labour | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Labour Type; Fetal monitoring prior to birth – not in labour | | |
|  | | | |
| Related business rules (Section 4): | ~~E002 Conditionally Mandatory Element Missing; E003 Value provided when none expected; E004 Invalid Code;~~ ### Fetal monitoring in labour and Labour type valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 2009 2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 2009 |

## Fetal monitoring prior to birth – not in labour

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Methods used to monitor the wellbeing of the fetus prior to birth (for example, prior to a caesarean section), but not in labour. | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | NN | Field size | 2 (x5) |
|  | | | |
| Location | Episode record | Position | 131 |
|  | | | |
| Permissible values | **Code Descriptor**  01 None  02 Intermittent auscultation  03 Admission cardiotocography  04 Intermittent cardiotocography  05 Continuous external cardiotocography  ~~06 Internal cardiotocography (scalp electrode)~~  ~~07 Fetal blood sampling~~  88 Other  99 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report this field if Labour Type is 5 – No labour.  More than one method of monitoring can be recorded.   * Code 02 Intermittent auscultation:  performed by Pinnards or sonicaid * Code 03 Admission cardiotocography:  a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission * Code 04 Intermittent cardiotocography:  fetal heart monitoring by CTG (not in labour) on a number of occasions, but not continuously. * Code 05 Continuous cardiotocography:  fetal heart monitoring by CTG more or less continuously from some point until abou the time of birth * ~~Code 07 Fetal blood sampling: includes scalp lactate~~ * If there was ~~no~~ labour, ~~report 01 None or~~ leave blank | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where there was no labour | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Labour Type; Fetal monitoring in labour | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified;~~ \*Fetal monitoring prior to birth – not in labour and Labour type valid combinations; \*Labour type ‘Woman in labour’ and associated data items valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 2017 2. January 2020 |
|  | | | |
| Codeset source | DHHS | Collection start date | 2017 |

## Gestational age at first antenatal visit

**Specification**

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

**Administration**

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

## Head circumference - baby

**Specification**

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

**Administration**

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

## Indications for operative delivery – free text

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The reason(s) given for an operative birth | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(300) | Field size | 300 |
|  | | | |
| Location | Episode record | Position | 75 |
|  | | | |
| Permissible values | Permitted characters:   * 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 | | |
|  | | | |
| Reporting guide | Report indications for operative delivery in this field when there is no ICD-10-AM code available for selection in the software. Report up to four reasons for operative delivery in order from the most to least influential in making the decision. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Indications for operative delivery – ICD-10-AM code, Method of birth | | |
|  | | | |
| Related business rules (Section 4): | Labour type ‘Failed induction’ conditionally mandatory data items; \*Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1982 2. January 2020 |
|  | | | |
| Codeset source | Not applicable | Collection start date | 1982 |

## Labour induction/augmentation agent

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Agents used to induce or assist in the progress of labour | | |
| Representation class | Code | Data type | Number |
| Format | N | Field size | 1 (x4) |
| Location | Episode record | Position | 68 |
| Permissible values | **Code Descriptor**  1 Oxytocin  2 Prostaglandins  3 Artificial rupture of membranes (ARM)  4 Cervical Ripening – balloon catheter  8 Other - specify  9 Not stated / inadequately described | | |
| Reporting guide | Code 2 Prostaglandins:   includes misoprostil  Code 4 Cervical Ripening – balloon catheter:   includes all catheter types  Code 8 Other – specify:   if code 8 is reported, specify the agent of induction or  augmentation in Labour induction/augmentation agent –   other specified description  If labour is not induced or augmented do not report a value, leave blank. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes where labour was induced or augmented | | |
| Related concepts (Section 2): | Augmentation, Labour type | | |
| Related data items (this section): | ~~Indication for Induction – free text, Indication for Induction – ICD-10-AM code~~ Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Labour induction/ augmentation agent – other specified description | | |
| Related business rules (Section 4): | ~~None specified~~ 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 | DHHS | Version | 1. January 1999 2. January 2017 |
| Codeset source | METEOR 270037 | Collection start date | 1999 |

## Last birth – caesarean section indicator

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | An indicator of whether a caesarean section was performed for the most recent previouspregnancy that resulted in a birth. | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 44 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Last birth was caesarean section  2 Last birth was not caesarean section  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Previous birth includes live birth, stillbirth or neonatal death. Only relates to the last birth, not the last pregnancy when the outcome of last pregnancy was an abortion or ectopic pregnancy. Do not report a value for episodes where the mother has not had a previous birth. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Episodes where the mother has had a previous birth | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Total number of previous caesareans | | |
|  | | | |
| Related business rules (Section 4): | \*Gravidity ‘Multigravida’ conditionally mandatory data items; Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items | | |

**Administration**

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

## Maternal alcohol use at less than 20 weeks

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | A self-reported indicator of alcohol frequency intake at any time during the first 20 weeks of her pregnancy | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 135 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Never  2 Monthly or less  3 2-4 times a month  4 2-3 times a week  5 4 or more times a week  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report the statement that best describes maternal alcohol use behaviour during pregnancy before 20 weeks gestation | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Maternal alcohol volume intake at less than 20 weeks | | |
|  | | | |
| Related business rules (Section 4): | \*Mandatory to report data items; ### Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations | | |

**Administration**

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

## Maternal alcohol use at 20 or more weeks

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | A self-reported indicator of alcohol frequency at 20 or more weeks of her pregnancy | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 137 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Never  2 Monthly or less  3 2-4 times a month  4 2-3 times a week  5 4 or more times a week  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report the statement that best describes maternal alcohol use behaviour at 20 or more weeks gestation | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Maternal alcohol volume intake at 20 or more weeks | | |
|  | | | |
| Related business rules (Section 4): | \*Mandatory to report data items; ### Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations | | |

**Administration**

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

## Maternal alcohol volume intake at less than 20 weeks

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | A self-reported indicator of alcohol volume intake at any time during the first 20 weeks of her pregnancy | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 136 |
|  | | | |
| Permissible values | **Code Descriptor**  1 1 or 2 standard drinks  2 3 or 4 standard drinks  3 5 or 6 standard drinks  4 7 to 9 standard drinks  5 10 or more standard drinks  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report the average amount of standard drinks consumed per occasion when drinking | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes who report any alcohol intake in the first 20 weeks of pregnancy | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Maternal alcohol use at less than 20 weeks | | |
|  | | | |
| Related business rules (Section 4): | \*~~Mandatory to report data items~~ ### Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations | | |

**Administration**

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

## Maternal alcohol volume intake at 20 or more weeks

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | A self-reported indicator of alcohol volume intake at 20 or more weeks of her pregnancy | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | N | Field size | 1 |
|  | | | |
| Location | Episode record | Position | 138 |
|  | | | |
| Permissible values | **Code Descriptor**  1 1 or 2 standard drinks  2 3 or 4 standard drinks  3 5 or 6 standard drinks  4 7 to 9 standard drinks  5 10 or more standard drinks  9 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | Report the average amount of standard drinks consumed per occasion when drinking | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes who report any alcohol intake at 20 or more weeks’ gestation | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Maternal alcohol use at 20 or more weeks | | |
|  | | | |
| Related business rules (Section 4): | \*~~Mandatory to report data items~~ ### Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations | | |

**Administration**

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

## Method of birth

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The method of complete expulsion or extraction from the woman of a product of conception in a birth event | | |
|  | | | |
| Representation class | Code | Data type | Number |
|  | | | |
| Format | NN | Field size | 2 |
|  | | | |
| Location | Episode record | Position | 74 |
|  | | | |
| Permissible values | **Code Descriptor**  1 Forceps  3 Vaginal birth – non-instrumental  4 Planned caesarean – no labour  5 Unplanned caesarean – labour  6 Planned caesarean – labour  7 Unplanned caesarean – no labour  8 Vacuum extraction  9 Not stated / inadequately described  10 Other operative birth | | |
|  | | | |
| Reporting guide | In the case of multiple births, the method of birth is reported in each baby’s episode record.  Where forceps/vaccuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.  ~~Where a hysterotomy is performed to extract trhe baby, code as caesarean section.~~  Code 1 Forceps  Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the head during breech presentations. Includes vaginal breech with forceps to the aftercoming head  Code 3 Vaginal birth – non-instrumental  Includes manual assistance for example, a vaginal breech that has been manually rotated  Code 4 Planned caesarean – no labour  Caesarean takes place as a planned procedure before the onset of labour  Code 5 Unplanned caesarean – 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 labour  Code 7 Unplanned caesarean – no labour  Procedure is undertaken for an urgent indication before the onset of labour. If a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate  Code 10 Other operative birth  Includes D&C, D&E, hysterotomy and laparotomy.  Excludes operative methods of birth for which a specific code exists | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Anaesthesia for operative delivery – indicator, Anaesthesia for operative delivery – type, Analgesia for labour – indicator, Analgesia for labour – type | | |
|  | | | |
| Related business rules (Section 4): | Anaesthesia for operative delivery – indicator and Method of birth valid combinations; ###Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – 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, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations; \*Perineal laceration – indicator and Method of birth valid combinations | | |

**Administration**

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

## Number of antenatal care visits

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The total number of antenatal care visits attended by a pregnant female | | |
| Representation class | Total | Data type | Number |
| Format | NN | Field size | 2 |
| Location | Episode record | Position | 124 |
| Permissible values | Range: zero to 30 (inclusive)  **Code Descriptor**  99 Not stated / inadequately described | | |
| Reporting guide | **Guide for use:**  Antenatal care visits are attributed to the pregnant woman.  In rural and remote locations where a midwife or doctor is not employed, registered Aboriginal health workers and registered nurses may perform this role within the scope of their training and skill licence.  Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record.  An antenatal care visit does not include a visit where the sole purpose of contact is to confirm the pregnancy only, or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues.  An antenatal care visit does not include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of bloods or tissue for pathology testing. Exception to this rule is made when the health professional performing the procedure or test is a doctor or midwife and the appointment directly relates to this pregnancy and the health and wellbeing of the fetus.  **Collection methods:**  Collect the total number of antenatal care visits for which there is documentation included in the health record of pregnancy and/or birth. To be collected once, after the onset of labour. Include all medical specialist appointments or medical specialist clinic appointments where the provider of the service event has documented the visit on the health record.  Multiple visits on the same day should be recorded as one visit. | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | None specified | | |
| Related business rules (Section 4): | Discipline of antenatal care provider and Number of antenatal care visits valid combinations; Gestational age at first antenatal care visit and Number of antenatal care visits valid combinations; \*Mandatory to report data items | | |

**Administration**

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

## Obstetric complications – free text

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Complications arising during the pregnancy ~~period immediately before delivery (not including the intrapartum period~~ that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome. | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(300) | Field size | 300 |
|  | | | |
| Location | Episode record | Position | 51 |
|  | | | |
| Permissible values | Permitted characters:   * 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 | Report conditions in this field when there is no ICD-10-AM code available for selection in the software.  Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension.  Exclude conditions arising during the intrapartum period: these are to be reported in Events of labour and birth – ICD-10-AM code and/or Events of labour and birth – free text | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where an obstetric complication is present | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | None specified | | |
|  | | | |
| Related business rules (Section 4): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items | | |

**Administration**

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

## Obstetric complications – ICD-10-AM code

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Complications arising during the pregnancy ~~period immediately before delivery (not including the intrapartum period~~ that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome. | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (x15) |
|  | | | |
| Location | Episode record | Position | 52 |
|  | | | |
| Permissible values | ~~ICD-10-AM (8~~~~th~~ ~~edition) available on request, please email~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@health.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).  An additional code has been created solely for VPDC reporting in this data element:  **Code Descriptor**  ~~O142 HELLP Syndrome~~  *[same code in ICD-10-AM 11th edition]*  ~~O149 Pre-eclampsia, unspecified~~  *[same code in ICD-10-AM 11th edition]*  ~~O2442 Diabetes mellitus arising at or after 24 weeks’ gestation,~~  ~~insulin treated~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Diabetes mellitus arising during pregnancy, insulin treated]*  ~~O2444 Diabetes mellitus arising at or after 24 weeks’ gestation, diet~~  ~~controlled~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Diabetes mellitus arising during pregnancy, other [treatment]]*  ~~O365 Suspected fetal growth restriction~~  *[same code in ICD-10-AM 11th edition, descriptor changes to:  Maternal care for poor fetal growth]*  ~~O440 Placenta praevia without haemorrhage~~  *[same code in ICD-10-AM 11th edition]*  ~~O441 Placenta praevia with haemorrhage~~  *[same code in ICD-10-AM 11th edition]*  ~~O459 Premature separation of placenta (abruptio placentae)~~  *[same code in ICD-10-AM 11th edition]*  ~~O468 Other antepartum haemorrhage~~  *[same code in ICD-10-AM 11th edition]*  Z223 Carrier of streptococcus group B (GBS+) | | |
|  | | | |
| Reporting guide | Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension.  Exclude conditions arising during the intrapartum period: these are to be reported in Events of labour and birth – ICD-10-AM code and/or Events of labour and birth – free text | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where an obstetric complication is present | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Obstetric complications – free text | | |
|  | | | |
| Related business rules (Section 4): | \*Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Date of admission – mother and Date of birth – baby conditionally mandatory data items | | |

**Administration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | | |
|  | | | | |
| Definition source | NHDD | Version | 1. January 1982 2. July 2015 3. January 2020 | |
|  | | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | | 1982 |

## Postpartum complications – ICD-10-AM code

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Medical and obstetric complications of the mother occurring during the postnatal period, up to the time of separation from care | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | ANN[NN] | Field size | 5 (x6) |
|  | | | |
| Location | Episode record | Position | 92 |
|  | | | |
| Permissible values | ~~ICD-10-AM (8~~~~th~~ ~~edition) available on request, please email~~ [~~perinatal.data@dhhs.vic.gov.au~~](mailto:perinatal.data@health.vic.gov.au)  Codes relevant to this data element are listed in the 11th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@dhhs.vic.gov.au](mailto:hdss.helpdesk@dhhs.vic.gov.au).  **~~Code Descriptor~~**  ~~O142 HELLP Syndrome~~  *[same code in ICD-10-AM 11th edition]* | | |
|  | | | |
| Reporting guide | Postpartum complications arising after the delivery of the placenta up until the time of separation from care. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where complications are present in the postpartum period | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother | | |
|  | | | |
| Related business rules (Section 4): | \*Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items | | |

**Administration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | | |
|  | | | | |
| Definition source | NHDD | Version | 1. January 2009 2. July 2015 3. January 2020 | |
|  | | | | |
| Codeset source | ICD-10-AM ~~eighth~~ eleventh edition plus CCOPMM additions | Collection start date | | 2009 |

## Procedure – free text

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(300) | Field size | 300 |
|  | | | |
| Location | Episode record | Position | 55 |
|  | | | |
| Permissible values | Permitted characters:   * 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 | Report procedures in this field when there is no ACHI code available for selection in the software. This includes procedures and operations performed during the current pregnancy, labour, delivery and the puerperium. For example, cholecystectomy, ligation of vessels for twin-to-twin transfusion, hysterectomy and amniocentesis. A procedure should only be coded once, regardless of how many times it is performed. Procedures that are reported in other data elements do not need to be reported in this field. These include anaesthesia or analgesia relating to the birth, augmentation or induction, caesarean section, forceps or vacuum extraction, suture/repair of tears and allied health procedures. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Birth episodes where a medical procedure and/or operation is performed and/or a procedure related to the pregnancy, including assisted reproductive technology, occurred during the pregnancy | | |
|  | | | |
| Related concepts (Section 2): | Procedure | | |
|  | | | |
| Related data items (this section): | Artificial reproductive technology – indicator, Procedure – ACHI code | | |
|  | | | |
| Related business rules (Section 4): | \*Artificial reproductive technology – indicator conditionally mandatory data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | DHHS | Version | 1. January 1982 2. January 2020 |
|  | | | |
| Codeset source | Not applicable | Collection start date | 1982 |

## Residential road name – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The name of the road or thoroughfare of the mother’s normal residential address | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(45) | Field size | 45 |
|  | | | |
| Location | Episode record | Position | 14 |
|  | | | |
| Permissible values | Permitted characters:   * 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 | The name of the road on which the mother normally resides. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | ~~None specified~~ Residential locality; Residential postcode; Residential road number – mother; Residential road suffix code – mother; Residential road type - mother | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified \*~~Mandatory to report data items | | |

**Administration**

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

## Residential road number – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The number in the road or thoroughfare of the mother’s normal residential address | | |
|  | | | |
| Representation class | Text | Data type | String |
|  | | | |
| Format | A(~~300~~ 12) | Field size | 12 |
|  | | | |
| Location | Episode record | Position | 13 |
|  | | | |
| 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 | The number of the road on which the mother normally resides. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Residential locality; Residential postcode; Residential road name – mother; Residential road suffix code – mother; Residential road type - mother | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified \*~~Mandatory to report data items | | |

**Administration**

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

## Residential road suffix code – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The abbreviation code used to represent the suffix of the road or thoroughfare of the mother’s normal residential address | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | AA | Field size | 2 |
|  | | | |
| Location | Episode record | Position | 15 |
|  | | | |
| Permissible values | Codeset available on request, please email [perinatal.data@dhhs.vic.gov.au](file:///\\N059\GROUP\FHIP\H_Info\Hlth_Data_Acqn\VPDC\Manual\Version%205%20Draft\perinatal.data@health.vic.gov.au) | | |
|  | | | |
| Reporting guide | The type of road on which the mother normally resides | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Residential locality; Residential postcode; Residential road name – mother, Residential road number – mother; Residential road type – mother | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified \*~~Mandatory to report data items | | |

**Administration**

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

## Residential road type – mother

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The type of road or thoroughfare of the mother’s normal residential address | | |
|  | | | |
| Representation class | Code | Data type | String |
|  | | | |
| Format | AAAA | Field size | 4 |
|  | | | |
| Location | Episode record | Position | 16 |
|  | | | |
| Permissible values | Codeset available on request, please email [perinatal.data@dhhs.vic.gov.au](file:///\\N059\GROUP\FHIP\H_Info\Hlth_Data_Acqn\VPDC\Manual\Version%205%20Draft\perinatal.data@health.vic.gov.au) | | |
|  | | | |
| Reporting guide | The type of road where the mother normally resides | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Residential locality; Residential postcode; Residential road name – mother, Residential road number – mother, Residential road suffix code – mother | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified \*~~Mandatory to report data items | | |

**Administration**

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

## Total number of previous caesareans

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Total number of previous pregnancies where the method of delivery was caesarean section | | |
|  | | | |
| Representation class | Total | Data type | Number |
|  | | | |
| Format | NN | Field size | 2 |
|  | | | |
| Location | Episode record | Position | 45 |
|  | | | |
| Permissible values | Range: zero to 9 (inclusive)  **Code Descriptor**  99 Not stated / inadequately described | | |
|  | | | |
| Reporting guide | This relates to all births including the last birth. If the mother has had any previous births, then check and report the total number of births by caesarean section, regardless of whether the last birth was a caesarean section or not. If neither the last birth nor any other previous births were by caesarean section, report 0. For multiple births, if one baby is delivered via caesarean section and the other baby or babies via any other form of delivery (excluding caesarean), record this pregnancy as a previous caesarean. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Gravidity; Last birth – caesarean section indicator; Plan for vaginal birth after caesarean | | |
|  | | | |
| Related business rules (Section 4): | \*Gravidity ‘Multigravida’ conditionally mandatory data items; \*Gravidity ‘Primigravida’ and associated data items valid combinations; \*Mandatory to report data items; Total number of previous caesareans and Plan for VBAC conditionally mandatory data item | | |

**Administration**

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

## Total number of previous ectopic pregnancies

**Specification**

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

**Administration**

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

## Transfer destination – baby

**Specification**

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

**Administration**

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

## Transfer destination – mother

**Specification**

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

**Administration**

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

## Version identifier

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | Version of the data collection | | |
|  | | | |
| Representation class | Identifier | Data type | Number |
|  | | | |
| Format | NNNN | Field size | 4 |
|  | | | |
| Location | Episode record, Header record | Position | 2 |
|  | | | |
| Permissible values | **Code**  2009  2015  2017  2018  2019  2020 | | |
|  | | | |
| Reporting guide | Software-system generated. A VPDC electronic submission file with a missing or invalid Version identifier will be rejected and the submission file will not be processed. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | Each VPDC electronic submission file (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 | DHHS | Version | 1. January 2009 2. July 2015 3. January 2017 4. January 2018 5. January 2019 6. January 2020 | |
|  | | | | |
| Codeset source | DHHS | Collection start date | | 2009 |

## Year of arrival in Australia

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| Definition | The year a person (born outside of Australia) first arrived in Australia, from another country. | | |
|  | | | |
| Representation class | Code | Data type | ~~Numeric~~ Number |
|  | | | |
| Format | NNNN | Field size | 4 |
|  | | | |
| Location | Episode record | Position | 128 |
|  | | | |
| Permissible values | Valid year, between ~~1900~~ 1960 and current year  9998 Not intending to stay in Australia for one year or more  9999 Not stated/inadequately described | | |
|  | | | |
| Reporting guide | Recommended question:  In what year did you/the person first arrive in Australia to live here for one year or more?  It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. An instruction such as 'Please indicate the year of first arrival only' should be included with the question.  If mother is born in Australia, leave blank. | | |
|  | | | |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
|  | | | |
| Reported for | All birth episodes where Country of birth is not Australia | | |
|  | | | |
| Related concepts (Section 2): | None specified | | |
|  | | | |
| Related data items (this section): | Country of Birth | | |
|  | | | |
| Related business rules (Section 4): | ~~None specified~~ ### Country of birth and Year of arrival in Australia conditionally mandatory data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
|  | | | |
| Definition source | METeOR ID 269929 | Version | 1 January 2017  2 January 2020 |
|  | | | |
| Codeset source | NHDD | Collection start date | 2017 |

# Other changes to Section 4 Business rules

### Anaesthesia for operative delivery – indicator and Anaesthesia for operative delivery – type valid combinations

|  |  |
| --- | --- |
| **When anaesthesia for operative delivery – indicator is:** | **Anaesthesia for operative delivery – type must be:** |
| Blank | Blank |
| 1 Anaesthesia administered | 2 Local anaesthetic to perineum **or**  3 Pudendal block **or**  4 Epidural or caudal block **or**  5 Spinal block **or**  6 General anaesthetic **or**  7 Combined spinal-epidural block **or**  8 Other anaesthesia |
| 2 Anaesthesia not administered | Blank |

### Analgesia for labour – indicator and Analgesia for labour – type valid combinations

|  |  |
| --- | --- |
| **If Analgesia for labour – indicator is:** | **Analgesia for labour – type must be:** |
| Blank | Blank |
| 1 Analgesia administered | 2 Nitrous oxide **or**  3 Systemic opioids **or**  4 Epidural or caudal block **or**  5 Spinal block **or**  7 Combined spinal / epidural block **or**  8 Other analgesia |
| 2 Analgesia not administered | Blank |

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

|  |  |
| --- | --- |
| **If Birth status is:** | **then the following items cannot be blank:** |
| 1 Live born | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – Baby  Antenatal corticosteroid exposure  Breastfeeding attempted  Formula given in hospital  Head circumference – baby  Hepatitis B vaccine received  Last feed before discharge taken exclusively from the breast  Separation date – baby  Separation status – baby |

### Country of birth and Year of arrival in Australia conditionally mandatory data items

|  |  |
| --- | --- |
| **Where Country of birth is not reported as one of the following codes:** | **A valid value must be reported in Year of arrival in Australia** |
| 1100 Australia (includes External Territories, nfd) **or**  1101 Australia **or**  1102 Norfolk Island **or**  1199 Australian External Territories, nec | In format NNNN and in the range 1960 to current year or  9998 Not intending to stay in Australia for one year or more |
| **Where Country of birth is reported as one of the following codes:** | **Year of arrival in Australia must be:** |
| 1100 Australia (includes External Territories, nfd) **or**  1101 Australia **or**  1102 Norfolk Island **or**  1199 Australian External Territories, nec | Blank |

### Date of birth – baby, Date of admission – mother and Setting of birth – actual valid combinations

|  |  |  |
| --- | --- | --- |
| **Date of birth – baby must be:** | **Date of admission – mother** | **Where Setting of birth – actual is:** |
| Equal to or after |  | The same Hospital code as the Hospital code (agency identifier) reported in this birth record |

\*Date of birth – baby and Separation date – baby conditionally mandatory data items

|  |  |  |
| --- | --- | --- |
| **Data item:** | **Rule:** | **Data item:** |
| Separation date – baby | greater than 28 days after | Date of birth – baby |

Then Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby must be code 1 Admitted to special care nursery or code 2 Admitted to neonatal intensive care unit and data must be reported in at least one of:

* Neonatal morbidity – free text ~~ICD-10-AM code~~
* Neonatal morbidity – ICD-10-AM code
* Congenital anomalies – ICD-10-AM code

\*Episiotomy – indicator and Method of birth valid combinations

|  |  |
| --- | --- |
| **If Episiotomy – indicator is:** | **Method of birth must be:** |
| 1 Incision of the perineum and vagina made | 1 Forceps **or**  3 Vaginal birth – non-instrumental **or**  5 Unplanned caesarean – labour **or**  8 Vacuum extraction **or**  **10 Other operative birth** |

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

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

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

### Fetal monitoring in labour and Labour type valid combinations

|  |  |
| --- | --- |
| **If Labour Type is:** | **Fetal monitoring in labour must report:** |
| 1 Spontaneous **or**  2 Induced medical **or**  3 Induced surgical **or**  4 Augmented  **without**  5 No labour | Either:  01 None **or**  99 Not stated/inadequately described **or**  At least one, and up to seven, of the following codes, with no code reported more than once:  02 Intermittent auscultation  03 Admission cardiotocography  04 Intermittent cardiotocography  05 Continuous external cardiotocography  06 Internal cardiotocography (scalp electrode)  07 Fetal blood sampling  88 Other |
| Any value **including**  5 No labour | Blank |
| 9 Not stated/inadequately described | Any value **or** Blank |

\*Fetal monitoring prior to birth – not in labour and Labour type valid combinations

|  |  |
| --- | --- |
| **If Labour Type is:** | **Fetal monitoring prior to birth – not in labour must be:** |
| 1 Spontaneous **or**  2 Induced medical **or**  3 Induced surgical **or**  4 Augmented  **without**  5 No labour | ~~01 None~~ **~~or~~**  Blank |
| Any value **including**  5 No labour | Either: 01 None **or** 99 Not stated/inadequately described **or**  At least one, and up to five, of the following codes, with no code reported more than once:  02 Intermittent auscultation  03 Admission cardiotocography  04 Intermittent cardiotocography  05 Continuous external cardiotocography  ~~06 Internal cardiotocography (scalp electrode)~~  ~~07 Fetal blood sampling~~  88 Other |
| 9 Not stated/inadequately described | Any value **or** Blank |

\*Gravidity ‘Multigravida’ conditionally mandatory data items

|  |  |
| --- | --- |
| **If Gravidity is:** | **the following items cannot be blank:** |
| Greater than one | Date of completion of last pregnancy  Last birth – caesarean section indicator  Outcome of last pregnancy  Total number of previous caesareans |

\*Gravidity ‘Primigravida’ and associated data items valid combinations

|  |  |
| --- | --- |
| **If Gravidity is** 01 | |
| **the following data items:** | **must be reported as:** |
| Parity  Total number of previous abortions – induced  Total number of previous abortions – spontaneous  Total number of previous caesareans  Total number of previous ectopic pregnancies  Total number of previous live births  Total number of previous neonatal deaths  Total number of previous stillbirths (fetal deaths)  Total number of previous unknown outcomes of pregnancy  Date of completion of last pregnancy  Outcome of last pregnancy | 00  00  00  00  00  00  00  00  00  Blank  Blank |

### 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 | Cannot be blank |

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

|  |  |
| --- | --- |
| **If Labour type is:** | **Failed induction must be reported in at least one of the following data items:** |
| 2 Induced medical **and** 5 No labour | Indications for operative delivery – free text **or**  Indications for operative delivery – ICD-10-AM code: O610 – failed medical induction of labour |
| 3 Induced surgical **and** 5 No labour | Indications for operative delivery – free text **or**  Indications for operative delivery – ICD-10-AM code: O611 – failed ~~instrumental~~ surgical induction of labour |
| 2 Induced medical **and** 3 Induced surgical and 5 No labour | Indications for operative delivery – free text **or**  Indications for operative delivery – ICD-10-AM code O610 – Failed medical induction of labour **and** O611 – Failed ~~instrumental~~ surgical induction of labour |

\*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**  1 Spontaneous **and** 4 Augmented **or**  2 Induced medical **and** 3 Induced surgical | 1 Forceps **or**  3 Vaginal birth – non-instrumental **or**  8 Vacuum extraction |
| **the following data items:** | **must report:** |
| Date of onset of labour  Date of onset of second stage of labour  Date of rupture of membranes  Fetal monitoring prior to birth – not in labour  Time of onset of labour  Time of onset of second stage of labour  Time of rupture of membranes | DDMMCCYY  DDMMCCYY  DDMMCCYY **or** 77777777  blank  HHMM or 7777  HHMM  HHMM **or** 7777 |

|  |  |
| --- | --- |
| **If labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or**  2 Induced medical **or**  3 Induced surgical **or**  1 Spontaneous **and** 4 Augmented **or**  2 Induced medical **and** 3 Induced surgical | 5 Unplanned caesarean – labour **or**  6 Planned caesarean – labour |
| **the following data items:** | **must report:** |
| Date of onset of labour  Date of onset of second stage of labour  Date of rupture of membranes  Fetal monitoring prior to birth – not in labour  Time of onset of labour  Time of onset of second stage of labour  Time of rupture of membranes | DDMMCCYY  DDMMCCYY **or** 88888888  DDMMCCYY **or** 77777777 **or** 88888888  blank  HHMM or 7777  HHMM **or** 8888  HHMM **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**  2 Induced medical **and** 3 Induced surgical **and** 5 No labour | 4 Planned caesarean – no labour **or**  7 Unplanned caesarean – no labour **or**  10 Other operative delivery |
| **The data items listed below must be:** | |
| *Data item:*  Date of onset of labour  Date of onset of second stage of labour  Date of rupture of membranes  Fetal monitoring in labour  Time of onset of labour  Time of onset of second stage of labour  Time of rupture of membranes | *Value:*  88888888  88888888  DDMMYYYY **or** 77777777 **or** 88888888  ~~01 or~~ blank  8888  8888  HHMM **or** 7777 **or** 8888 |

\*Mandatory to report data items

A valid value must be reported for the following data items. The value must not be a code for the descriptor ‘Not stated/Inadequately described’, as available for some of these items.

* Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother
* Admitted patient election status – mother
* Antenatal corticosteroid exposure
* Apgar score at one minute
* Apgar score at five minutes
* Artificial reproductive technology – indicator
* Birth order
* Birth plurality
* Birth presentation
* Birth status
* Birth weight
* Blood product transfusion – mother
* ~~Chorionicity of multiples~~
* Collection identifier
* Congenital anomalies – indicator
* Cord complications
* Country of birth
* Date of admission – mother
* Date of birth – baby
* Date of birth – mother
* Date of onset of labour
* Date of onset of second stage of labour
* Date of rupture of membranes
* Diabetes mellitus during pregnancy – type
* Discipline of antenatal care provider
* Discipline of lead intrapartum care provider
* Episiotomy – indicator
* Episode identifier
* ~~Estimated blood~~ Blood loss (ml)
* Estimated date of confinement
* Estimated gestational age
* First given name – mother
* Gestational age at first antenatal visit
* Gravidity
* Height – self-reported – mother
* Hospital code (agency identifier)
* Indigenous status – baby
* Indigenous status – mother
* Influenza vaccination status
* Labour type
* Marital status
* Maternal alcohol use at less than 20 weeks
* Maternal alcohol use at 20 or more weeks
* ~~Maternal alcohol volume intake at less than 20 weeks~~
* ~~Maternal alcohol volume intake at 20 or more weeks~~
* Maternal smoking < 20 weeks
* Maternal smoking ≥ 20 weeks
* Method of birth
* Number of antenatal care visits
* ~~Number of ultrasounds ≥ 27 weeks~~
* ~~Number of ultrasounds 10–14 weeks~~
* ~~Number of ultrasounds 15–26 weeks~~
* Parity
* Patient identifier – mother
* Perineal laceration – indicator
* Pertussis (whooping cough) vaccination status
* Prophylactic oxytocin in third stage
* Residential locality
* Residential postcode
* Residential road name – mother
* Residential road number – mother
* Residential road suffix code – mother
* Residential road type – mother
* Resuscitation method – drugs
* Resuscitation method – mechanical
* Separation date – mother
* Separation status – mother
* Setting of birth – actual
* Setting of birth – intended
* Sex – baby
* Surname / family name – mother
* Time of birth
* Time of onset of labour
* Time of onset of second stage of labour
* Time of rupture of membranes
* Time to established respiration (TER)
* Total number of previous abortions – induced
* Total number of previous abortions – spontaneous
* Total number of previous caesareans
* Total number of previous ectopic pregnancies
* Total number of previous live births
* Total number of previous neonatal deaths
* Total number of previous stillbirths (fetal deaths)
* Total number of previous unknown outcomes of pregnancy
* Transaction type flag
* Version identifier
* Weight – self-reported – mother

### Manual removal of placenta and Method of birth conditionally mandatory data items

|  |  |
| --- | --- |
| **If Manual removal of placenta is:** | **then Method of birth must be:** |
| Blank | 4 Planned caesarean – no labour **or**  5 Unplanned caesarean – labour **or**  6 Planned caesarean – labour **or**  7 Unplanned caesarean – no labour |
| 1 Placenta manually removed **or**  2 Placenta not manually removed **or**  9 Not stated / inadequately described | 1 Forceps **or**  3 Vaginal birth – non-instrumental **or**  8 Vacuum extraction **or**  9 Not stated / inadequately described **or**  10 Other operative birth |

### Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations

|  |  |
| --- | --- |
| **Where Maternal alcohol use at less than 20 weeks is** | **Maternal alcohol volume intake at less than 20 weeks must be** |
| 1 Never | Blank |
| 2 Monthly or less **or**  3 2-4 times a month **or**  4 2-3 times a week **or**  5 4 or more times a week | A code from:  1 1 or 2 standard drinks  2 3 or 4 standard drinks  3 5 or 6 standard drinks  4 7 to 9 standard drinks  5 10 or more standard drinks  9 Not stated / inadequately described |
| **Where Maternal alcohol use at 20 weeks or more is** | **Maternal alcohol volume intake at 20 weeks or more must be** |
| 1 Never | Blank |
| 2 Monthly or less **or**  3 2-4 times a month **or**  4 2-3 times a week **or**  5 4 or more times a week | A code from:  1 1 or 2 standard drinks  2 3 or 4 standard drinks  3 5 or 6 standard drinks  4 7 to 9 standard drinks  5 10 or more standard drinks  9 Not stated / inadequately described |

\*Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data item

|  |  |
| --- | --- |
| **If Method of birth is:** | **then the following item cannot be blank:** |
| 1 Forceps  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 delivery | Anaesthesia for operative delivery – indicator |

\*Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM 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 | Indications for operative delivery – free text  Indications for operative delivery – ICD-10-AM code |

\*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 or  10 Other operative birth | 1 Spontaneous or  2 Induced medical or  3 Induced surgical or  1 Spontaneous and 4 Augmented  2 Induced medical and 3 Induced surgical |
| 4 Planned caesarean – no labour  ~~10 Other operative birth~~ | 5 No labour |
| 7 Unplanned caesarean – no labour **or**  10 Other operative birth | 5 No labour or 2 Induced medical and 5 No labour or  3 Induced surgical and 5 No labour or  2 Induced medical and 3 Induced surgical 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 delivery | 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 |

\*Perineal laceration – indicator and Method of birth valid combinations

|  |  |
| --- | --- |
| **If Perineal laceration – indicator is:** | **Method of birth must be:** |
| 1 Laceration/tear of the perineum following birth | 1 Forceps **or**  3 Vaginal birth – non-instrumental **or**  5 Unplanned caesarean – labour **or**  8 Vacuum extraction **or**  10 Other operative delivery |

\*Separation status – baby, Reason for transfer out – baby and Transfer destination – baby conditionally mandatory data item

|  |  |
| --- | --- |
| **If Separation status – baby is:** | **then the following item cannot be blank:** |
| 3 – Transferred | Transfer destination – baby |
| **And Reason for transfer out – baby is not:** |
| 4 – HITH |

\*Separation status – mother, Reason for transfer out – mother and Transfer destination – mother – conditionally mandatory data item

|  |  |
| --- | --- |
| **If Separation status – mother is:** | **then the following item cannot be blank:** |
| 3 Transferred | Transfer destination – mother |
| **And Reason for transfer out – mother is not:** |
| 4 HITH |

# Section 5: Compilation and submission

File structure specifications

The file structure details the sequence, length, type and layout of data items to be submitted.

File structure notes:

* Do not zero fill items unless specified
* Padding fields with space characters (either to the left or right) is not necessary and should be avoided.
* Deleted fields will retain their position number but any data reported in these fields will not be appended to the VPDC.

Header record

The header record must be included as the first record of all submission files reported to the VPDC.

Episode records within a data submission file must be reported as per the version of the data collection as specified in the header record. For example, to submit new records for births between 1 December ~~2018~~ 2019 and 31 January ~~2019~~ 2020, at least two data submission files are to be compiled:

* The first containing records for births from 1 December ~~2018~~ 2019 to 31 December ~~2018~~ 2020 (inclusive) as per the appropriate specifications with the version identifier reported as ~~‘2018’~~ ‘2019’ in the header and episode records
* The second containing records for births from 1 January ~~2019~~ 2020 to 31 January ~~2019~~ 2020 (inclusive) as per the appropriate specifications with the version identifier reported as ~~‘2019’~~ ‘2020’ in the header and episode records

The convention for naming is:

CCCC | VVVV | NNNN | YYYYMMDDhhmm | TT | NNNNN | AAA…AAA

where:

CCCC: = Collection identifier

VVVV: = Version identifier

NNNN: = Hospital code (agency identifier)

YYYYMMDDhhmm: = Data submission identifier

TT: = Submission number

NNNNN: = Number of records following

AAA…AAA: = Name of software

Episode records

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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) | ~~String~~ Number | AAAA | 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(~~300~~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 | ~~1~~ 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 (x3) |
| 68 | Labour induction/augmentation agent | Number | N | 1 (x4) |
| 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~~ Number | 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 – free text | String | A(300) | 300 |
| 76 | Indications for operative delivery – ICD-10-AM code | String | ANN[NN] | 5 (x4) |
| 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 (x2) |
| 87 | Perineal laceration – repair | Number | N | 1 |
| 88 | Episiotomy – indicator | Number | N | 1 |
| 89 | ~~Estimated~~ 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 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 ~~(x7)~~ | 2 (~~x7~~ 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] ~~(x9)~~ | 5 (x9) |
| 135 | Maternal alcohol use at less than 20 weeks | ~~Code~~ Number | N | 1 |
| 136 | Maternal alcohol volume intake at less than 20 weeks | ~~Code~~ Number | N | 1 |
| 137 | Maternal alcohol use at 20 or more weeks | ~~Code~~ Number | N | 1 |
| 138 | Maternal alcohol volume intake at 20 or more weeks | ~~Code~~ Number | N | 1 |
| 139 | Antenatal corticosteroid exposure | ~~Code~~ Number | N | 1 |
| 140 | Chorionicity of multiples | ~~Code~~ Number | N | 1 |
| 141 | Cord complications | String | N[NNNN] | 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 | Number | N | 1(x3) |
| 146 | Main reason for excessive blood loss following childbirth | Number | N | 1 |
| 147 | Blood loss assessment – indicator | Number | N | 1 |