Section 3: Data Definitions

Victorian Perinatal Data Collection (VPDC) Manual, Version 4.0
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<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of previous neonatal deaths</td>
<td>126</td>
</tr>
<tr>
<td>Total number of previous stillbirths (foetal deaths)</td>
<td>127</td>
</tr>
<tr>
<td>Total number of previous unknown outcomes of pregnancy</td>
<td>128</td>
</tr>
<tr>
<td>Transaction type flag</td>
<td>129</td>
</tr>
<tr>
<td>Transfer destination – baby</td>
<td>129</td>
</tr>
<tr>
<td>Transfer destination – mother</td>
<td>130</td>
</tr>
<tr>
<td>Version identifier</td>
<td>131</td>
</tr>
<tr>
<td>Weight – self-reported – mother</td>
<td>132</td>
</tr>
</tbody>
</table>
Introduction

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

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

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

Additional items are derived from the items reported in the VPDC. These are referenced in Section 2: Concept and derived item definitions, for information only.
**Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother**

**Specification**

- **Definition**: Whether the mother is admitted into a high dependency unit (HDU) / intensive care unit (ICU)

- **Representation class**:
  - **Code**  
  - **Data type**  
  - **Number**

- **Format**: N  
  - **Field size**: 1

- **Location**: Episode record  
  - **Position**: 94

- **Permissible values**:
  - **Code**  
  - **Descriptor**
    - 1  
    - Admitted to high dependency unit / intensive care unit
    - 2  
    - Not admitted to high dependency unit / intensive care unit
    - 9  
    - Not stated / inadequately described

- **Reporting guide**: Depending on the facilities, and policies of the hospital, this high dependency care may take place in the labour ward, high dependency unit, intensive care unit, coronary care unit, or any other specialist unit. The mother may spend time in this unit for days either before and/or after the birth.

- **Reported by**: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

- **Reported for**: All birth episodes

- **Related concepts** (Section 2): High dependency unit (HDU), intensive care unit (ICU)

- **Related data items** (this section): None specified

- **Related business rules** (Section 4): Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Mandatory to report data items

**Administration**

- **Principal data users**: Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)

- **Definition source**: DHHS  
  - **Version**: 1. January 1999

- **Codeset source**: DHHS  
  - **Collection start date**: 1999
### Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby

#### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether the neonate is admitted into a special care nursery (SCN) or neonatal intensive care unit (NICU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td>1</td>
<td>Admitted to SCN</td>
</tr>
<tr>
<td>2</td>
<td>Admitted to NICU</td>
</tr>
<tr>
<td>3</td>
<td>Not admitted to SCN or NICU</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

#### Reporting guide

The criteria for admissions to SCN may vary depending on the facilities available and level of care provided within a particular hospital. This data element is a flag for neonatal morbidity and/or congenital anomalies. If code 1, Admitted to SCN or code 2, Admitted to NICU is selected, then morbidity and/or anomalies must be documented. If the neonate is admitted to both SCN and NICU, report code 2 Admitted to NICU. Do not report a value for stillbirth episodes, leave blank.

#### Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

#### Reported for

All live birth episodes

#### Related concepts (Section 2):

Intensive care unit (ICU)

#### Related data items (this Section):

Congenital anomalies – free text, Hospital code (agency identifier), Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code

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

Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations

### Administration

#### Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

#### Definition source

DHHS

#### Version

1. January 1999
2. January 2007
Admitted patient election status – mother

Specification

- **Definition**: Whether the mother is admitted as a public or private patient
- **Representation class**: Code
- **Format**: N
- **Location**: Episode record
- **Permissible values**:
  - Code: 1, 2, 9
  - Descriptor: Public, Private, Not stated / inadequately described
- **Reporting guide**: Homebirths under the care of an independent midwife or medical practitioner should be reported as code 2 Private. Homebirths under the public homebirth program must be reported as code 1 Public. Transport Accident Commission (TAC), Department of Veterans’ Affairs (DVA) and WorkCover patients must be reported as code 1 Public.
- **Reported by**: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
- **Reported for**: All birth episodes
- **Related concepts (Section 2)**: None specified
- **Related data items (this section)**: None specified
- **Related business rules (section 4)**: Mandatory to report data items, Setting of birth – actual and Admitted patient election status – mother valid combinations

Administration

- **Principal data users**: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- **Definition source**: DHHS
- **Codeset source**: DHHS
- **Collection start date**: 1998
Anaesthesia for operative delivery – indicator

Specification

Definition
Whether anaesthesia is administered to the mother for, or associated with, the operative delivery of the baby (forceps, vacuum/ventouse or caesarean section)

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Code</td>
<td>Data type</td>
</tr>
<tr>
<td></td>
<td>Episode record</td>
<td>Position</td>
</tr>
</tbody>
</table>

Class

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anaesthesia administered</td>
</tr>
<tr>
<td>2</td>
<td>Anaesthesia not administered</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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 (including birth centres) and homebirth practitioners.

Reported for
Birth episodes with an operative delivery.

Related concepts
None specified

Related data items
(this section):
None specified

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source
DHHS

Version
1. January 1999
2. January 2009

Codeset source
DHHS

Collection start date
1999
Anaesthesia for operative delivery – type

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The type of anaesthesia administered to a woman during a birth event.</th>
</tr>
</thead>
</table>

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Field size</td>
<td>1 (x4)</td>
</tr>
</tbody>
</table>

**Format**

<table>
<thead>
<tr>
<th>Location</th>
<th>Episode record</th>
<th>Position</th>
<th>80</th>
</tr>
</thead>
</table>

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Local anaesthetic to perineum</td>
</tr>
<tr>
<td>3</td>
<td>Pudendal block</td>
</tr>
<tr>
<td>4</td>
<td>Epidural or caudal block</td>
</tr>
<tr>
<td>5</td>
<td>Spinal block</td>
</tr>
<tr>
<td>6</td>
<td>General anaesthetic</td>
</tr>
<tr>
<td>7</td>
<td>Combined spinal-epidural block</td>
</tr>
<tr>
<td>8</td>
<td>Other anaesthesia</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

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

Combined spinal-epidural block.

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

Other anaesthesia.

May include parenteral opioids, nitrous oxide.

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

Birth episodes with an operative delivery

**Related concepts**

None specified

**Related data items**

Anaesthesia for operative delivery – indicator

**Related business rules**

Mandatory to report data items

Administration

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and
Morbidity

Definition source NHDD

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Format**
N

**Field size**
1

**Location**
Episode record

**Position**
77

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Analgesia administered</td>
</tr>
<tr>
<td>2</td>
<td>Analgesia not administered</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**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 (including birth centres) and homebirth practitioners

**Reported for**
Birth episodes where there is a labour

**Related concepts**
None specified

**Related data items**
None specified

**Related business rules**
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
### Analgesia for labour – type

#### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The type of analgesia administered to the woman during a birth event.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

#### Reporting guide

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

Systemic opioids.

Includes intramuscular and intravenous opioids.

Combined spinal / epidural block.

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

Other analgesia.

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

#### Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

#### Reported for

Birth episodes where there is a labour

#### Related concepts (Section 2):

None specified

#### Related data items

Analgesia for labour – indicator
Related business rules (Section 4): Mandatory to report data items

Administration

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


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 (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Birth status ‘Stillborn’ and associated data items valid combinations
Administration

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

Definition source: NHDD


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

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 (including birth centres) 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
### Artificial reproductive technology – indicator

#### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether artificial reproductive technology (ART) was used to assist the current pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>1</td>
<td>Artificial reproductive technology was used to assist this pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Artificial reproductive technology was not used to assist this pregnancy</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
<tr>
<td>Reporting guide</td>
<td>If reporting code 1 Artificial reproductive technology was used to assist this pregnancy, also report the type of ART in Procedure – free text and/or Procedure – ACHI code, for example, IVF, Clomid, GIFT or ICSI.</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>All birth episodes</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related business rules (Section 4):</td>
<td>Artificial reproductive technology – indicator conditionally mandatory data items, Mandatory to report data items</td>
</tr>
</tbody>
</table>
Morbidity

Definition source: DHHS  

Codeset source: DHHS  
Collection start date: 2009

Birth order

Specification

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

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Singleton or first of a multiple birth</td>
</tr>
<tr>
<td>2</td>
<td>Second of a multiple birth</td>
</tr>
<tr>
<td>3</td>
<td>Third of a multiple birth</td>
</tr>
<tr>
<td>4</td>
<td>Fourth of a multiple birth</td>
</tr>
<tr>
<td>5</td>
<td>Fifth of a multiple birth</td>
</tr>
<tr>
<td>6</td>
<td>Sixth of a multiple birth</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Format: N  
Field size: 1

Location: Episode record  
Position: 99

Permissible values

Reporting guide: Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be reported as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Birth plurality and Birth order valid combinations, Mandatory to report data items

Administration

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

Definition source: NHDD  
Birth plurality

Specification

Definition
The total number of babies resulting from a single pregnancy

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Singleton</td>
</tr>
<tr>
<td>2</td>
<td>Twins</td>
</tr>
<tr>
<td>3</td>
<td>Triplets</td>
</tr>
<tr>
<td>4</td>
<td>Quadruplets</td>
</tr>
<tr>
<td>5</td>
<td>Quintuplets</td>
</tr>
<tr>
<td>6</td>
<td>Sextuplets</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Format
N

Field size
1

Location
Episode record

Position
98

Permissible values

Reported 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 foetus 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 foetus 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 (including birth centres) and homebirth practitioners

Related concepts (Section 2):
None specified

Related data items (this section):
Birth order

Related business rules (Section 4):
Birth plurality and Birth order valid combinations, Mandatory to report data items

Administration

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

Definition source
NHDD

Version
1. January 1982
2. July 2015
Birth presentation

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Presenting part of the foetus (at the cervix) at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
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<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

Reporting guide

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

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

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Birth presentation conditionally mandatory data items, Mandatory to report data items
## Administration

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

**Definition source**
NHDD

**Version**
1. January 1982
2. January 1999
3. January 2009

**Codeset source**
NHDD (DHHS modified)

**Collection start date**
1982

## Birth status

### Specification

**Definition**
Status of the baby at birth

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**
Episode record

**Position**
100

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Live born</td>
</tr>
<tr>
<td>2</td>
<td>Stillborn (occurring before labour)</td>
</tr>
<tr>
<td>3</td>
<td>Stillborn (occurring during labour)</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

Live birth is the complete expulsion or extraction from its mother of the product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born. (WHO, 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of the product of conception of 20 or more completed weeks of gestation, or of 400g or more birth weight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts**

Section 2: Live birth, Stillbirth (foetal death)
Related data items (this section): Apgar score at one minute, Apgar score at five minutes

Related business rules (Section 4): Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Mandatory to report data items, Scope ‘Stillborn’

Administration

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

Definition source: NHDD

Version
1. January 1982
2. July 2015

Codeset source: NHDD

Collection start date: 1982

Birth weight

Specification

Definition: The first weight, in grams, of the live born or stillborn baby, obtained after birth or the weight of the neonate or infant on the date admitted if this is different from the date of birth.

Representation class: Total

Data type: Number

Format: NN[NN]

Field size: 4

Location: Episode record

Position: 101

Permissible values: Range: 10 to 9,998 (inclusive)

Code   Descriptor
9999   Not stated / inadequately described

Reporting guide: Unit of measure is in grams. For live births, birth weight should preferably be measured within the first few hours after birth before significant postnatal weight loss has occurred. While statistical tabulations include 500g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In the case of babies born before arrival at the hospital, the birth weight should be taken shortly after the baby has been admitted to hospital.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts: Birth weight
(Section 2):

Related data items (this section): None specified

Related business rules (Section 4): Mandatory to report data items, Scope ‘Stillborn’

Administration

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


Codeset source NHDD Collection start date 1982

Blood product transfusion – mother

Specification

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

Representation class Code Data type Number

Format N Field size 1

Location Episode record Position 90

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

Reporting guide Blood products may include:
- whole blood
- packed cells
- platelets
- fresh frozen plasma (FFP).

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Estimated blood loss (ml)

Related business Mandatory to report data items
Administration

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

Definition source NHDD  Version 1. January 2009

Codeset source NHDD  Collection start date 2009

Breastfeeding attempted

Specification

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

Representation

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

Location Episode record  Position 115

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attempted to breastfeed / express breast milk</td>
</tr>
<tr>
<td>2</td>
<td>Did not attempt to breastfeed / express breast milk</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

- Code 1 Attempted to breastfeed/express breast milk: includes if the baby was put to the breast at all, regardless of the success of the attempt, or if there was any attempt to express milk for the baby.

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

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All live birth episodes

Related concepts (Section 2): None specified
Related data items (this section): None specified

Related business rules (Section 4): Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations

Administration

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

Definition source: DHHS


Codeset source: DHHS

Collection start date: 2009

Collection identifier

Specification

Definition: A unique identifier for VPDC data collection

Representation class: Identifier

Data type: String

Format: AAAA

Field size: 4

Location: Episode record, Header record, File name

Position: 1

Permissible values

Code  Descriptor
VPDC  Victorian Perinatal Data Collection

Reporting guide: Software-system generated

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: Each VPDC electronic submission file

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Mandatory to report data items
Administration

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

Definition source: DHHS

Codeset source: DHHS

Collection start date: 2009

Congenital anomalies – free text

Specification

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

Representation class: Text

Data type: String

Format: A(300)

Field size: 300

Location: Episode record Position

108

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: Specify the defect(s) or congenital anomaly(ies) with as much detail as possible, for example; cleft lip and palate – unilateral/left or right. If a baby is diagnosed with a syndrome, then it should be specified with the other associated conditions; for example, Down syndrome with associated congenital heart disease and/or duodenal atresia. When congenital anomalies are reported, the name and surname of the paediatrician must be reported in First given name – paediatrician and Surname/family name – paediatrician where applicable.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes where a congenital anomaly is present

Related concepts (Section 2): None specified

Related data items (this section): Congenital anomalies – indicator

Related business: Admission to special care nursery (SCN) / neonatal intensive care
rules (Section 4): unit (NICU) – baby conditionally mandatory data items, Congenital anomalies – indicator and Congenital anomalies – free text conditionally mandatory data item, Date of birth – baby and Separation date – baby conditionally mandatory data items

Administration

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

Definition source NHDD (DHHS modified) Version 1. January 1982

Codeset source Not applicable Collection start date 1982

Congenital anomalies – indicator

Specification

Definition Whether there were any congenital anomalies identified

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

Location Episode record Position 107

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital anomalies identified</td>
</tr>
<tr>
<td>2</td>
<td>Congenital anomalies not identified</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide Where congenital abnormalities are identified, please specify details in Congenital Abnormalities – Free Text and report First Given Name – Paediatrician and Surname/Family Name – Paediatrician where applicable.

Reported by All Victorian hospitals where a birth has occurred (including birth centres) 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): Congenital anomalies – indicator and Congenital anomalies – free text 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

Codeset source: DHHS

Collection start date: 1999

Country of birth

 Specification

Definition: The country in which the mother was born

Representation class:

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NNNN</td>
<td>Field size</td>
<td>4</td>
</tr>
</tbody>
</table>

Format: NNNN

Location: Episode record

Position: 18


Reporting guide: Report the country in which the person was born, not the country of residence

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Mandatory to report data items

Administration

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

Definition source: NHDD


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

**Representation class**  Identifier  
**Data type**  Date/time

**Format**  YYYYMMDDHHMM  
**Field size**  12

**Location** Header record, File name  
**Position** Not applicable

**Permissible values**  A valid calendar date and time value using a 24-hour clock (not 0000 or 2400)

**Reporting guide**  Software-system generated. Time must be in 24-hour clock format.

** Reported by**  All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**  Each VPDC electronic submission file

**Related concepts (Section 2):** None specified

**Related data items (this section):** None specified

**Related business rules (Section 4):** None specified

## Administration

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

**Definition source**  DHHS  
**Version**  1. January 2009

**Codeset source**  DHHS  
**Collection start date**  2009

## Date of admission – mother

### Specification

**Definition**  The date on which the mother is admitted
Date of birth – baby

**Specification**

**Definition**

The date of birth of the baby

<table>
<thead>
<tr>
<th>Representation class</th>
<th>Date</th>
<th>Data type</th>
<th>Date/time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format</td>
<td>DDMCCYY</td>
<td>Field size</td>
<td>8</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
<td>Position</td>
<td>95</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid calendar date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

Report the appropriate date based on the circumstances of the birth (attending hospital or using a home practitioner)

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts (Section 2):** None specified

**Related data items (this section):** None specified

**Related business rules (Section 4):** Date and time data item relationships, Date of admission – mother and Date of birth – baby conditionally mandatory data items, Mandatory to report data items

**Administration**

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

NHDD

**Version**

1. January 1982
2. January 1998

**Codeset source**

NHDD

**Collection start date**

1982
### Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

### Reporting guide

Century (CC) can only be reported as 20

### Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

### Reported for

All birth episodes

### Related concepts (Section 2):

None specified

### Related data items (this section):

Date of admission – mother

### Related business rules (Section 4):

Date and time data item relationships, Date of admission – mother and Date of birth – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Mandatory to report data items

---

### Administration

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

NHDD

**Version**

1. January 1982

2. January 1998

**Codeset source**

NHDD

**Collection start date**

1982

---

### Date of birth – mother

**Specification**

**Definition**

The date of birth of the mother

**Representation class**

Date

**Data type**

Date/time

**Format**

DD MM CC YY

**Field size**

8

**Location**

Episode record

**Position**

22

**Permissible values**

A valid calendar date

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

Century (CC) can only be 19 or 20

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): Date and time data item relationships, Mandatory to report data items

Administration

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

Definition source: NHDD

Definition: NHDD

2. January 1998

Codeset source: NHDD

Collection start date: 1982

Date of completion of last pregnancy

Specification

Definition: Date on which the pregnancy preceding the current pregnancy was completed

Representation class: Date

Data type: Date/time

Format: {DD}MMCCYY

Field size: 6 (8)

Location: Episode record

Position: 42

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

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

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

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Reported for
Birth episodes where Gravidity is greater than 01 Primigravida

Related concepts
(Section 2):
None specified

Related data items
(this section):
None specified

Related business rules (Section 4):
Date and time data item relationships, Gravidity ‘Multigravida’ conditionally mandatory data items, Gravidity ‘Primigravida’ and associated data items valid combinations, Parity and associated data items valid combinations

Administration

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

Definition source
NHDD
Version
1. January 1982
2. January 1999

Codeset source
NHDD
Collection start date
1982

Date of onset of labour

Specification

Definition
The date of onset of labour

Representation class
Date
Data type
Date/time

Format
DDMMCCYY
Field size
8

Location
Episode record
Position
61

Permissible values
A valid calendar date

Code
Descriptor
88888888
No labour

99999999
Not stated / inadequately described

Reporting guide
Century (CC) can only be reported as 20.

Code 88888888 No labour: this code is only reported when the mother has a planned or unplanned caesarean section with no labour.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts
(Section 2):
None specified
Related data items (this section): Date of rupture of membranes, Method of birth

Related business rules (Section 4): Date and time data item relationships, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations, Mandatory to report data items

Administration

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


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

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>888888888</td>
<td>No labour</td>
</tr>
<tr>
<td>999999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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 (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts
None specified

Related data items
Date of onset of labour, Date of rupture of membranes, Method of birth

Administration

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

Definition source
DHHS

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>7777777777</td>
<td>No record of date of rupture of membranes</td>
</tr>
<tr>
<td>8888888888</td>
<td>Membranes ruptured at caesarean</td>
</tr>
<tr>
<td>9999999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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 the date and unknown time. Only report unknown date and time of ROM for episodes where there is absolutely no evidence in the medical record to indicate the timing of the rupture of membranes. An estimate of at least the date of ROM is far preferable to no record. Use of the no record codes will be monitored and sites reporting a high frequency of no record codes will be followed up.

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 (including birth centres) 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

Administration

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

Definition source DHHS


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
Discipline of lead intrapartum care provider

**Specification**

**Definition**

The discipline of the clinician who, at the time of admission for the birth, is expected to be primarily responsible for making decisions regarding intrapartum care.
**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Format**

- N
- Field size 1

**Location**

- Episode record
- Position 93

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obstetrician</td>
</tr>
<tr>
<td>2</td>
<td>Midwife</td>
</tr>
<tr>
<td>3</td>
<td>General practitioner</td>
</tr>
<tr>
<td>4</td>
<td>No intrapartum care provider</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

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

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

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts (Section 2):**

None specified

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

None specified

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

Mandatory to report data items

---

**Administration**

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

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether an incision of the perineum and vagina was made</th>
</tr>
</thead>
</table>

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Format**

- N
- Field size: 1

**Location**

- Episode record
- Position: 88

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Incision of the perineum and vagina made</td>
</tr>
<tr>
<td>2</td>
<td>Incision of the perineum and vagina not made</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

For episiotomies extended by laceration or laceration extended by episiotomy record Perineal laceration – indicator as code 1 Laceration of the perineum following birth, Episiotomy indicator as code 1 Incision of perineum and vagina made and Perineal laceration – repair as code 1 Repair of perineum undertaken. Specify the degree of the tear in Perineal/genital laceration – degree/type.

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts (Section 2):**

None specified

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

Method of birth

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

Episiotomy – indicator and Method of birth valid combinations, Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations, Mandatory to report data items

**Administration**

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

DHHS

**Version**

1. January 1999
   2. January 2009

**Codeset source**

DHHS

**Collection start date**

2009
Estimated blood loss (ml)

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>An estimate of the amount of blood lost at the time of birth and in the following 24 hours in millilitres (whether the loss is from the vagina, from an abdominal incision, or retained for example, broad ligament haematoma)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Total Data type Number</td>
</tr>
<tr>
<td>Format</td>
<td>N[NNNN] Field size 5</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record Position 89</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Range: zero to 12,000 (inclusive)</td>
</tr>
</tbody>
</table>

Code Descriptor

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide

Report the best estimate of the amount of blood lost in millilitres (ml). This is usually reported to the nearest 50 ml, but may be more accurate than this if desired, for example when there is a very small amount of bleeding.

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2):

None specified

Related data items (this section):

None specified

Related business rules (Section 4):

Mandatory to report data items

Administration

Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Codeset source | DHHS Collection start date 2009


**Estimated date of confinement**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The estimated date of confinement (agreed due date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Date</td>
</tr>
<tr>
<td>Format</td>
<td>DDMMCYY</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid calendar date</td>
</tr>
</tbody>
</table>

**Code**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
The Estimated date of confinement (agreed due date) may be based on the date of the last normal menstrual period (LNMP) or on clinical or ultrasound assessments. If there is uncertainty in each of these, report the agreed due date based on the best available information in the particular case. Century (CC) can only be reported as 20.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
None specified

**Related data items (this section):**
None specified

**Related business rules (Section 4):**
Date and time data item relationships, Mandatory to report data items

**Administration**

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

**Definition source**

**Codeset source**
DHHS | Collection start date 2009
Estimated gestational age

Specification

Definition
The number of completed weeks of the period of gestation as measured from the first day of the last normal menstrual period to the date of birth

Representation class
Total

Data type
Number

Format
NN

Field size
2

Location
Episode record

Position
48

Permissible values
Range: 16 to 45 (inclusive)

Code	Descriptor
99	Not stated / inadequately described

Reporting guide
The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed weeks (for example, if a baby is 37 weeks and six days, this should be recorded as 37 weeks).

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts
(Section 2):
None specified

Related data items
(this section):
Estimated date of confinement

Related business rules (Section 4):
Estimated gestational age and Gestational age at first antenatal visit valid combinations, Estimated gestational age conditionally mandatory data items, Mandatory to report data items, Scope 'Stillborn'

Administration

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

Definition source
NHDD

Version
1. January 1982

Codeset source
NHDD

Collection start date
1982
Events of labour and birth – free text

Specification

Definition
Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta

Representation class
Text

Data type
String

Format
A(300)

Field size
300

Location
Episode record

Position
81

Permissible values
Permitted characters:
• 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 complications arising after the onset of labour and before the completed birth of the baby and placenta. Only report conditions in this field when there is no ICD-10-AM code available for selection in your software.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
Births where events occurred during the labour and/or birth

Related concepts (Section 2):
None specified

Related data items (this section):
Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Birth presentation, Events of labour and birth – ICD-10-AM code

Related business rules (Section 4):
Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Birth presentation conditionally mandatory data items

Administration

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

Definition source
NHDD

Version
1. January 2009

Codeset source
Not applicable

Collection start date
2009
Events of labour and birth – ICD-10-AM code

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>ANN[NN]</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Descriptor</td>
</tr>
<tr>
<td>O660</td>
<td>Shoulder dystocia</td>
</tr>
<tr>
<td>O839</td>
<td>Water birth</td>
</tr>
<tr>
<td>Z292</td>
<td>Antibiotic therapy in labour</td>
</tr>
</tbody>
</table>

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

Reporting guide

Complications arising after the onset of labour and before the completed birth of the baby and placenta. Conditions related to the neonate classifiable to code range P00–P96. Certain conditions originating in the perinatal period must be reported in data element Neonatal morbidity – ICD-10-AM code.

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

Births where events occurred during the labour and/or birth

Related concepts (Section 2): None specified

Related data items (this section): Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Birth presentation

Related business rules (Section 4): Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Birth presentation conditionally mandatory data items

Administration

Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source

NHDD

Version

1. January 2009

2. January 2015

Codeset source

ICD-10-AM eighth edition

Collection start date

2009
Foetal monitoring in labour

Specification

Definition
Methods used to monitor the wellbeing of the foetus during labour

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>String</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Format
NN

Field size
2 (x7)

Location
Episode record
Position
72

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>None</td>
</tr>
<tr>
<td>02</td>
<td>Intermittent auscultation</td>
</tr>
<tr>
<td>03</td>
<td>Admission cardiotocography</td>
</tr>
<tr>
<td>04</td>
<td>Intermittent cardiotocography</td>
</tr>
<tr>
<td>05</td>
<td>Continuous external cardiotocography</td>
</tr>
<tr>
<td>06</td>
<td>Internal cardiotocography (scalp electrode)</td>
</tr>
<tr>
<td>07</td>
<td>Fetal blood sampling</td>
</tr>
<tr>
<td>88</td>
<td>Other</td>
</tr>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide

More than one method of monitoring can be recorded.

- Code 03 Admission cardiotocography: a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission
- Code 04 Intermittent cardiotocography: foetal heart monitoring by CTG on a number of occasions in labour, but not continuously
- Code 05 Continuous cardiotocography: foetal 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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
None specified

Related business rules (Section 4):
Mandatory to report data items

Administration

Principal data users
Consultative Council on Obstetric and Paediatric Mortality and Morbidity
**Definition source**  DHHS  
**Version**  1. January 2009

**Codeset source**  DHHS  
**Collection start date**  2009

---

**First given name – mother**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The first given name of the mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Text</td>
</tr>
<tr>
<td>Format</td>
<td>A(40)</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Field size</td>
<td>40</td>
</tr>
<tr>
<td>Position</td>
<td>9</td>
</tr>
</tbody>
</table>
| 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 given name(s) of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character.

**Reported by**  All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**  All birth episodes

**Related concepts** (Section 2): None specified

**Related data items** (this section): None specified

**Related business rules** (Section 4): Mandatory to report data items

---

**Administration**

<table>
<thead>
<tr>
<th>Principal data users</th>
<th>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</th>
</tr>
</thead>
</table>
| Definition source    | DHHS  
**Version**  1. January 1982 |
| Codeset source       | Not applicable  
**Collection start date**  1982 |
First given name – paediatrician

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The first given name of the paediatrician responsible for the care of the baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Text</td>
</tr>
<tr>
<td>Format</td>
<td>A(40)</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Field size</td>
<td>40</td>
</tr>
<tr>
<td>Position</td>
<td>110</td>
</tr>
</tbody>
</table>
| 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 given name(s) of the paediatrician. If the baby is not referred to a paediatrician, leave blank. If the birth is a termination for congenital abnormality, report the given name(s) of the medical officer responsible for the women’s care. |
| Reported by | All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners |
| Reported for | All birth episodes where a congenital anomaly is present and/or the baby is referred to a paediatrician |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | Congenital anomalies – free text, Congenital anomalies – indicator |
| Related business rules (Section 4): | None specified |

Administration

| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DHHS |
| Codeset source | Not applicable |
| Collection start date | 2009 |
Formula given in hospital

Specification

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

Representation class
- Code: Code
- Data type: Data type
- Number: Number

Format
- N
- Field size: 1

Location
- Episode record
- Position: 116

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infant formula given in hospital</td>
</tr>
<tr>
<td>2</td>
<td>Infant formula not given in hospital</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All live birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
None specified

Related business rules (Section 4):
Birth status 'Live born' and associated conditionally mandatory data items, Birth status 'Stillborn' and associated data items valid combinations

Administration

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

Definition source
DHHS


Codeset source
DHHS

Collection start date: 2009

Gestational age at first antenatal visit

Specification

Definition
The number of completed weeks' gestation at the time of the first antenatal visit (excluding a consultation for confirmation of pregnancy), as measured from the first day of the last normal
Representation class

<table>
<thead>
<tr>
<th>Representation class</th>
<th>Total</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
</table>

Format

<table>
<thead>
<tr>
<th>Format</th>
<th>Field size</th>
<th>2</th>
</tr>
</thead>
</table>

Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Position</th>
<th>53</th>
</tr>
</thead>
</table>

Permissible values

Range: two to 45 (inclusive)

Code Descriptor

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>No antenatal care</td>
</tr>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide

The duration of gestation is measured from the first day of the last normal menstrual period. The first antenatal visit is the first visit to a midwife or doctor arranged specifically for the purpose of providing maternity care. It excludes visits for confirmation of pregnancy and medical visits for incidental problems while pregnant. Gestational age at first visit should be recorded in completed weeks, for example, if gestation is eight weeks and six days, this should be recorded as eight weeks.

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2):

None specified

Related data items (this section):

None specified

Related business rules (Section 4):

Estimated gestational age and Gestational age at first antenatal visit valid combinations, Mandatory to report data items

Administration

Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source

DHHS

Version

1. January 2009

Codeset source

DHHS

Collection start date

2009

Gravidity

Specification

Definition

The total number of pregnancies including the current one

Representation class

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

**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

**Height – self-reported – mother**

**Specification**

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

**Administration**

<table>
<thead>
<tr>
<th>Principal data users</th>
<th>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition source</td>
<td>NHDD (DHHS modified) Version 1. January 2009</td>
</tr>
<tr>
<td>Codeset source</td>
<td>NHDD Collection start date 2009</td>
</tr>
</tbody>
</table>

**Hepatitis B vaccine received**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether the baby received an immunisation vaccine for hepatitis B during the birth admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>1</td>
<td>Hepatitis B vaccine received before or at seven days of age</td>
</tr>
<tr>
<td>2</td>
<td>Hepatitis B vaccine received after seven days of age</td>
</tr>
<tr>
<td>3</td>
<td>Hepatitis B vaccine not received</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

| Reporting guide | Report the administration of a dose of paediatric hepatitis B vaccine. | |
|-----------------|-----------------------------------------------------------------------|
Do not report immunoglobulin. Do not report a value for stillbirth episodes, leave blank.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.

Reported for: All live birth episodes.

Related concepts:

- None specified.

Related data items (this section):

- Birth status.

Related business rules (Section 4):

- Birth status 'Live born' and associated conditionally mandatory data items, Birth status 'Stillborn' and associated data items valid combinations.

Administration:

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

Definition source: DHHS.

Codeset source: DHHS.

Collection start date: 2009.

Hospital code (agency identifier):

Specification:

Definition: Numeric code for the hospital campus reporting to the VPDC.

Representation class: Code.

Data type: Number.

Format: NNNN.

Field size: 4.

Location: Episode record, Header record, File name.


Reporting guide: Software-system generated. Report the campus code for your maternity hospital (includes birth centres).

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.

Reported for: Each VPDC electronic submission file.

Related concepts: 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

### Indication for induction – free text

#### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The primary reason given for an induction of labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Text</td>
</tr>
<tr>
<td>Format</td>
<td>A(50)</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
</tbody>
</table>

**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 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 (including birth centres) and homebirth practitioners

**Reported for**: All birth episodes where an induction was performed

**Related concepts (Section 2)**: Induction

**Related data items (this section)**: Indication for induction – ICD-10-AM code

**Related business**: Labour type, Indication for induction – free text and Indication for
Indication for induction – ICD-10-AM code

**Specification**

**Definition**
The primary reason given for an induction of labour

**Representation class**
Code

**Data type**
String

**Format**
ANN[NN]

**Field size**
5 (X1)

**Location**
Episode record

**Position**
71

**Permissible values**
For applicable codes for indications for operative delivery refer to the ICD-10-AM/ACHI (8th edition) library file available on request, by email to perinatal.data@dhhs.vic.gov.au

**Reporting guide**
Report where a medical or surgical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously. For documentation of social induction, report code O480 Social induction. Note: this is a VPDC-created code.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes where an induction was performed

**Related concepts (Section 2):**
Induction

**Related data items (this section):**
None specified

**Related business rules (Section 4):**
Labour type, Indication for induction – free text and Indication for induction – ICD-10-AM code valid combinations

---

**Administration**

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

**Definition source**
DHHS

**Version**
1. January 1999

**Codeset source**
Not applicable

**Collection start date**
1999

---

**rules (Section 4):**
induction – ICD-10-AM code valid combinations
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 (including birth centres) and homebirth practitioners

Reported for
All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse)

Related concepts (Section 2):
None specified

Related data items (this section):
Indications for operative delivery – ICD-10-AM code, Method of birth

Related business rules (Section 4):
Labour type ‘Failed induction’ conditionally mandatory data items, Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations
Indications for operative delivery – ICD-10-AM code

Specification

Definition
The reason(s) given for an operative birth

Representation class
Code

Data type
String

Format
ANN[NN]

Field size
5 (x4)

Location
Episode record

Position
76

Permissible values
For applicable codes for indications for operative delivery refer to the ICD-10-AM/ACHI (8th edition) library file available on request, by email to perinatal.data@dhhs.vic.gov.au

Reporting guide
Report up to four reasons for operative delivery in order from the most to least influential in making the decision.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse)

Related concepts
None specified

Related data items
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
Indigenous status – baby

Specification

**Definition**
Indigenous status is a measure of whether a person (baby) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community in which they live.

**Representation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Field size</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>1</td>
<td>20</td>
</tr>
</tbody>
</table>

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aboriginal but not Torres Strait Islander origin</td>
</tr>
<tr>
<td>2</td>
<td>Torres Strait Islander but not Aboriginal origin</td>
</tr>
<tr>
<td>3</td>
<td>Both Aboriginal and Torres Strait Islander origin</td>
</tr>
<tr>
<td>4</td>
<td>Neither Aboriginal nor Torres Strait Islander origin</td>
</tr>
<tr>
<td>8</td>
<td>Question unable to be asked</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

Code 8 Question unable to be asked should only be used under the following circumstances:
- when the patient’s medical condition prevents the question of Indigenous status being asked
- in the case of an unaccompanied child who is too young to be asked their Indigenous status.

This information must be collected for every admitted patient episode and updated each time the patient presents to the hospital for admission. Software must not be set up to input a default code.
Rather than asking every patient about his or her indigenous status, first ask the patient, ‘Were you born in Australia?’ Then, proceed as follows:
- If no, the patient should be asked, ‘What country were you born in?’
- If yes, the patient should be asked, ‘Are you of Aboriginal or Torres Strait Islander origin?’
If the patient answers yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to correctly record the person’s Indigenous status.

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

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Country of birth

Related business rules (Section 4): Mandatory to report data items

Administration

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

Definition source: NHDD


Codeset source: NHDD (DHHS modified)

Collection start date: 2009

Indigenous status – mother

Specification

Definition: Indigenous status is a measure of whether a person (mother) identifies as being of Aboriginal or Torres Strait Islander origin and is accepted as such by the community in which she lives.

Representation class

Code | Data type | Number
--- | --- | ---
N | Field size | 1

Format: Episode record

Location: Position 19

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aboriginal but not Torres Strait Islander origin</td>
</tr>
<tr>
<td>2</td>
<td>Torres Strait Islander but not Aboriginal origin</td>
</tr>
<tr>
<td>3</td>
<td>Both Aboriginal and Torres Strait Islander origin</td>
</tr>
</tbody>
</table>
Neither Aboriginal nor Torres Strait Islander origin
Question unable to be asked
Not stated / inadequately described

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

Code 8 Question unable to be asked should only be used under the following circumstances:
- when the patient’s medical condition prevents the question of Indigenous status being asked.

This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission. Software must not be set up to input a default code. Rather than asking every patient about his or her indigenous status, first ask the patient, “Were you born in Australia?”:
- If no, the patient should be asked, “What country were you born in?”
- If yes, the patient should be asked, “Are you of Aboriginal or Torres Strait Islander origin?”

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

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Country of birth, Indigenous status – baby

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source
Influenza vaccination status

**Specification**

**Definition**
Whether or not the mother has received an influenza vaccine during this pregnancy

**Representation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**
Episode record

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Influenza vaccine received at any time during this pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Influenza vaccine not received at any time during this pregnancy</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

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

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
None specified

**Related data items (this section):**
None specified

**Related business rules (Section 4):**
Mandatory to report

**Administration**

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

**Definition source**
DHHS

**Version**
1. July 2015

**Codeset source**
DHHS

**Collection start date**
1982
Labour induction/augmentation agent

Specification

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

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Data type</td>
<td>Number</td>
</tr>
</tbody>
</table>

**Format**

N Field size 1 (x3)

**Location**
Episode record Position 68

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oxytocin</td>
</tr>
<tr>
<td>2</td>
<td>Prostaglandins</td>
</tr>
<tr>
<td>3</td>
<td>Artificial rupture of membranes (ARM)</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

Code 2 Prostaglandins includes misoprostil
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 (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes where labour was induced or augmented.

**Related concepts** (Section 2):
Augmentation, Labour type

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

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

**Codeset source**
NHDD Collection start date 1999
Labour induction/augmentation agent – other specified description

Specification

**Definition**
The agent used to induce or augment labour

**Representation class**
Text

**Data type**
String

**Format**
A(20)

**Field size**
20

**Location**
Episode record

**Position**
69

**Permissible values**
Permitted characters:
- a–z and A–Z
- special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols)
- numeric characters
- blank characters

**Reporting guide**
Specify the type of Labour induction/augmentation agent as free text.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
When Labour induction/augmentation agent code 8 other – specify is reported

**Related concepts**
(Section 2): None specified

**Related data items**
(this section):
Labour induction/augmentation agent

**Related business rules**
(Section 4):
Labour induction/augmentation agent and Labour induction/augmentation agent – other specified description conditionally mandatory data item

Administration

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

**Definition source**
DHHS

**Version**
1. January 2009

**Codeset source**
Not applicable

**Collection start date**
2009
Labour type

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The manner in which labour starts in a birth event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

Reporting guide

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

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

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

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

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
Labour type
Related data items (this section): Mandatory to report


Administration

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


Codeset source NHDD (DHHS Modified)  Collection start date 1982

Last birth – caesarean section indicator

Specification

Definition An indicator of whether a caesarean section was performed for the most recent previous pregnancy that resulted in a birth.

Representation class Code  Data type  Number

Format N  Field size  1

Location Episode record  Position  44

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Last birth was caesarean section</td>
</tr>
<tr>
<td>2</td>
<td>Last birth was not caesarean section</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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 (including birth centres) and homebirth practitioners

Reported for Episodes where the mother has had a previous birth

Related concepts (Section 2): None specified
Related data items (this section): None specified

Related business rules (Section 4): Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items

**Administration**

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

**Definition source** NHDD **Version** 1. January 1999
2. January 2009

**Codeset source** NHDD (DHHS Modified) **Collection start date** 1999

**Last feed before discharge taken exclusively from the breast**

**Specification**

**Definition** Whether the last feed prior to discharge was taken exclusively from the breast, with no complementary feeding of any kind

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location** Episode record

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Last feed before discharge taken exclusively from breast</td>
</tr>
<tr>
<td>2</td>
<td>Last feed before discharge not taken exclusively from breast</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

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

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

**Reported by** All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Reported for: All live birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Breastfeeding attempted

Related business rules (Section 4):
- Birth status ‘Live born’ and associated conditionally mandatory data items
- Birth status ‘Stillborn’ and associated data items valid combinations
- Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations

Administration

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

Definition source: NHDD

Codeset source: NHDD

Collection start date: 2009

Manual removal of placenta

Specification

Definition: Whether the placenta was manually removed

Representation class: Code

Data type: Number

Format: N

Field size: 1

Location: Episode record Position 84

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

Reporting guide: This includes the placenta that is trapped behind the cervix by an oxytocic contraction and requires the placenta to be removed by inserting the hand through the cervix. If method of birth is via caesarean section, do not report a value, leave blank.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes, except for those who delivered via caesarean section

Related concepts (Section 2): None specified
Related data items (this section): Method of birth

Related business rules (Section 4): Method of birth and Manual removal of placenta conditionally mandatory data item

Administration

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

Definition source: DHHS

Codeset source: DHHS

Collection start date: 2009

Marital status

Specification

Definition: A person’s current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage

<table>
<thead>
<tr>
<th>Representation class</th>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format</td>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
<td>Position</td>
<td>21</td>
</tr>
</tbody>
</table>

Permissible values:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Never married</td>
</tr>
<tr>
<td>2</td>
<td>Widowed</td>
</tr>
<tr>
<td>3</td>
<td>Divorced</td>
</tr>
<tr>
<td>4</td>
<td>Separated</td>
</tr>
<tr>
<td>5</td>
<td>Married</td>
</tr>
<tr>
<td>6</td>
<td>De facto</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide: Report the current marital status of the mother

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Date of birth – mother

Related business rules (Section 4): Mandatory to report data items
### Administration

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

**Definition source**  
NHDD  
**Version**  
1. January 1982

**Codeset source**  
NHDD (DHHS Modified)  
**Collection start date**  
1982

### Maternal medical conditions – free text

#### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>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</th>
</tr>
</thead>
</table>
| Representation class | Text  
| Data type | String |
| Format | A(300)  
| Field size | 300 |
| Location | Episode record  
| Position | 49 |
| 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.  
Only record conditions that affected the care or surveillance of this pregnancy. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded.  
Do not report past operations such as appendectomy, knee reconstruction that do not affect or have not occurred during this pregnancy. |
| Reported by | All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners |
| Reported for | Birth episodes where a maternal medical condition is present |
| Related concepts (Section 2): | None specified |
| Related data items (this section): | None specified |
Related business rules (Section 4):

Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items

Administration

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

Definition source: NHDD


Codeset source: Not applicable

Collection start date: 1982

Maternal medical conditions – ICD-10-AM code

Specification

Definition: Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome

Representation class:

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>String</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Format: ANN[NN]  Field size  5 (X12)

Location: Episode record  Position  50

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0100</td>
<td>Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>0142</td>
<td>HELLP Syndrome</td>
</tr>
<tr>
<td>0240</td>
<td>Pre-existing diabetes mellitus, type 1, in pregnancy</td>
</tr>
<tr>
<td>02419</td>
<td>Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified</td>
</tr>
<tr>
<td>02681</td>
<td>Renal disease, pregnancy related</td>
</tr>
<tr>
<td>0993</td>
<td>Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium (psychosocial problems)</td>
</tr>
<tr>
<td>0994</td>
<td>Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium</td>
</tr>
</tbody>
</table>

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

Examples of maternal medical conditions include past history of a hydatidiform mole, rheumatoid arthritis, asthma, deafness, polycystic ovaries and multiple sclerosis. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded.
Do not report past operations such as appendectomy, knee reconstruction, which do not affect or have not occurred during this pregnancy. When pregnancy-related renal disease, psychosocial problem or disease of the circulatory system (cardiac condition) is reported, also report the specified condition in this field or in the Medical conditions – free text field.

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

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) 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

**Codeset source**

ICD-10-AM eighth edition

**Collection start date**

1982

---

**Maternal smoking at less than 20 weeks**

**Specification**

**Definition**

A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy.

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**

Episode record

**Position**

31

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
</table>
1 No smoking at all before 20 weeks of pregnancy  
2 Quit smoking during pregnancy (before 20 weeks)  
3 Continued smoking before 20 weeks of pregnancy  
9 Not stated / inadequately described

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

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Maternal smoking at more than or equal to 20 weeks

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source
NHDD (DHHS modified)  
2. July 2015

Codeset source
DHHS  
Collection start date 2009

Maternal smoking at more than or equal to 20 weeks

Specification

Definition
The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth.

Representation class
Total  
Data type Number

Format
NN  
Field size 2

Location
Episode record  
Position 32

Permissible values
Range: zero to 97 (inclusive)

Code Descriptor
98  Occasional smoking (less than one)
99  Not stated / inadequately described

**Reporting guide**

Data should be collected after the birth.

After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (>=20 weeks + 0 days).

'Usually' is defined as 'according to established or frequent usage, commonly, ordinarily, as a rule'.

If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

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

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts** (Section 2):
None specified

**Related data items** (this section):
None specified

**Related business rules** (Section 4):
Mandatory to report data items

---

**Administration**

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

**Definition source**

**Codeset source**
DHHS Collection start date 2009

---

**Method of birth**

**Specification**

**Definition**
The method of complete expulsion or extraction from the woman of a product of conception in a birth event

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NN</td>
<td>Field size</td>
<td>2</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
<td>Descriptor</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Forceps</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Vaginal birth – non-instrumental</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Planned caesarean – no labour</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Unplanned caesarean – labour</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Planned caesarean – labour</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Unplanned caesarean – no labour</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Vacuum extraction</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Other operative birth</td>
</tr>
</tbody>
</table>

**Reporting guide**

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

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

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

**Code 1 Forceps**

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

**Code 3 Vaginal birth – non-instrumental**

Includes manual assistance for example, a vaginal breech that has been manually rotated.

**Code 4 Planned caesarean – no labour**

Caesarean takes place as a planned procedure before the onset of labour.

**Code 5 Unplanned caesarean**

Caesarean is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced.

**Code 6 Planned caesarean – labour**

Caesarean was a planned procedure, but occurs after spontaneous onset of labour.

**Code 7 Unplanned caesarean – no labour**

Procedure is undertaken for an urgent indication before the onset of labour. If a woman 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 (including birth centres) 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


Administration

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

Definition source: NHDD

2. January 1999
3. January 2009
4. June 2015

Codeset source: NHDD (DHHS Modified)

Collection start date: 1982

Middle name – mother

Specification

Definition: The middle name of the mother

Representation class: Text

Data type: String

Format: A(40)

Field size: 40

Location: Episode record

Position: 10

Permissible values:
- 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 middle name of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes when applicable

Related concepts (Section 2):
None specified

Related data items (this section):
First given name – mother, Surname/family name – mother

Related business rules (Section 4):
None specified

Administration

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

Definition source
DHHS

Version
1. January 2009

Codeset source
Not applicable

Collection start date
2009

Name of software

Specification

Definition
Name of the software used by the hospital

Representation class
Identifier

Data type
String

Format
A(10)

Field size
10

Location
Header record

Position
Not applicable

Permissible values
Permitted characters:
• 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
Software-system generated

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) 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


Codeset source DHHS Collection start date 2009

Neonatal morbidity – free text

Specification

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

Representation class Text Data type String

Format A(300) Field size 300

Location Episode record Position 111

Permissible values Permitted characters:
  • 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 conditions in this field when there is no ICD-10-AM code available for selection in the software.

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

Examples of such morbidity include jaundice that required phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections.
It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates, record all associated morbidity.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.

Reported for: Birth episodes where neonatal morbidity is present.

Related concepts (Section 2): None specified.

Related data items (this section): None specified.

Related business rules (Section 4): Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Estimated gestational age conditionally mandatory data items.

Administration

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

Definition source: DHHS


Codeset source: Not applicable

Collection start date: 1982

Neonatal morbidity – ICD-10-AM code

Specification

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

Representation class:
- Code
- Data type: String

Format: ANN[NN]
- Field size: 5 (x10)

Location: Episode record
- Position: 112

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

Reporting guide: Excludes congenital anomalies. Morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU.

Examples of such morbidity includes jaundice that required
phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections.

It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates record all associated morbidity.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
Birth episodes where neonatal morbidity is present

Related concepts (Section 2):
None specified

Related data items (this section):
Neonatal morbidity – free text

Related business rules (Section 4):
Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Estimated gestational age conditionally mandatory data items

Administration

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

Definition source
DHHS

Version
1. January 1982
2. January 1999
3. January 2009

Codeset source
ICD-10-AM eighth edition

Collection start date
1982
Number of antenatal care visits

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The total number of antenatal care visits attended by a pregnant female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Total</td>
</tr>
<tr>
<td>Format</td>
<td>Data type: Number</td>
</tr>
<tr>
<td>Location</td>
<td>Field size: NN</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Field size: 2</td>
</tr>
<tr>
<td></td>
<td>Position: Episode record 124</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Range: zero to 30 (inclusive)</td>
</tr>
</tbody>
</table>

Code Descriptor

99  Not stated / inadequately described

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 foetus.

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 (including birth centres) and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2):

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

Administration
Principal data users: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Definition source: NHDD
Codeset source: NHDD
Collection start date 1 July 2015

Number of records following

Specification

Definition: The total numbers of records in the submission file
Representation class: Total
Data type: Number
Format: N[NNNN]
Field size: 5
Location: Header record
Position: Not applicable
Permissible values: Range: one to 99,999 (inclusive)
Reporting guide: Software-system generated. This is the total number of records, excluding the header record, in a VPDC electronic submission file. The submission file will be rejected and not be processed by VPDC if the number of records following in the header record does not match the actual count of the relevant records.
Reported by: All Victorian hospitals where a birth has occurred (including birth centres) 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
Number of ultrasounds at or after 27 weeks

Specification

Definition
The total number of ultrasounds the mother has at or after 27 weeks’ gestation

Representation class
Total

Data type
Number

Format
NN

Field size
2

Location
Episode record

Position
59

Permissible values
Range: zero to 20 (inclusive)

Code Descriptor
99 Not stated / inadequately described

Reporting guide
Enter the number of ultrasounds performed at greater than or equal to 26 completed weeks of gestation.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Number of ultrasounds 10–14 weeks, Number of ultrasounds 15–26 weeks

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source
DHHS

Version
1. January 2009

Codeset source
DHHS

Collection start date
1999
**Number of ultrasounds 10–14 weeks**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The total number of ultrasounds the mother has had between 10 and 14 weeks’ gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Total</td>
</tr>
<tr>
<td>Format</td>
<td>NN</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Range: zero to 20 (inclusive)</td>
</tr>
<tr>
<td>Code</td>
<td>99</td>
</tr>
<tr>
<td>Descriptor</td>
<td>Not stated / inadequately described</td>
</tr>
<tr>
<td>Reporting guide</td>
<td>Enter the number of ultrasounds performed at greater than or equal to 10 weeks and equal to or less than 14 weeks’ gestation.</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>All birth episodes</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related business rules (Section 4):</td>
<td>Mandatory to report data items</td>
</tr>
</tbody>
</table>

**Administration**

- **Principal data users**: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- **Definition source**: DHHS
- **Codeset source**: DHHS
- **Collection start date**: 1999

**Number of ultrasounds 15–26 weeks**

**Specification**

| Definition | The total number of ultrasounds the mother has had between 15 and 26 weeks’ gestation |
Representation
class

<table>
<thead>
<tr>
<th>Total</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Format
NN
Field size
2

Location
Episode record
Position
58

Permissible values
Range: zero to 20 (inclusive)

Code Descriptor
99 Not stated / inadequately described

Reporting guide
Enter the number of ultrasounds performed at greater than or equal to 15 weeks and equal to or less than 26 weeks’ gestation.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Number of ultrasounds 10–14 weeks

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source
DHHS
Version
1. January 1999
2. January 2009

Codeset source
DHHS
Collection start date
1999

Obstetric complications – free text

Specification

Definition
Complications arising during the period immediately before delivery (not including the intrapartum period) that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome

Representation class
Text
Data type
String

Format
A(300)
Field size
300

Location
Episode record
Position
51
Permissible values
Permitted characters:

- 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.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) 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


Codeset source Not applicable

Collection start date 1982

Obstetric complications – ICD-10-AM code

Specification

Definition
Complications arising during the period immediately before delivery (not including the intrapartum period) that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome

Representation class
Code Data type String

Format ANN[NN] Field size 5 (x15)
### Location
Episode record

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

### Codes and Descriptions

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

### Reporting guide
Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension

### Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

### Reported for
All birth episodes where an obstetric complication is present

### Related concepts
None specified

### Related data items
Obstetric complications – free text

### Related business rules
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

#### Codeset source
ICD-10-AM eighth edition

#### Collection start date
1982

### Outcome of last pregnancy

#### Specification

**Definition**
Outcome of the most recent pregnancy preceding the current pregnancy
**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Live birth</td>
</tr>
<tr>
<td>2</td>
<td>Spontaneous abortion</td>
</tr>
<tr>
<td>3</td>
<td>Not stated / inadequately described</td>
</tr>
<tr>
<td>4</td>
<td>Stillbirth</td>
</tr>
<tr>
<td>5</td>
<td>Induced abortion</td>
</tr>
<tr>
<td>6</td>
<td>Neonatal death</td>
</tr>
<tr>
<td>7</td>
<td>Ectopic pregnancy</td>
</tr>
</tbody>
</table>

**Permissible values**

In the case of a multiple pregnancy with foetal loss before 20 weeks, report the outcome of the surviving foetus(es) beyond 20 weeks. In multiple pregnancies with more than one type of outcome, select the appropriate outcome based on the following hierarchy: neonatal, death, stillbirth, live birth.

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

Birth episodes where Gravidity is greater than code 01 Primigravida

**Related concepts (Section 2):**

None specified

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

Date of completion of last pregnancy, Gravidity, Last birth – caesarean section indicator, Total number of previous abortions – induced, Total number of previous abortions – spontaneous, Total number of previous ectopic pregnancies, Total number of previous live births, Total number of previous neonatal deaths, Total number of previous stillbirths (foetal deaths), Total number of previous unknown outcomes of pregnancy

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

Gravidity ’Multigravida’ conditionally mandatory data items, Gravidity ’Primigravida’ and associated data items valid combinations, Outcome of last pregnancy and associated data item valid combinations, Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items, Parity and associated data items valid combinations

**Administration**

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

NHDD METeOR identifier: 270006

1. January 1982
2. January 1999

**Codeset source**

NHDD (DHHS modified)

Collection start date 1982
Parity

Specification

**Definition**
The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.

**Representation**

- **Total**
  - **Data type**: Number
  - **Field size**: NN
  - **Position**: 35

**Permissible values**
Range: zero to 20 (inclusive)

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

**Reporting guide**
To calculate parity, count all previous pregnancies that resulted in a live birth or a stillbirth of at least 20 weeks gestation or at least 400 grams birth weight. Excluded from the count are:

- the current pregnancy,
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman giving birth for the first time) has a parity of 00.

A pregnancy with multiple foetuses is counted as one pregnancy.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.

**Reported for**
All birth episodes.

**Related concepts**
Live birth, Neonatal death, Stillbirth (foetal death)

**Related data items**
Gravidity, Outcome of last pregnancy, Total number of previous live births, Total number of previous neonatal deaths, Total number of previous stillbirths (foetal deaths)

**Related business rules**
Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and Parity valid combinations, Mandatory to report data items, Parity and associated data items valid combinations, Parity and related data items.

Administration

**Principal data users**
Consultative Council on Obstetric and Paediatric Mortality and Morbidity.
**Patient identifier – baby**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>An identifier, unique to the baby within the hospital or campus (patient’s record number / unit record number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Identifier Data type String</td>
</tr>
<tr>
<td>Format</td>
<td>A(10) Field size 10</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record Position 6</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Permitted characters:</td>
</tr>
<tr>
<td></td>
<td>• a–z and A–Z</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td>• numeric characters</td>
</tr>
<tr>
<td></td>
<td>• blank characters</td>
</tr>
<tr>
<td>Reporting guide</td>
<td>Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.</td>
</tr>
<tr>
<td></td>
<td>For planned births occurring outside the hospital system, enter the birth number or an equivalent number used to identify the mother.</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>Birth episodes where available</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related business rules (Section 4):</td>
<td>None specified</td>
</tr>
</tbody>
</table>

**Administration**

Principal data users Consultative Council on Obstetric and Paediatric Mortality and
Patient identifier – mother

**Specification**

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

**Representation class**
Identifier

**Data type**
String

**Format**
A(10)

**Field size**
10

**Location**
Episode record

**Position**
5

**Permissible values**
Permitted characters:
- 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**
Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system. Private homebirth practitioner only: report 9999999 for ‘unknown’.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
None specified

**Related data items (this section):**
None specified

**Related business rules (Section 4):**
Mandatory to report data items

---

**Administration**

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

**Definition source**
DHHS

**Version**
1. January 1982

**Codeset source**
Not applicable

**Collection start date**
1982
Perineal/genital laceration – degree/type

Specification

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

Representation class

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Field size</td>
<td>1 (x2)</td>
</tr>
</tbody>
</table>

Location
Episode record
Position
86

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First degree laceration/tear</td>
</tr>
<tr>
<td>2</td>
<td>Second degree laceration/tear</td>
</tr>
<tr>
<td>3</td>
<td>Third degree laceration/tear</td>
</tr>
<tr>
<td>4</td>
<td>Fourth degree laceration/tear</td>
</tr>
<tr>
<td>5</td>
<td>Labial / clitoral laceration/tear</td>
</tr>
<tr>
<td>6</td>
<td>Vaginal wall laceration/tear</td>
</tr>
<tr>
<td>7</td>
<td>Cervical laceration/tear</td>
</tr>
<tr>
<td>8</td>
<td>Other laceration, rupture or tear</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

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

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

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

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes where the perineum is not intact following the birth

Related concepts (Section 2):
None specified
Administration

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

Definition source NHDD (DHHS modified) Version 1. January 1999

Codeset source DHHS Collection start date 1999

Perineal laceration – indicator

Specification

Definition The state of the perineum following birth

Representation class Code Data type Number

Format N Field size 1

Location Episode record Position 85

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

Reporting guide For episiotomies extended by laceration or laceration extended by episiotomy, record Perineal laceration – indicator as code 1 Laceration of the perineum following birth and Episiotomy indicator as code 1 Incision of perineum and vagina made. Specify the degree of the tear in Perineal/genital laceration – degree/type.

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Episiotomy – indicator, Method of birth

Pertussis (whooping cough) vaccination status

Specification

**Definition**
Whether or not the mother has received a pertussis containing vaccine during this pregnancy.

**Representation**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Field size</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Number</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**
Episode record

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pertussis containing vaccine received at any time during this pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Pertussis containing vaccine not received at any time during this pregnancy</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

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

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

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts (Section 2):**
None specified

**Related data items (this section):**
None specified

**Related business rules (Section 4):**
Mandatory to report
**Perineal laceration – repair**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether a repair to a laceration/tear or incision to the perineum during birth was undertaken</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Representation class</th>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format</td>
<td>N</td>
<td>Field size</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Episode record</th>
<th>Position</th>
<th>87</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Permissible values</th>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Repair of perineum undertaken</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Repair of perineum not undertaken</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

Suturing of any injury to the perineum, including repair to perineal lacerations/tears and/or episiotomy

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes where the perineum is not intact following the birth

**Related concepts (Section 2):**

None specified

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

Episiotomy – indicator, Method of birth, Perineal laceration – indicator

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


**Administration**

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeset source</td>
<td>DHHS</td>
<td>Collection start date</td>
<td>2009</td>
</tr>
</tbody>
</table>
Plan for vaginal birth after caesarean

Specification

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

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>1</td>
</tr>
</tbody>
</table>

**Location**
Episode record 46

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vaginal birth after caesarean section was planned</td>
</tr>
<tr>
<td>2</td>
<td>Vaginal birth after caesarean section was not planned</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
Where a woman is planning to have a VBAC and then becomes overdue at 42 weeks and has a caesarean section, the plan for VBAC should be recorded as VBAC not planned.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
Birth episodes where total number of previous caesareans is greater than 00

**Related concepts**
None specified

**Related data items**
Last birth – caesarean section indicator

**Related business rules**
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**

**Codeset source**
DHHS  Collection start date 2009
Postpartum complications – free text

**Specification**

| Definition | Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care |
| Representation class | Text | Data type | String |
| Format | A(300) | Field size | 300 |
| Location | Episode record | Position | 91 |
| Permissible values | Permitted characters: |
| | • 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.

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 (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes where complications are present in the postpartum period

**Related concepts (Section 2):**

None specified

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

Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Postpartum complications – ICD-10-AM code

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

Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items

---

**Administration**

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

NHDD

**Version**

1. January 2009

**Codeset source**

Not applicable

**Collection start date**

2009
## Postpartum complications – ICD-10-AM code

### Specification

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

### Administration

<table>
<thead>
<tr>
<th>Principal data users</th>
<th>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeset source</td>
<td>ICD-10-AM eighth edition</td>
</tr>
</tbody>
</table>
Procedure – ACHI code

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>NNNNNNN</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>ICD-10-AM (8th edition) available on request, please email <a href="mailto:perinatal.data@dhhs.vic.gov.au">perinatal.data@dhhs.vic.gov.au</a></td>
</tr>
</tbody>
</table>

**Code** | **Descriptor** |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1651100</td>
<td>Cervical suture for cervical shortening</td>
</tr>
<tr>
<td>9619703</td>
<td>Intramuscular administration of two doses of steroids antenatally</td>
</tr>
</tbody>
</table>

**Reporting guide**

Code 9619703 Intramuscular administration of two doses of steroids antenatally.

Report antenatal steroids only if two doses were given, 24 hours apart at less than 34 weeks' gestation. 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.

The order of the codes should be determined using the following hierarchy, in accordance with the ICD-10-AM/ACHI sixth edition 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 (including birth centres) and homebirth practitioners

**Reported for**

Birth episodes where a medical procedure and/or operation are performed

**Related concepts (Section 2):**

Procedure
Related data items (this section): Artificial reproductive technology – indicator

Related business rules (Section 4): Artificial reproductive technology – indicator conditionally mandatory data items

Administration

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

Definition source DHHS

Version
1. January 1982
2. January 2009

Codeset source ICD-10-AM eighth edition

Collection start date 1982

Procedure – free text

Specification

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

Representation class Text

Data type String

Format A(300)

Field size 300

Location Episode record

Position 55

Permissible values Permitted characters:
- 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 (including birth centres) and homebirth practitioners

Reported for Birth episodes where a medical procedure and/or operation is performed

Related concepts (Section 2): Procedure

Related data items (this section): Artificial reproductive technology – indicator, Procedure – ACHI code

Related business rules (Section 4): Artificial reproductive technology – indicator conditionally mandatory data items

Administration

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

Definition source DHHS Version 1. January 1982

Codeset source Not applicable Collection start date 1982

Prophylactic oxytocin in third stage

Specification

Definition Whether oxytocin was given prophylactically in the third stage of labour

Representation class Code Data type Number

Format N Field size 1

Location Episode record Position 83

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oxytocin given prophylactically</td>
</tr>
<tr>
<td>2</td>
<td>Oxytocin not given prophylactically</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide

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

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All birth episodes
Related concepts (Section 2):
Post-partum haemorrhage

Related data items (this section):
Estimated blood loss (ml)

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source DHHS

Codeset source DHHS
Collection start date 2009

Residential locality

Specification

Definition
The geographic location of the woman's usual residence (suburb/town/locality for Australian residents, country for overseas residents), not the postal address

Representation class
Code Data type String

Format A(46) Field size 46

Location Episode record Position 11

Permissible values

Reporting guide
Locality must be blank if the postcode is 1000 (No fixed abode) or 9988 (Unknown). Where the postcode is 8888 (overseas), report the country where the patient lives in Locality. The four-digit country code must be one that corresponds with a code listed against 8888 (overseas) in the postcode/locality reference file.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
None specified

Related business Mandatory to report data items, Residential locality and Residential
rules (Section 4): postcode valid combinations

Administration

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


Codeset source ABS National Locality Index (Cat. no. 1252) (DHHS Modified) Collection start date 1982

Residential postcode

Specification

Definition Postcode or locality in which the woman usually resides (not postal address)

Representation class Code Data type Number

Format NNNN Field size 4

Location Episode record Position 12


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

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

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified
Related data items (this section): Residential locality

 Related business rules (Section 4): Mandatory to report data items, Residential locality and Residential postcode valid combinations

Administration

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


Codeset source ABS National Locality Index (Cat. no. 1252) (DHHS Modified)  Collection start date 1982

Residential road name – mother

Specification

Definition The name of the road or thoroughfare of the mother’s normal residential address

Representation class Text  Data type String

Format A(45)  Field size 45

Location Episode record  Position 14

Permissible values Permitted characters:
  • 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 (including birth centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

Related business rules (Section 4): None specified
Residential road number – mother

Definition
The number in the road or thoroughfare of the mother’s normal residential address

Representation class
Text

Data type
String

Format
A(300)

Field size
12

Location
Episode record

Position
13

Permissible values
Permitted characters:
• 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 (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Residential road name – mother

Related business rules (Section 4):
None specified
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
Code
Data type
String

Format
AA
Field size
2

Location
Episode record
Position
15

Permissible values
Codeset available on request, please email perinatal.data@dhhs.vic.gov.au

Reporting guide
The type of road on which the mother normally resides

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts (Section 2):
None specified

Related data items (this section):
Residential road name – mother, Residential road number – mother

Related business rules (Section 4):
None specified

Administration

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

Definition source
DHHS
Version
1. January 2009

Codeset source
Not applicable
Collection start date
2009
Residential road type – mother

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The type of road or thoroughfare of the mother’s normal residential address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>AAAA</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Codeset available on request, please email <a href="mailto:perinatal.data@dhhs.vic.gov.au">perinatal.data@dhhs.vic.gov.au</a></td>
</tr>
<tr>
<td>Reporting guide</td>
<td>The type of road where the mother normally resides</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>All birth episodes</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>Residential road name – mother, Residential road number – mother, Residential road suffix code – mother</td>
</tr>
<tr>
<td>Related business rules (Section 4):</td>
<td>None specified</td>
</tr>
</tbody>
</table>

**Administration**

| Principal data users           | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Codeset source                 | Not applicable | Collection start date | 2009 |

**Resuscitation method – drugs**

**Specification**

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

### Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None (no drug therapy)</td>
</tr>
<tr>
<td>2</td>
<td>Narcotic antagonist</td>
</tr>
<tr>
<td>3</td>
<td>Sodium bicarbonate</td>
</tr>
<tr>
<td>4</td>
<td>Adrenalin</td>
</tr>
<tr>
<td>5</td>
<td>Volume expander</td>
</tr>
<tr>
<td>8</td>
<td>Other drugs</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**

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

**Reported by**

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**

All birth episodes

**Related concepts** (Section 2):

None specified

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

Birth status

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

Mandatory to report data items

---

### Administration

**Principal data users**

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

**Definition source**

DHHS

**Version**

1. January 2009

**Codeset source**

Not applicable

**Collection start date**

2009

---

### Resuscitation method – mechanical

#### Specification

**Definition**

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

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>String</td>
</tr>
</tbody>
</table>

**Format**

NN | Field size | 2 (x10)
Permissible values

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

Reporting guide

If during resuscitation both air and oxygen are given, report both codes. A combination of up to ten valid types of mechanical resuscitation methods can be used.

Code 01 None: includes such strategies as tactile stimulation.

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

All birth episodes

Related concepts (Section 2):

None specified

Related data items (this section):

Apgar score at one minute, Apgar score at five minutes, Birth status, Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code, Resuscitation method – drugs

Related business rules (Section 4):

Mandatory to report data items, Time to established respiration and Resuscitation method – mechanical valid combinations

Administration

Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source

NHDD

Codeset source

NHDD (DHHS modified)

Collection start date

1982
**Separation date – baby**

**Specification**

<table>
<thead>
<tr>
<th>Definition</th>
<th>The date on which the baby is separated or transferred from the place of birth or on which they died</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Date Data type Date/time</td>
</tr>
<tr>
<td>Format</td>
<td>DDMMCCYY Field size 8</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record Position 119</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid calendar date</td>
</tr>
</tbody>
</table>

**Reporting guide**
The relocation of the baby within the hospital of birth does not constitute a separation (or transfer). Transfers from a private hospital located within a public hospital, to the public hospital for special or intensive care, are considered transfers (and therefore the baby is separated). For babies who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs, the Separation status – baby is 3 Transferred, and the Transfer destination – baby is the campus code of the campus providing the HITH service. In the case of planned homebirths, occurring at home, the separation date is the date that the baby's immediate post birth care is completed and the midwife leaves the place of birth. Please note that this date may be different to the baby's date of birth, for example if the birth occurs shortly before midnight. Do not report a value for stillbirth episodes, leave blank.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All live birth episodes

**Related concepts** (Section 2):
None specified

**Related data items** (this section):
Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Birth status. Neonatal morbidity – free text, Neonatal morbidity – ICD-10-AM code

**Related business rules** (Section 4):
Birth status 'Live born' and associated conditionally mandatory data items, Birth status 'Stillborn' and associated data items valid combinations, Date and time data item relationships, Date of birth – baby and Separation date – baby conditionally mandatory data items

**Administration**

**Principal data users**
Consultative Council on Obstetric and Paediatric Mortality and Morbidity
**Separation date – mother**

**Specification**

**Definition**
The date on which the mother is separated, transferred or died after the birth episode.

**Representation class**
Date

**Data type**
Date/time

**Format**
DDMMCCYY

**Field size**
8

**Location**
Episode record

**Position**
118

**Permissible values**
A valid calendar date

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99999999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
The relocation of the mother within the hospital of birth does not constitute a separation (or transfer). For mothers who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs, the Separation status – mother is code 3 Transferred, and the Transfer destination – mother is the campus code of the campus providing the HITH service. In the case of planned homebirths, occurring at home, the separation date is the date that the mother’s immediate post-birth care is completed and the midwife leaves the place of birth. Please note that this date may differ from the baby’s date of birth, for example, if the birth occurs shortly before midnight.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts**
None specified

**Related data items**
Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Date of admission – mother

**Related business rules**
Date and time data item relationships, Mandatory to report data items

**Administration**

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

**Definition source**
DHHS

**Version**
1. January 1982
**Separation status – baby**

**Specification**

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

**Representation class**
Code | Data type | Number
--- | --- | ---

**Format**
N | Field size | 1

**Location**
Episode record | Position | 121

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discharged</td>
</tr>
<tr>
<td>2</td>
<td>Died</td>
</tr>
<tr>
<td>3</td>
<td>Transferred</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
Do not report a value for stillbirth episodes, leave blank.
For babies who are transferred to Hospital in the Home (HITH), the Separation status – baby is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – baby is the campus code of the campus providing the HITH service.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All live birth episodes

**Related concepts (Section 2):**
Infant death, Separation

**Related data items (this section):**
Birth status, Separation date – baby

**Related business rules (Section 4):**
Birth status 'Live born' and associated conditionally mandatory data items, Birth status 'Stillborn' and associated data items valid combinations, Separation status – baby and Transfer destination – baby conditionally mandatory data item

**Administration**

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

**Definition source**
DHHS

**Version**
1. January 1982
2. July 2015

**Codeset source**
DHHS

**Collection start date**
1982
Separation status – mother

Specification

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

**Representation class**

<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Format**
N

**Location**
Episode record

**Field size**
1

**Location**

**Position**
120

**Permissible values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Discharged</td>
</tr>
<tr>
<td>2</td>
<td>Died</td>
</tr>
<tr>
<td>3</td>
<td>Transferred</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
For mothers who are transferred to Hospital in the Home (HITH), Separation status – mother is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – mother is the campus code of the campus providing the HITH service.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts**
(Section 2):
Separation

**Related data items**
(this section):
None specified

**Related business rules** (Section 4):
Mandatory to report data items, Separation status – mother and Transfer destination – mother – conditionally mandatory data item

Administration

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

**Definition source**
DHHS

**Version**
1. January 1982
2. July 2015

**Codeset source**
DHHS

**Collection start date**
1982
Setting of birth – change of intent

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Whether the change of intent between where the mother intended to give birth and the actual birth setting took place before or during labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>N</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Reporting guide</td>
<td>This field is to determine where a change has occurred in the intended model of care. If the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended place of birth. She is holidaying on the coast at 38 weeks and realises that she going to have this second baby quickly, so is admitted to Warrnambool Hospital. This becomes the actual hospital. The change of intent is during labour. The reason is unintended (see Setting of birth – actual and Setting of birth – change of intent – reason). Or, if the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended place of birth. She moves to Warrnambool for her husband's work at 39 weeks where she gives birth at term. This becomes the actual hospital. The change of intent is before onset of labour. The reason is geographical (see Setting of birth – actual and Setting of birth – change of intent – reason).</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>All episodes where the actual birth place differs from the intended place of birth</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>Setting of birth – actual</td>
</tr>
</tbody>
</table>

Administration

Principal data users: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Setting of birth – change of intent – reason

Specification

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

Representation class
<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>Data type</td>
<td></td>
</tr>
</tbody>
</table>

Format
N
Field size
1

Location
Episode record
Position
30

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Recognition of higher risk</td>
</tr>
<tr>
<td>2</td>
<td>Actual complication of pregnancy</td>
</tr>
<tr>
<td>3</td>
<td>Social or geographic</td>
</tr>
<tr>
<td>4</td>
<td>Unintended/unplanned</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
All episodes where the actual birth place differs from the initially booked place of birth

Related concepts (Section 2):
None specified

Related data items (this section):
Setting of birth – change of intent, Setting of birth – actual

Related business rules (Section 4):
Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items
Administration

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

Definition source DHHS

Codeset source DHHS

Collection start date 2009

Setting of birth – actual

Specification

Definition The actual place where the birth occurred

Representation class Code Data type Number

Format NNNN Field size 4

Location Episode record Position 27


<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>Birth centre</td>
</tr>
<tr>
<td>0003</td>
<td>Home (other)</td>
</tr>
<tr>
<td>0005</td>
<td>In transit</td>
</tr>
<tr>
<td>0006</td>
<td>Home – Private midwife care</td>
</tr>
<tr>
<td>0007</td>
<td>Home – Public homebirth program</td>
</tr>
<tr>
<td>0008</td>
<td>Other - specify</td>
</tr>
<tr>
<td>0009</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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 (including birth
centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): None specified

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

Administration

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

Definition source NHDD


Codeset source NHDD (DHHS modified)

Collection start date 1982

Setting of birth – actual – other specified description

Specification

Definition The actual place where the birth occurred

Representation class Text Data type String

Format A(20) Field size 20

Location Episode record Position 28

Permissible values Permitted characters:
• 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 Only report the description of the place of birth if the place of birth is not one identified in the codeset of data element Setting of birth – actual.

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for Births where code 0008 Other – specify in Setting of birth – actual is
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>Birth centre</td>
</tr>
<tr>
<td>0003</td>
<td>Home (other)</td>
</tr>
<tr>
<td>0006</td>
<td>Home – Private midwife care</td>
</tr>
<tr>
<td>0007</td>
<td>Home – Public homebirth program</td>
</tr>
<tr>
<td>0008</td>
<td>Other - specify</td>
</tr>
<tr>
<td>0009</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

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

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

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Reported for All birth episodes
Related concepts (Section 2): None specified
Related data items (this section): Setting of birth – change of intent, Setting of birth – change of intent – reason, Setting of birth – actual

Administration
Principal data users Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Definition source NHDD
Codeset source NHDD (DHHS modified)
Collection start date 1999

Setting of birth – intended – other specified description

Specification
Definition The intended place of birth at the onset of labour
Representation class Text
Data type String
Format A(20)
Field size 20
Location Episode record
Position 26
Permissible values Permitted characters:
• 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

Only report the description of the intended place of birth if the intended place of birth is not one identified in the codeset of data element Setting of birth – intended.

Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for

When Code 0008 Other – specify is reported in Setting of birth – intended birth

Related concepts (Section 2):

None specified

Related data items (this section):

Setting of birth – intended

Related business rules (Section 4):

Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item

Administration

Principal data users

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source

NHDD


Codeset source

Not applicable

Collection start date 1999

Sex – baby

Specification

Definition

The biological distinction between a male and female baby

Representation class

Code

Data type Number

Format

N

Field size 1

Location

Episode record Position 97

Permissible values

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>Indeterminate</td>
</tr>
<tr>
<td>9</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide

Sex is the biological distinction between male and female.

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

Reported by

All Victorian hospitals where a birth has occurred (including birth
centres) and homebirth practitioners

Reported for
All birth episodes

Related concepts
None specified

(Section 2):

Related data items
Congenital anomalies – free text

(this section):

Related business
Mandatory to report data items, Sex – baby and Congenital
rules (Section 4):
anomalies – indicator conditionally mandatory data item

Administration

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

Definition source

Codeset source
NHDD  Collection start date  1982

Submission number

Specification

Definition
The number of times a particular piece of data is submitted or resubmitted

Representation class
Identifier  Data type  String

Format
NN  Field size  2

Location
Header record, File name  Position  Not applicable

Permissible values
Range: one to 99 (inclusive)

Reporting guide
Software-system generated. The incrementing submission number must cycle back to ‘01’ each time the Data submission identifier (submission end date) changes.

Reported by
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for
Each VPDC electronic submission file

Related concepts
None specified

(Section 2):

Related data items
None specified

(this section):

Related business
None specified

None specified
rules (Section 4):

Administration

Principal data users Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Codeset source DHHS Collection start date 2009

Surname / family name – mother

Specification

Definition The surname of the mother
Representation class Text Data type String
Format A(40) Field size 40
Location Episode record Position 8
Permissible values Permitted characters:
• 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 Surname of the mother
Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Reported for All birth episodes
Related concepts (Section 2): None specified
Related data items (this section): First given name – mother
Related business rules (Section 4): Mandatory to report data items
Surname / family name – paediatrician

**Specification**

- **Definition**: The surname of the paediatrician responsible for the care of the baby
- **Representation class**: Text
- **Data type**: String
- **Format**: A(40)
- **Field size**: 40
- **Location**: Episode record, Position 109
- **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 surname of the paediatrician. If the baby is not referred to a paediatrician, leave blank. If the birth is a termination for congenital abnormality, report the surname of the medical officer responsible for the woman’s care.

** Reported by**: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**: All birth episodes where a congenital anomaly is present and/or the baby is referred to a paediatrician

**Related concepts (Section 2)**: None specified

**Related data items (this section)**: Congenital anomalies – free text, Congenital anomalies – indicator, First given name – paediatrician

**Related business rules (Section 4)**: None specified

---

**Administration**

- **Principal data users**: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Definition source: DHHS

Codeset source: Not applicable
Collection start date: 2009

**Time of birth**

**Specification**

- **Definition**: The time of birth measured as hours and minutes using a 24-hour clock
- **Representation class**: Time
- **Data type**: Date/time
- **Format**: HHMM
- **Field size**: 4
- **Location**: Episode record
- **Position**: 96
- **Permissible values**: A valid time value using a 24-hour clock (not 0000 or 2400)
  - **Code**: 9999
  - **Descriptor**: Not stated / inadequately described
- **Reporting guide**: Report hours and minutes using a 24-hour clock
- **Reported by**: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
- **Reported for**: All birth episodes
- **Related concepts (Section 2)**: None specified
- **Related data items (this section)**: Time of onset of labour, Time of onset of second stage of labour, Time of rupture of membranes
- **Related business rules (Section 4)**: Date and time data item relationships, Mandatory to report data items

**Administration**

- **Principal data users**: Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- **Definition source**: DHHS

- **Codeset source**: DHHS
Collection start date: 2009
Time of onset of labour

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The time of onset of labour measured as hours and minutes using a 24-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Time</td>
</tr>
<tr>
<td>Format</td>
<td>HHMM</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid time value using a 24-hour clock (not 0000 or 2400)</td>
</tr>
</tbody>
</table>

**Code** | **Descriptor**
--- | ---
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.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts** (Section 2):
None specified

**Related data items** (this section):
Method of birth

**Related business rules** (Section 4):
Date and time data item relationships, Labour type 'Woman in labour' and associated data items valid combinations, Labour type 'Woman not in labour' and associated data items valid combinations, Mandatory to report data items

Administration

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

**Definition source**
DHHS

**Version**
1. January 2009

**Codeset source**
DHHS

**Collection start date**
2009
# Time of onset of second stage of labour

## Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The time of the start of the second stage of labour measured as hours and minutes using a 24-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Time</td>
</tr>
<tr>
<td>Format</td>
<td>HHMM</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid time value using a 24-hour clock (not 0000 or 2400).</td>
</tr>
</tbody>
</table>

### Code Descriptions

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>8888</td>
<td>No labour</td>
</tr>
<tr>
<td>9999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

### Reporting guide

Report hours and minutes using a 24-hour clock. Code 8888 No second stage of labour is to be used when the mother has a planned or unplanned caesarean section and did not reach second stage of labour.

In the instance of a woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:
1. Had she had a show or ROM?
2. Had she vomited at all within the hour prior to giving birth or think 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 the 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 (including birth centres) and homebirth practitioners

### Reported for

All birth episodes

### Related concepts (Section 2):

None specified

### Related data items (this section):

Method of birth, Time of onset of labour

### Related business rules (Section 4):

Date and time data item relationships, Labour type 'Woman in labour' and associated data items valid combinations, Labour type 'Woman not in labour' and associated data items valid combinations, Mandatory to report data items
## Administration

<table>
<thead>
<tr>
<th>Principal data users</th>
<th>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition source</td>
<td>DHHS</td>
</tr>
<tr>
<td>Codeset source</td>
<td>DHHS</td>
</tr>
<tr>
<td>Collection start date</td>
<td>2009</td>
</tr>
</tbody>
</table>

## Time of rupture of membranes

### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>The time at which the mother’s membranes ruptured (spontaneously or artificially) measured as hours and minutes using a 24-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Time</td>
</tr>
<tr>
<td>Format</td>
<td>HHMM</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>A valid time value using a 24-hour clock (not 0000 or 2400)</td>
</tr>
</tbody>
</table>

### Code Descriptor

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>7777</td>
<td>No record of rupture of membranes</td>
</tr>
<tr>
<td>8888</td>
<td>No labour</td>
</tr>
<tr>
<td>9999</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

### Reporting guide

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

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

### Reported by

All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.
Reported for: All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Method of birth, Time of onset of labour, Time of onset of second stage of labour

Related business rules (Section 4): Date and time data item relationships, Labour type ‘Woman in labour’ and associated data items valid combinations, Labour type ‘Woman not in labour’ and associated data items valid combinations, Mandatory to report data items

Administration

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

Definition source: DHHS

Codeset source: DHHS

Collection start date: 2009

Time to established respiration

Specification

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

Representation class: Total

Data type: Number

Format: NN

Field size: 2

Location: Episode record

Position: 104

Permissible values: Range: zero to 30 (inclusive)

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>Newborn does not take a breath is intubated and ventilated</td>
</tr>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

Reporting guide: Most newborns establish spontaneous respirations within one to two minutes of birth. If spontaneous respirations are not established within this time, active intervention is required. Round up the time the baby took to establish regular spontaneous breathing to the next whole minute. For example a baby who takes 2.5 minutes to establish regular breathing should have three minutes recorded.

If the baby breathes immediately and continues to have regular spontaneous breathing upon delivery the TER is one minute. If the baby does not take a breath and is intubated and ventilated and accurate assessment of time is not possible report 98 Newborn does not take a breath – is intubated and ventilated. If the baby is born
before arrival, where the time to established respiration is unknown report 99 Not stated / inadequately described.

For stillbirth episodes, report the time to established respiration as 00.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
None specified

**Related data items (this section):**
Apgar score at one minute, Apgar score at five minutes, Birth status, Resuscitation method – drugs, Resuscitation method – mechanical

**Related business rules (Section 4):**
Birth status 'Stillborn' and associated data items valid combinations, Mandatory to report data items, Time to established respiration and Resuscitation method – mechanical valid combinations

---

**Administration**

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

**Definition source**
DHHS

**Version**
1. January 1982

**Codeset source**
DHHS

**Collection start date**
1982

---

**Total number of previous abortions – induced**

**Specification**

**Definition**
The total number of previous pregnancies resulting in induced abortion (termination of pregnancy before 20 weeks’ gestation)

**Representation class**
Total

**Data type**
Number

**Format**
NN

**Field size**
2

**Location**
Episode record

**Position**
39

**Permissible values**
Range: zero to 30 (inclusive)

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
Report the number of previously induced abortions. Aborted pregnancies of multiple foetuses should be counted as only one pregnancy. That is, a twin pregnancy, for example, is counted as one pregnancy. In the case of No previous abortions – induced, report 0 No previous abortions – induced.
Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for All birth episodes

Related concepts (Section 2): None specified

Related data items (this section): Gravidity

Related business rules (Section 4): Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations

Administration

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

Definition source DHHS

Codeset source DHHS

Collection start date 1982

Total number of previous abortions – spontaneous

Specification

Definition The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks’ gestational age, or less than 400 grams birthweight if gestational age is unknown, and showed no sign of life after birth)

Representation class Total Data type Number

Format NN Field size 2

Location Episode record Position 38

Permissible values Range: zero to 30 (inclusive)

Code Descriptor
99 Not stated / inadequately described

Reporting guide Report the number of previous spontaneous abortions. Aborted pregnancies of multiple foetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy. In the case of no previous abortions – spontaneous, report 0 No previous abortions – spontaneous.

Reported by All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners
Administration

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

Definition source
DHHS

Codeset source
DHHS
Collection start date 1982

Total number of previous caesareans

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Total number of previous pregnancies where the method of delivery was caesarean section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Total</td>
</tr>
<tr>
<td>Format</td>
<td>NN</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Range: zero to 9 (inclusive)</td>
</tr>
</tbody>
</table>

**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 (including birth centres) and homebirth practitioners

Reported for
All birth episodes
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**
99

**Descriptor**
Not stated / inadequately described

**Reporting guide**
Report the number of previous ectopic pregnancies. Ectopic pregnancies of multiple foetuses 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 (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes where a previous ectopic outcome occurred.

**Related concepts**
None specified

**Related data items**
Gravidity

**Related business rules**
Gravidity ‘Primigravida’ and associated data items valid
Total number of previous live births

**Specification**

**Definition**
The total number of live births that resulted from each previous pregnancy and who lived at least 28 days.

**Representation class**
Total

**Data type**
Number

**Format**
NN

**Field size**
2

**Location**
Episode record

**Position**
34

**Permissible values**
Range: zero to 20 (inclusive)

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

**Reporting guide**
Report the number of known previous live births, excluding those who die in the first 28 days. For those who die in the first 28 days, they are reported as a neonatal death. This includes all multiples. For example live born twins are reported as two.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
Live birth

**Related data items (this section):**
Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans

**Related business rules (Section 4):**
Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items
Administration

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

Definition source: DHHS

Codeset source: DHHS

Collection start date: 1982

Total number of previous neonatal deaths

Specification

Definition: The total number of live births that died during the first 28 days of life from each previous pregnancy

Representation class: Total

Data type: Number

Format: NN

Field size: 2

Location: Episode record

Position: 37

Permissible values: Range: zero to 20 (inclusive)

Reporting guide: A neonatal death refers to the death of a live born which occurs during the first 28 days of life. A live born resulting in a neonatal death should be recorded only as a neonatal death. This includes all multiples. For example twins that died during the first 28 days of life are reported as two.

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): Neonatal death

Related data items (this section): Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans

Related business rules (Section 4): Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items

Administration
Total number of previous stillbirths (foetal deaths)

**Specification**

**Definition**
The total number of stillbirths from previous pregnancies (at least 20 weeks gestational age or 400g birthweight)

**Representation class**
<table>
<thead>
<tr>
<th>Code</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NN</td>
<td>Field size</td>
<td>2</td>
</tr>
</tbody>
</table>

**Location**
Episode record Position 36

**Permissible values**
Range: zero to 20 (inclusive)

**Code**  **Descriptor**
99  Not stated / inadequately described

**Reporting guide**
This includes all multiples. For example, stillborn twins are reported as two.

**Reported by**
All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners

**Reported for**
All birth episodes

**Related concepts (Section 2):**
Stillbirth (foetal death)

**Related data items (this section):**
Gravidity, Last birth – caesarean section indicator, Total number of previous caesareans

**Related business rules (Section 4):**
Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations, Parity and related data items

**Administration**

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

**Definition source**
DHHS  **Version**  1. January 1982

**Codeset source**
DHHS  **Collection start date**  1982
Total number of previous unknown outcomes of pregnancy

Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Total number of previous pregnancies where the outcome is unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Representation class</th>
<th>Total</th>
<th>Data type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Format</td>
<td>NN</td>
<td>Field size</td>
<td>2</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
<td>Position</td>
<td>41</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Range: zero to 20 (inclusive)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Not stated / inadequately described</td>
</tr>
</tbody>
</table>

| Reporting guide | Record the number of previous outcomes that do not meet the criteria of live birth, stillbirth, neonatal death, spontaneous or induced abortions or ectopic pregnancies. |

| Reported by | All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners |

| Reported for | All birth episodes |

| Related concepts (Section 2): | None specified |

| Related data items (this section): | Gravidity |

| Related business rules (Section 4): | Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and related data items, Mandatory to report data items, Outcome of last pregnancy and associated data item valid combinations |

Administration

<table>
<thead>
<tr>
<th>Principal data users</th>
<th>Consultative Council on Obstetric and Paediatric Mortality and Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition source</td>
<td>DHHS</td>
</tr>
<tr>
<td>Codeset source</td>
<td>DHHS</td>
</tr>
<tr>
<td>Collection start date</td>
<td>1982</td>
</tr>
</tbody>
</table>
## Transaction type flag

### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>An indicator that identifies the type of transaction to the VPDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation class</td>
<td>Code</td>
</tr>
<tr>
<td>Format</td>
<td>A</td>
</tr>
<tr>
<td>Location</td>
<td>Episode record</td>
</tr>
<tr>
<td>Permissible values</td>
<td>Code</td>
</tr>
<tr>
<td></td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>U</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Reporting guide</td>
<td>Software-system generated.</td>
</tr>
<tr>
<td>Reported by</td>
<td>All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners</td>
</tr>
<tr>
<td>Reported for</td>
<td>Each VPDC electronic submission file</td>
</tr>
<tr>
<td>Related concepts (Section 2):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related data items (this section):</td>
<td>None specified</td>
</tr>
<tr>
<td>Related business rules (Section 4):</td>
<td>Mandatory to report data items</td>
</tr>
</tbody>
</table>

### Administration

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

### Transfer destination – baby

### Specification

<table>
<thead>
<tr>
<th>Definition</th>
<th>Identification of the hospital campus to which the baby is transferred following separation from this hospital campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation</td>
<td>Code</td>
</tr>
</tbody>
</table>
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

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
Permissible values

Please refer to ‘Hospital Code Table’ located at

Code  Descriptor
9999  Not stated / inadequately described

Reporting guide
For mothers transferred to Hospital in the Home (HITH), the
transfer destination is the campus code of the campus providing the
HITH service.

Reported by
All Victorian hospitals where a birth has occurred (including birth
centres) and homebirth practitioners

Reported for
All episodes where Separation status – mother is code 3 Transferred
or 4 Transferred and died

Related concepts
(Section 2): Transfer

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

Related business
rules (Section 4): Separation status – mother and Transfer destination – mother –
conditionally mandatory data item

Administration

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

Definition source
DHHS

2. January 2009

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  Descriptor
2009
2015

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 (including birth centres) and homebirth practitioners.

Reported for: Each VPDC electronic submission file.

Related concepts (Section 2): None specified.

Related data items (this section): None specified.

Related business rules (Section 4): Mandatory to report data items.

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**Administration**

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

Definition source: DHHS.


Codeset source: DHHS.

Collection start date: 2009.

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**Weight – self-reported – mother**

**Specification**

Definition: Mother’s self-reported weight (body mass) about the time of conception.

Representation class: Total. Data type: Number.

Format: NN[N]. Field size: 3.


Permissible values: Range: 20 to 300 (inclusive).

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

Reporting guide: A weight in kilograms (kg).

Reported by: All Victorian hospitals where a birth has occurred (including birth centres) and homebirth practitioners.

Reported for: All birth episodes.

Related concepts (Section 2): None specified.
Related data items (this section):
Height – self-reported – mother

Related business rules (Section 4):
Mandatory to report data items

Administration

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

Definition source: NHDD

Codeset source: NHDD
Collection start date: 2009