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| Specifications for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 July 2022 – Errata |
| 6 April 2022 |
| OFFICIAL |

Contents

[Executive summary 2](#_Toc100064841)

[Orientation to this document 3](#_Toc100064842)

[Summary table of changes – Errata 3](#_Toc100064843)

[Other proposals that are not proceeding 4](#_Toc100064844)

[Section 3 Data definitions 5](#_Toc100064845)

[Antenatal mental health risk screening status (new) 5](#_Toc100064846)

[Date of completion of last pregnancy 7](#_Toc100064847)

[Edinburgh Postnatal Depression Scale score (new) 9](#_Toc100064848)

[Family violence screening status (new) 11](#_Toc100064849)

[Hepatitis B antenatal screening – mother (new) 12](#_Toc100064850)

[HIV antenatal screening – mother (new) 13](#_Toc100064851)

[Maternity model of care – antenatal (new) 14](#_Toc100064852)

[Maternity model of care – at onset of labour or non-labour caesarean section (new) 16](#_Toc100064853)

[Syphilis antenatal screening – mother (new) 18](#_Toc100064854)

[Section 4 Business rules 19](#_Toc100064855)

[### Analgesia for labour~~operative delivery~~ – type valid codes 19](#_Toc100064856)

[Date and time data item relationships 19](#_Toc100064857)

[###Date of completion of last pregnancy, Date of birth – baby and Estimated gestation valid combinations [Warning error] 21](#_Toc100064858)

[Gravidity ‘Multigravida’ conditionally mandatory data items 21](#_Toc100064859)

[### Hypertensive disorder during pregnancy, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complication – ICD-10-AM code, Postpartum complications – ICD-10-AM code valid combinations 22](#_Toc100064860)

[### Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations 24](#_Toc100064861)

[### Patient identifier – baby not reported 24](#_Toc100064862)

# Executive summary

The document ‘Specifications for revisions to the Victorian Perinatal Data Collection (VPDC) for 1.7.2022’ was released in December 2021, setting out changes as known at that time. It has since become apparent that clarification is required in the Reporting guide of some new data elements, and correction required of some errors in business rules set out in that document: those changes are included in this ‘Specifications for revisions to the VPDC for 1.7.2021 – **Errata**’ document, and are listed in the sequence in which they will appear in the VPDC manual. They comprise:

* Notice of a proposed change that is not proceeding
* An additional supplementary code for Maternity Model of care – antenatal
* An additional supplementary code for Maternity Model of care – at onset of labour or non-labour caesarean section
* Additional wording in the Reporting guide for new data elements:
- Antenatal mental health risk screening status
- Edinburgh Postnatal Depression Scale score
- Family violence screening status
- Hepatitis B antenatal screening – mother
- HIV antenatal screening – mother
- Maternity model of care – antenatal
- Maternity model of care – at onset of labour or non-labour caesarean section
- Syphilis antenatal screening – mother
* Correction of error in the title of new business rule ‘Analgesia for labour – type valid codes
* A note added to existing business rule ‘Date and Time relationships’ to clarify the treatment of Date values 99999999, 88888888 and 77777777, and Time values 9999, 8888 and 7777
* Amendment of new business rule ‘Date of completion of last pregnancy, Date of birth – baby and Estimated gestation valid combinations’ to a ‘Warning error’ level
* Correction of error in existing business rule ‘Gravidity ‘Multigravida’ conditionally mandatory data items’
* Correction of error in new business rule ‘Hypertensive disorder during pregnancy, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complication – ICD-10-AM code, Postpartum complications – ICD-10-AM code valid combinations
* Addition of new codes in new business rule ‘Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations
* Correction of error in new business rule ‘Patient identifier – baby not reported’

**The entries in this Errata replace only the corresponding entries in the Specifications released in December 2021,** with all other aspects of those Specifications remaining as previously published. Other changes set out in that document are **not** repeated here, but remain accessible at the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>, where this Errata document will also be available. **Together, the Specifications document and this Errata document list all changes to be made to the VPDC effective on and from 1 July 2022.**

Any further changes required during the year, for example to reference files such as the postcode locality file, data validation rules or supporting documentation, will be advised at the time.

An updated VPDC manual will be published before 1 July 2022. Until then, the current VPDC manual, accessible at the VPDC website, along with the Specifications for revisions to the VPDC for 1.7.2022 **and** this Specifications for revisions to the VPDC for 1.7.2021 – Errata, form the data submission specifications for births on and from 1.7.2022.

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

Submission of **test files in 2022-23 file format is strongly recommended** prior to submitting any July 2022 data. Test files must include the **filename extension ‘\_TEST’** and be submitted via the [non-prod MFT portal](https://prs2np-mft.prod.services/) <https://prs2np-mft.prod.services/>, as set out in section 5 of the VPDC manual. Please contact the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au> **prior to submitting any test file.** Test files will be acceptedbetween 2.5.2022 and 24.6.2022, or at other times by prior arrangement.

## Orientation to this document

Changes to entries in the Specifications for revisions to the VPDC from 1.7.2022 are highlighted in aqua.

Annotations used in the Specifications for revisions to the VPDC from 1.7.2022, and retained in this Errata:

New data items are marked as (new).

Changes to existing data items are highlighted in green.

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

New validations/business rules are marked ###

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

Changes are shown under the relevant VPDC manual section headings.

# Summary table of changes – Errata

| **Nature of entry/ Change** | **Data element** | **VPDC manual sections changed** |
| --- | --- | --- |
| **Section 3** | **Section 4** | **Section 5** |
| Reporting guide | Antenatal mental health risk screening status | Checkmark |  |  |
| Validation level | Date of completion of last pregnancy | Checkmark | Checkmark |  |
| Reporting guide | Edinburgh Postnatal Depression Scale score | Checkmark |  |  |
| Reporting guide | Family violence screening status | Checkmark |  |  |
| Reporting guide | Hepatitis B antenatal screening - mother | Checkmark |  |  |
| Reporting guide | HIV antenatal screening - mother | Checkmark |  |  |
| Extra code, Reporting guide | Maternity model of care - antenatal | Checkmark | Checkmark |  |
| Extra code, Reporting guide | Maternity model of care – at onset of labour or non-labour caesarean section | Checkmark | Checkmark |  |
| Reporting guide | Syphilis antenatal screening - mother | Checkmark |  |  |
| Clarification of business rule | Analgesia for labour – type valid codes |  | Checkmark |  |
| Clarification of business rule | Date and time data item relationships |  | Checkmark |  |
| Validation level | Date of completion of last pregnancy, Date of birth – baby and Estimated gestation valid combinations |  | Checkmark |  |
| Correction of error in business rule | Gravidity ‘multigravida’ conditionally mandatory data items |  | Checkmark |  |
| Correction of error in business rule published in Specifications | Hypertensive disorder during pregnancy, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code, Postpartum complications – ICD-10-AM valid combinations |  | Checkmark |  |
| Change to new business rule | Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations |  | Checkmark |  |
| Change to new business rule | Patient identifier – baby not reported |  | Checkmark |  |

# Other proposals that are not proceeding

The following proposal was received and considered by the CCOPMM, however it was determined that it would not be implemented for 1.7.2022:

Amend existing data item: Labour type [this proposal was to merge two existing codes]

# Section 3 Data definitions

## Antenatal mental health risk screening status (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | Whether a woman has received screening for mental health risk using a validated screening tool during the antenatal period.  |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 156 |
| **Permissible values** | **Code Descriptor**1. Yes

2 Not offered3 Declined9 Not stated stated/inadequately described |
| **Reporting guide** | Antenatal screening for mental health risk is conducted using a validated screening tool, which is an instrument that has been psychometrically tested for reliability, validity and sensitivity, for example the Edinburgh Postnatal Depression Scale (EPDS).Code 1 YesThe woman was screened using a validated screening toolReport whether the screening was conducted at the same health service where the birth occurs, or at another service or health care providerCode 2 Not offeredThe woman was not offered screening using a validated screening toolReport also when screening was not offered at the time of birth, or in other circumstances where a care plan was interrupted due to an atypical course during the pregnancy, for example a precipitate labour or premature birthCode 3 DeclinedThe woman declined screening for mental health risk.Report also when screening was offered to and accepted by the woman, but could not be completed, for example due to safety risk |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None specified |
| **Related data items (this section):** | Edinburgh Postnatal Depression Scale score; Presence or history of mental health condition - indicator  |
| **Related business rules (Section 4):** | \*Mandatory to report data items |

**Administration**

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| --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | ~~DHHS~~ AIHW | **Version** | 1. July 2022
 |
| **Codeset source** | ~~DHHS~~ AIHW | **Collection start date** | 2022 |

## 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**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)99YYYY Year known, month unknown  (where YYYY = year)999999 Not stated / inadequately described |
| **Reporting guide** | Record the date of completion ~~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.99CCYY should not be reported if the value of CCYY is the same as, or the year preceding, the value of CCYY reported in Date of birth – baby.Regardless of the format reported, the value of the year component (CCYY) cannot be greater than the value of CCYY reported in Date of birth – baby.If this is the first pregnancy, that is, there is no preceding pregnancy, do not report a value, leave blank. |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | Birth episodes where Gravidity is greater than 01 Primigravida |
| **Related concepts (Section 2):** | None specified |
| **Related data items (this section):** | Gravidity; Parity |
| **Related business rules (Section 4):** | \*Date and time data item relationships; ###Date of completion of last pregnancy, Date of birth – baby and Estimated gestational age valid combinations [Warning validation]; \*Gravidity ‘Multigravida’ conditionally mandatory data items; \*Gravidity ‘Primigravida’ and associated data items valid combinations; Parity and associated data items valid combinations |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | NHDD | **Version** | 1. January 19822. January 19993. July 2022 |
| **Codeset source** | NHDD | **Collection start date** | 1982 |

## Edinburgh Postnatal Depression Scale score (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | The degree of the woman’s possible symptoms of depression at an antenatal care visit, as represented by an Edinburgh Postnatal Depression Scale (EPDS) score |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N[N] | **Field size** | 2 |
| **Location** | Episode record | **Position** | 157 |
| **Permissible values** | Valid score range: 0 to 30 inclusive**Code Description**77 Edinburgh Postnatal Depression Scale not evaluated at any antenatal care visit during this pregnancy98 Unknown EPDS score99 Not stated stated/inadequately described |
| **Reporting guide** | Report the total score on the Edinburgh Postnatal Depression Scale (EPDS) derived at an antenatal care visit.This data may be self-reported or derived from medical information.If an EPDS score was derived during the antenatal period by a service other than the antenatal care provider (eg at a mental health service), and there was no EPDS score derived during any antenatal care visits, report the EPDS score derived by the other care provider.Where there is more than one EPDS score taken during this pregnancy, report the highest score. 77 Edinburgh Postnatal Depression Scale not evaluated at any  antenatal care visit during this pregnancy Report this code also where:  - the woman was offered, and declined, the EPDS evaluation - the woman had no antenatal care - an assessment was attempted but not completed |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None stated |
| **Related data items (this section):** | Antenatal mental health risk screening status; Presence or history of mental health condition – indicator  |
| **Related business rules (Section 4):** | \*Mandatory to report data items |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | ~~DHHS~~ AIHW | **Version** | 1. July 2022 |
| **Codeset source** | ~~DHHS~~ AIHW | **Collection start date** | July 2022 |

## Family violence screening status (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | Whether the woman has received screening for family violence  |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 159 |
| **Permissible values** | **Code Description**1 Yes2 Not offered3 Declined9 Not stated stated/inadequately described |
| **Reporting guide** | Screening for family violence is conducted using a validated screening tool, which is an instrument that has been psychometrically tested for reliability, validity and sensitivity eg, the Humiliation, Afraid, Rape, Kick (HARK) tool.Code 1 YesThe woman was screened using a validated screening toolCode 2 Not offeredThe woman was not offered screening using a validated screening toolCode 3 DeclinedThe woman declined screening using a validated screening toolReport also when screening was offered to and accepted by the woman, but could not be completed, for example due to safety risk, or the woman declined to respond to further questions |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None stated |
| **Related data items (this section):** | None stated |
| **Related business rules (Section 4):** | \*Mandatory to report data items |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | ~~DHHS~~ AIHW | **Version** | 1. July 2022 |
| **Codeset source** | ~~DHHS~~ AIHW | **Collection start date** | July 2022 |

## Hepatitis B antenatal screening – mother (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | Whether the woman had a hepatitis B serology (HBsAg) screening test during this pregnancy, and if so, whether the result was positive or negative |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 160 |
| **Permissible values** | **Code Descriptor**1 Hepatitis serology (HBsAg) was negative2 Hepatitis serology (HBsAg) was positive3 Hepatitis serology (HBsAg) was not performed at any time during this pregnancy 9 Not stated/inadequately described |
| **Reporting guide** | Report the results of hepatitis B screening in all pregnant woman. Where a hepatitis serology screening test was conducted, but the result cannot be located or is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9. |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None stated |
| **Related data items (this section):** | None stated |
| **Related business rules (Section 4):** | \*Mandatory to report data items |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | DH~~HS~~ | **Version** | 1. July 2022 |
| **Codeset source** | DH~~HS~~ | **Collection start date** | July 2022 |

## HIV antenatal screening – mother (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | Whether the mother had an HIV antenatal screening serology test during this pregnancy, and if so, the result |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 161 |
| **Permissible values** | **Code Descriptor**1. HIV serology was performed: result was negative
2. HIV serology was performed: result was positive
3. No HIV serology performed at any time during this pregnancy

9 Not stated stated/inadequately described |
| **Reporting guide** | Report whether HIV serology screening was performed during this pregnancy, and if so, report the laboratory result. Where a HIV serology screening test was conducted, but the result cannot be located or is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9. |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None stated |
| **Related data items (this section):** | None stated |
| **Related business rules (Section 4):** | \*Mandatory to report data items |

**Administration**

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| --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | DH~~HS~~ | **Version** | 1. July 2022 |
| **Codeset source** | DH~~HS~~ | **Collection start date** | July 2022 |

## Maternity model of care – antenatal (new)

**Specification**

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

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | ~~DHHS~~ AIHW | **Version** | 1. July 2022
 |
| **Codeset source** | ~~NHDD~~ AIHW (DH~~HS~~ modified) | **Collection start date** | July 2022 |

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

**Specification**

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

**Administration**

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

## Syphilis antenatal screening – mother (new)

**Specification**

|  |  |
| --- | --- |
| **Definition** | Whether the mother had any syphilis serology testing during this pregnancy, and if so, the results |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 162 |
| **Permissible values** | **Code Descriptor**1. Syphilis serology was negative on all testing undertaken during this pregnancy
2. Syphilis serology was positive at any point during this pregnancy
3. Syphilis serology was not performed at any time during this pregnancy

9 Not stated stated/inadequately described |
| **Reporting guide** | Report the status based on the laboratory results of all syphilis screening during this pregnancy.Where syphilis serology screening was conducted, but no result can be located or it is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9. |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| **Reported for** | All birth episodes |
| **Related concepts (Section 2):** | None specified |
| **Related data items (this section):** | None specified |
| **Related business rules (Section 4):** | \*Mandatory to report data item |

**Administration**

|  |  |
| --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| **Definition source** | DH~~HS~~ | **Version** | 1. July 2022
 |
| **Codeset source** | DH~~HS~~ | **Collection start date** | July 2022 |

# Section 4 Business rules

## ### Analgesia for labour~~operative delivery~~ – type valid codes

Cannot report codes 4 Epidural or caudal block **and** code 5 Spinal block **with** code 7 Combined spinal-epidural block

## Date and time data item relationships

Where a valid date\* and/or time\* is reported in the data elements listed in columns 1 and 3 below, validations check the data reflect logical sequence as indicated in the Relationship column:

|  |  |  |
| --- | --- | --- |
| **Data item 1:** | **Relation-ship:** | **Data item 2:** |
| Date and time of birth – baby  | ≥ | Date and time of onset of Labour |
| Date and time of birth – baby  | ≥ | Date and time of onset of second stage of labour |
| Date and time of birth – baby  | ≥ | Date and time of rupture of membranes |
| Date and time of birth – baby  | ≥ | Date and time of decision for unplanned caesarean section |
| Date and time of onset of labour  | < | Date and time of onset of second stage of labour |
| Date of admission – mother | > | Date of birth – mother |
| Date of birth – mother | < | Date ~~and time~~ of onset of labour |
| Date of birth – mother | < | Date ~~and time~~ of onset of second stage of labour |
| Date of birth – mother | < | Date ~~and time~~ of rupture of membranes |
| Date of birth – mother | < | Date of birth – baby |
| Date of birth – mother | < | Date ~~and time~~ of decision for unplanned caesarean section |
| Date of completion of last pregnancy | < | Date ~~and time~~ of onset of labour |
| Date of completion of last pregnancy | < | Date ~~and time~~ of onset of second stage of labour |
| Date of completion of last pregnancy | < | Date ~~and time~~ of rupture of membranes |
| Date of completion of last pregnancy | < | Date of admission – mother |
| Date of completion of last pregnancy | < | Date of birth – baby |

(Business rule table continues over page)

|  |  |  |
| --- | --- | --- |
| **Data item 1:** | **Relation-ship:** | **Data item 2:** |
| Date of completion of last pregnancy | > | Date of birth – mother |
| Date of completion of last pregnancy | < | Date ~~and time~~ of decision for unplanned caesarean section |
| Estimated date of confinement | > | Date of birth – mother |
| Estimated date of confinement | > | Date of completion of last pregnancy |
| Separation date – baby | > | Date of birth – mother |
| Separation date – baby | > | Date of completion of last pregnancy |
| Separation date – baby | ≥ | Date ~~and time~~ of onset of labour |
| Separation date – baby | ≥ | Date ~~and time~~ of onset of second stage of labour |
| Separation date – baby | ≥ | Date ~~and time~~ of rupture of membranes |
| Separation date – baby | ≥ | Date of admission – mother |
| Separation date – baby | ≥ | Date of Birth – baby |
| Separation date – baby | ≥ | Date ~~and time~~ of decision for unplanned caesarean section |
| Separation date – mother | > | Date of Birth – mother |
| Separation date – mother | > | Date of completion of last pregnancy |
| Separation date – mother | ≥ | Date ~~and time~~ of onset of labour  |
| Separation date – mother | ≥ | Date ~~and time~~ of onset of second stage of labour |
| Separation date – mother | ≥ | Date ~~and time~~ of rupture of membranes |
| Separation date – mother | ≥ | Date of admission – mother |
| Separation date – mother | ≥ | Date of birth – baby |
| Separation date – mother | ≥ | Date ~~and time~~ of decision for unplanned caesarean section |

 \*Date other than 99999999 or 88888888 or 77777777 or 999999 or 99CCYY;
 \*Time other than 9999 or 8888 or 7777

## ###Date of completion of last pregnancy, Date of birth – baby and Estimated gestation valid combinations [Warning error]

|  |  |  |
| --- | --- | --- |
| **Where Date of completion of last pregnancy is reported in format:** | **And Date of birth – baby has CCYY:** | **Then:** |
| 99CCYY | equal to or 1 year later than CCYY in Date of completion of last pregnancy | A warning error will be generated: please seek more accurate value of MM for Date of completion of last pregnancy |
| MMCCYY | equal to or 1 year later than CCYY in Date of completion of last pregnancy | The value of DD in Date of completion of last pregnancy will be assumed to be 16 for the purposes of this validation only\* |
| \*MMCCYY **or** DDMMCCYY | equal to or 1 year later than CCYY in Date of completion of last pregnancy | Date of birth – baby minus Date of completion of last pregnancy must be greater than ((the sum of Estimated gestational age + 6) multiplied by 7): if fails, record rejected |
| 99CCYY **or** MMCCYY **or** DDMMCCYY | CCYY that is 2 or more years later than CCYY in Date of completion of last pregnancy | Accept reported value of Date of completion of last pregnancy |

## Gravidity ‘Multigravida’ conditionally mandatory data items

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

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

|  |  |  |
| --- | --- | --- |
| **Hypertensive disorder during pregnancy** | **May not report any code below:** | **In any of the following data elements:** |
| Code 1 Eclampsia | O12O120O121O122 | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |
| Code 2 Pre-eclampsia | O12O120O121O122 | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |
| Code 3 Gestational hypertension | O10O11O12O120O121O122O16 | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |
| Code 4 Chronic hypertension | O12O120O121O122O13O16 | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |

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|  |  |  |
| --- | --- | --- |
| **Hypertensive disorder during pregnancy** | **May not report any code below:** | **In any of the following data elements:** |
| Code 7 Hypertension, not further specified | O10O11O12O120O121O122O13~~O16~~ | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |
| Code 8 No hypertensive disorder during this pregnancy**Or**Code 9 Not stated/ inadequately described | O10O11~~O12~~~~O120~~~~O121~~~~O122~~O13O14O140O141O142O149O15O150O151O152O159O16 | Events of labour and birth – ICD-10-AM code **or**Indication for induction (main reason) – ICD-10-AM code **or**Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code **or**Maternal medical conditions – ICD-10-AM code **or**Obstetric complications – ICD‑10‑AM code **or**Postpartum complications – ICD‑10‑AM code |

## ### Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations

|  |  |  |
| --- | --- | --- |
| **Where Maternity model of care – antenatal is reported as:** | **Maternity model of care – at onset of labour or non-labour caesarean section must be:** | **And Number of antenatal care visits must be:** |
| NNNNNN (a valid Maternity model of care code) **or**999994 Planned homebirth with care from a registered private homebirth midwife **or**988888 Majority of antenatal care at a health service interstate **or**988899 Majority of antenatal care at a health service in another country | NNNNNN (a valid Maternity model of care code) **or**999994 Planned homebirth with care from a registered private homebirth midwife **or**988888 Majority of antenatal care at a health service interstate **or**988899 Majority of antenatal care at a health service in another country | Greater than 0 |
| ~~9~~999997 No antenatal care | ~~9~~999997 No antenatal care | 0 |
| 999999 Not stated/ inadequately described | 999999 Not stated/ inadequately described | 99 Not stated/ inadequately described |

## ### Patient identifier – baby not reported

|  |  |  |
| --- | --- | --- |
| **Where Birth status is:** | **And Patient identifier – baby**  | **Then** |
| 1 Live born | Not reported (is blank) | A Warning error message will be returned: Please report Patient identifier – baby for live births |
| 2 Stillborn (occurring before labour) **or**3 Stillborn (occurring during labour) **or**4 Stillborn (timing of occurrence unknown) | Should be blank (not required) | Reporting of Patient identifier – baby is correct |
| 9 Not stated/ inadequately described | Reported **or** Not reported (is blank) | A Rejection error message will be returned: Please report a Birth status code that indicates the baby’s birth outcome [due to Birth status ~~not~~ being reported as code 9 Not stated/inadequately described] |

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