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| Specifications for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 July 2022 |
| December 2021 |
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# Executive Summary

The changes to be made to the Victorian Perinatal Data Collection (VPDC) for births on and from 1 July 2022 are summarised below:

**Amend data definition** (Section 2, VPDC manual):

* Labour type

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

* Antenatal mental health risk screening status
* Edinburgh Postnatal Depression Scale score
* Family violence screening status
* Gestation at third COVID19 vaccination during this pregnancy
* Hepatitis B antenatal screening – mother
* HIV antenatal screening – mother
* Hypertensive disorder during pregnancy
* Maternity model of care – antenatal
* Maternity model of care – at onset of labour or non-labour caesarean section
* Presence or history of mental health condition – indicator
* Syphilis antenatal screening - mother

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

* Birth presentation
* COVID19 vaccination during this pregnancy
* COVID19 vaccination status
* Date of completion of last pregnancy
* Date of rupture of membranes
* Episode identifier
* Gestation at first COVID19 vaccination during this pregnancy
* Gestation at second COVID19 vaccination during this pregnancy
* Head circumference
* Indications for operative delivery – free text
* Indications for operative delivery – ICD-10-AM code
* Influenza vaccination status
* Patient identifier – baby
* Patient identifier – mother
* Perineal/genital laceration – degree/type
* Procedure – ACHI code
* Procedure – free text
* Separation date – baby
* Time of rupture of membranes
* Update version of ICD-10-AM/ACHI codes to 12th edition
* Version identifier

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

### Anaesthesia for operative delivery – type valid combinations

### Analgesia for operative delivery – type valid codes

### Date of completion of last pregnancy, Date of birth – baby and Estimated gestational age valid combinations;

### Deceased baby conditionally mandatory data items

### Deceased mother conditionally mandatory data items

### 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 code valid combinations

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

### 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

### Maternity model of care code is invalid

### Patient identifier – baby not reported

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

* Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations
* Birth presentation conditionally mandatory data items
* Blood loss assessment – indicator, Episiotomy – indicator, ~~Indications for operative delivery – free text,~~ Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code, Indications for operative delivery (other) – free text, Method of birth, Perineal/ genital laceration – degree/type, Perineal laceration – indicator conditional reporting
* COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy~~, and~~ Gestation at second COVID19 vaccination during this pregnancy, Gestation at third COVID19 vaccination during this pregnancy valid combinations
* Date and time data item relationships
* Diabetes mellitus during pregnancy – type, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD‑10‑AM code, Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code and Postpartum complications – ICD‑10‑AM code valid combinations
* Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy, ~~and~~ Gestation at second COVID19 vaccination during this pregnancy, Gestation at third COVID19 vaccination during this pregnancy valid combinations
* Gravidity and related data items
* Gravidity ‘Multigravida’ conditionally mandatory data items
* Mandatory to report data items
* Maternal alcohol use at less than 2~~1~~0 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations
* Method of birth and Labour type valid combinations
* Method of birth, ~~Indications for operative delivery – free text and~~ Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations
* Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items
* Remove validation level ‘Review required’
* Validition of ICD-10-AM/ACHI codes updated to check for 12th edition codes

**Changes to VPDC submission file structure** (Section 5, VPDC manual)

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

# Introduction

Each year the Department of Health (the department) reviews the Victorian Perinatal Data Collection (VPDC) on behalf of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), to ensure the VPDC continues to support the CCOPMM’s objectives, state and national reporting obligations and planning and policy development, and considers stakeholder feedback.

Stakeholders are invited to submit proposals for changes, which are evaluated against criteria that include the data collection’s scope, best practice, the collectability and intended use of the data, feasibility and impact of implementation, data quality, cost and collection burden for health serivces.

Proposals meeting these criteria are distributed, as the document ‘Proposals for revisions to the VPDC’, to health services and software vendors involved in reporting births to the VPDC, and feedback is invited from stakeholders. Comments are reviewed and where possible, accommodated, resulting in alteration to or withdrawal of some proposals, on advice from the CCOPMM.

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

An updated VPDC manual will be published in 2022, before these changes take effect. Until then, the current VPDC manual and this document form the data submission specifications for births on and from 1.7.2022.

Victorian health service must ensure their software can capture all necessary data, create a VPDC submission file in accordance with these revised specifications, and ensure reporting capability is achieved to maintain compliance with reporting timeframes set out in the VPDC manual.

Submission of test files in 2022-23 file format is strongly recommended prior to submitting July 2022 data. Please contact the [HDSS HelpDesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au> to arrange test file submission prior to July 2022.

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

## Orientation to symbols and highlighting in this document

New data elements are marked as (new).

Changes to existing entries are highlighted in green

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

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

New business rules (validations) are marked ###

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

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

# Summary of changes

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **New data item / Amend existing** | **Proposal title and summary of impact** | **VPDC manual section changed** | | | |
| **2** | **3** | **4** | **5** |
| Amend | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations |  |  | Checkmark |  |
| New | Anaesthesia for operative delivery – type valid combinations |  |  | Checkmark |  |
| New | Analgesia for operative delivery – type valid combinations |  |  | Checkmark |  |
| New | Antenatal mental health risk screening status |  | Checkmark |  | Checkmark |
| Amend | Birth presentation |  | Checkmark | Checkmark |  |
| Amend | Birth presentation conditionally mandatory data items |  |  | Checkmark |  |
| Amend | Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting |  |  | Checkmark |  |
| Amend | COVID19 vaccination during this pregnancy |  | Checkmark | Checkmark |  |
| Amend | COVID19 vaccination status |  | Checkmark | Checkmark |  |
| Amend | COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations |  |  | Checkmark |  |
| Amend | Date and time data item relationships |  |  | Checkmark |  |
| Amend | Date of completion of last pregnancy |  | Checkmark | Checkmark |  |
| New | Date of completion of last pregnancy, Date of birth – baby and Estimated gestational age valid combinations |  |  | Checkmark |  |
| Amend | Date of rupture of membranes |  | Checkmark | Checkmark |  |
| New | Deceased baby conditionally mandatory data items |  |  | Checkmark |  |
| New | Deceased mother conditionally mandatory data items |  |  | Checkmark |  |

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| --- | --- | --- | --- | --- | --- |
| **New data item / Amend existing** | **Proposal title and summary of impact** | **VPDC manual section changed** | | | |
| **2** | **3** | **4** | **5** |
| Amend | Diabetes mellitus during pregnancy – type, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indications for operative delivery – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code and Postpartum complications – ICD-10-AM code valid combinations |  |  | Checkmark |  |
| New | Edinburgh Postnatal Depression Scale score |  | Checkmark |  | Checkmark |
| Amend | Episode identifier |  | Checkmark | Checkmark |  |
| Amend | Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations |  |  | Checkmark |  |
| New | Family violence screening status |  | Checkmark |  | Checkmark |
| Amend | Gestation at first COVID19 vaccination during this pregnancy |  | Checkmark | Checkmark |  |
| Amend | Gestation at second COVID19 vaccination during this pregnancy |  | Checkmark | Checkmark |  |
| New | Gestation at third COVID19 vaccination during this pregnancy |  | Checkmark | Checkmark | Checkmark |
| Amend | Gravidity and related data items |  |  | Checkmark |  |
| Amend | Gravidity ‘multigravida’ conditionally mandatory data items |  |  | Checkmark |  |
| Amend | Head circumference |  | Checkmark |  |  |
| New | Hepatitis B antenatal screening – mother |  | Checkmark |  | Checkmark |
| New | HIV antenatal screening – mother |  | Checkmark |  | Checkmark |
| New | Hypertensive disorder during pregnancy |  | Checkmark | Checkmark | Checkmark |
| New | 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 code valid combinations |  |  | Checkmark |  |

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| --- | --- | --- | --- | --- | --- |
| **New data item / Amend existing** | **Proposal title and summary of impact** | **VPDC manual section changed** | | | |
| **2** | **3** | **4** | **5** |
| New | Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations |  |  | Checkmark |  |
| Amend | Indications for operative delivery – free text |  | Checkmark | Checkmark |  |
| Amend | Indications for operative delivery – ICD-10-AM code |  | Checkmark | Checkmark |  |
| Amend | Influenza vaccination status |  | Checkmark |  |  |
| Amend | Labour type | Checkmark |  |  |  |
| Amend | Mandatory to report data items |  |  | Checkmark |  |
| Amend | Maternal alcohol use at less than 10 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations |  |  | Checkmark |  |
| New | Maternity model of care – antenatal |  | Checkmark | Checkmark | Checkmark |
| New | 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 |  |
| New | Maternity model of care – at onset of labour or non-labour caesarean section |  | Checkmark | Checkmark | Checkmark |
| New | Maternity model of care code is invalid |  |  | Checkmark |  |
| Amend | Method of birth and Labour type valid combinations |  |  | Checkmark |  |
| Amend | Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations |  |  | Checkmark |  |
| Amend | Patient identifier – baby |  | Checkmark | Checkmark |  |
| New | Patient identifier – baby not reported |  |  | Checkmark |  |
| Amend | Patient identifier – mother |  | Checkmark |  |  |
| Amend | Perineal/genital laceration – degree/type |  | Checkmark | Checkmark |  |
| Amend | Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items |  |  | Checkmark |  |
| New | Presence or history of mental health condition – indicator |  | Checkmark |  | Checkmark |
| Amend | Procedure – ACHI code |  | Checkmark |  |  |
| **New data item / Amend existing** | **Proposal title and summary of impact** | **VPDC manual section changed** | | | |
| **2** | **3** | **4** | **5** |
| Amend | Procedure – free text |  | Checkmark |  |  |
| Remove | ‘Review required’ validation level |  |  | Checkmark |  |
| Amend | Separation date – baby |  | Checkmark |  |  |
| New | Syphilis antenatal screening – mother |  | Checkmark |  | Checkmark |
| Amend | Time of rupture of membranes |  | Checkmark | Checkmark |  |
| Amend | Update version of ICD-10-AM/ACHI codes to 12th edition, affecting business rules that check for presence of ICD-10-AM/ACHI code(s) and fields:  Congenital anomalies – ICD-10-AM code  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  Neonatal morbidity – ICD-10-AM code  Obstetric complications – ICD-10-AM code  Postnatal complications – ICD-10-AM code  Procedures – ACHI code |  | Checkmark | Checkmark |  |
| Remove | Validation level ‘Review required’ |  |  | Checkmark |  |
| Amend | Version identifier |  | Checkmark |  | Checkmark |

# Other proposals that are not proceeding

The following proposals were received and were considered by the CCOPMM, however it was determined that they will not be implemented for 1.7.2022:

Add new data item: Administration of HBIG – baby

Amend existing data item: Admission to special care nursery (SCN)/neonatal intensive care unit (NICU) – baby

Amend existing data item: Cord complications – code set

Amend existing data item: Date of admission – mother

Add new data item: Date of congenital syphilis screening – baby

Add new data item: Date of influenza vaccination

Amend existing data item: Date of onset of second stage of labour

Add new data item: Date of pertussis-containing vaccine

Add new data item: Dental health referral

Add new data item: Estimated gestational age at influenza vaccination

Add new data item: Estimated gestational age at pertussis vaccination

Remove existing data item: Events of labour and birth – free text

Amend existing data item: Fetal monitoring prior to birth – not in labour

Add new data item: Hepatitis B treatment – mother

Add new data item: Hepatitis B vaccine birth dose timing – baby

Add new data item: Hepatitis B viral load (HBV DNA) test – mother

Add new data item: Hypertensive disorder during pregnancy – indicator

Amend existing data item: Indications for induction (other) – free text

Add new data item: Interventions to detect and treat congenital syphilis – baby

Amend business rule: Labour type ‘Failed induction’ conditionally mandatory data items

Remove existing data item: Maternal medical conditions – free text

Remove existing data item: Neonatal morbidity – free text

Remove existing data item: Obstetric complications – free test

Add new data item: Oral health assessment

Remove existing data item: Plan for vaginal birth after caesarean

Remove existing data item: Postpartum complications – free text

Remove existing data item: Procedure – free text

Amend existing data item: Separation date – mother

Add new data item: Syphilis antenatal screening dates – mother

Amend existing data item: Time of onset of second stage of labour

# End of financial year reporting – 30.6.2022

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

* Date of birth – baby is prior to 1/7/2022 – report all data elements in 2021-22 format
* Date of birth – baby is on or after 1/7/2022 – report all data elements in 2022-23 format

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

This is described under File structure specifications in Section 5 of the VPDC manual, accessible at the [VPDC website](https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection) < <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>>. An updated list of all data items in the submission file sequence applicable from 1.7.2022 is included in this Specifications document.

# Section 2 Concept and derived item definitions

|  |  |
| --- | --- |
| Labour type | |
| **Definition/guide for use** | The manner in which labour started in a birth event.  Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes (PROM).  If prostaglandins were given to induce labour and there is no resulting labour until after ~~48~~24 hours have passed, then ~~code the onset of labour as spontaneous~~a later onset of labour without further induction techniques should be coded as a spontaneous onset. |
| **Related data items (Section 3):** | Labour induction / augmentation agent; Labour induction / augmentation agent – other specified description; Labour type |

# 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 offered  3 Declined  9 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 Yes The woman was screened using a validated screening tool  Code 2 Not offered The woman was not offered screening using a validated screening tool  Code 3 Declined The woman declined screening for mental health 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**

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

## Birth presentation

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Presenting part of the fetus (at the cervix) at birth | | |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 73 |
| **Permissible values** | **Code Descriptor**  1 Vertex  2 Breech  3 Face  4 Brow  5 Compound  6 Cord  7 Shoulder  8 Other  9 Not stated / inadequately described | | |
| **Reporting guide** | For a multiple pregnancy with differing presentations, report the presentation of the fetus for each birth.  Code 1 Vertex Includes incomplete rotation of fetal head  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 details must be reported in Events of labour and birth – free text or Events of labour and birth – ICD-10-AM code. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | All birth episodes | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | None specified | | |
| **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  4. July 2022 |
| **Codeset source** | NHDD (DHHS modified) | **Collection start date** | 1982 |

COVID19 vaccination during this pregnancy

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the mother received one or more doses of a vaccination against novel coronavirus (SARS-CoV-2 or COVID19) during this pregnancy | | |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 152 |
| **Permissible values** | **Code Descriptor**  1 Yes  2 No  7 Declined to answer  9 Not stated / inadequately described | | |
| **Reporting guide** | Report the statement that best describes the woman’s understanding of her COVID19 vaccine status during this pregnancy.  Report this status as at the time of this birth.  Report code 1 Yes if the woman received one or more doses of any COVID19 vaccine in the period from conception of this pregnancy to the birth of this baby.  Where code 1 Yes is reported, also report the gestation during this pregnancy when COVID19 vaccination dose/s were received (Gestation at first COVID19 vaccination during this pregnancy and if relevant also Gestation at second COVID19 vaccination during this pregnancy and if relevant also Gestation at third COVID19 vaccination during this pregnancy).  Report code 2 No in the following cirumstances:  - where the woman had received one or more doses of a COVID19 vaccine before the conception of this pregnancy, but did not receive any doses between conception and the birth of this baby OR  - where the woman received one or more doses of a COVID19 vaccine after the birth of this baby and before discharge from this birth episode, but did not receive any doses between conception and the birth of this baby.  Report code 7 only where the woman declines to answer this question, or is unable to accurately respond to the question (eg is unconscious and does not regain consciousness before being transferred).  Leave blank where COVID19 vaccination status code 2 No or 7 Declined to answer are reported.  Report code 9 where COVID19 vaccination status code 9 is reported.  Details should be captured during the antenatal course, and updated if the status changes, and must be current as at the Discharge date – mother. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Mandatory for all birth episodes where COVID19 vaccination status code 1 Yes or 9 Not stated / inadequately describe is reported. | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | COVID19 vaccination status; Gestation at first COVID19 vaccination during this pregancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy | | |
| **Related business rules (Section 4):** | \*COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations | | |

**Administration**

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| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | Department of Health | **Version** | 1. July 2021 2. July 2022 |
| **Codeset source** | Department of Health | **Collection start date** | 1 July 2021 |

COVID19 vaccination status

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the mother has received a vaccination against the novel coronavirus (SARS-CoV-2 or COVID19) | | |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 151 |
| **Permissible values** | **Code Descriptor**  1 Yes  2 No  7 Declined to answer  9 Not stated / inadequately described | | |
| **Reporting guide** | Report the statement that best describes the woman’s understanding of her COVID19 vaccine status as at the end of this birth episode.  Report code 1 Yes in the following circumstances:  - if the woman received one or more doses of any COVID19 vaccine prior to the conception of this pregnancy OR  - if the woman received one or more doses of any COVID19 vaccine in the period from the conception of this pregnancy until the birth of this baby OR  - if the woman received one or more doses of any COVID19 vaccine during the current birth episode but after the birth of the baby.  This includes if one dose of a multi-dose course has been received at any time until the end of the current birth episode.  Where code 1 Yes is reported, also report:  - whether the mother received any dose/s of COVID19 vaccination during the current pregnancy (COVID19 vaccination during this pregnancy) and if so,  - the gestation during this pregnancy when COVID19 vaccination dose/s were received (Gestation at first COVID19 vaccination during this pregnancy and if relevant also Gestation at second COVID19 vaccination during this pregnancy and if relevant also Gestation at third COVID19 vaccination during this pregnancy).  Report code 2 No if the woman has not had any dose of any COVID19 vaccine prior to this pregnancy or during this pregnancy or after the birth of this baby but before discharge at the end of this birth episode.  Report code 7 only where the woman declines to answer this question, or is unable to accurately respond to the question (eg is unconscious and does not regain consciousness before being transferred).  Details should be captured during the antenatal course, and updated if the status changes, and must be current as at the Discharge date – mother. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | All birth episodes | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy | | |
| **Related business rules (Section 4):** | \*COVID19 vaccination status, COVID19 vaccination this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations; \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | Department of Health | **Version** | 1. July 2021 2. July 2022 |
| **Codeset source** | Department of Health | **Collection start date** | 1 July 2021 |

## 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; \*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  3. July 2022 |
| **Codeset source** | NHDD | **Collection start date** | 1982 |

## Date of rupture of membranes

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date on which the mother’s membranes ruptured (spontaneously or artificially) | | |
| **Representation class** | Date | **Data type** | Date/time |
| **Format** | DDMMCCYY | **Field size** | 8 |
| **Location** | Episode record | **Position** | 65 |
| **Permissible values** | A valid calendar date  **Code Descriptor**  77777777 No record of date of rupture of membranes  88888888 Membranes ruptured at caesarean  99999999 Not stated / inadequately described | | |
| **Reporting guide** | Report the date on which it is believed the membranes 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.~~  For 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 known date and report time as unknown. 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 and homebirth practitioners | | |
| Reported for | All birth episodes | | |
| Related concepts (Section 2): | None specified | | |
| Related data items (this section): | Date of onset of labour; Date of onset of second stage of labour; Method of birth; 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; 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**

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| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. January 2009 2. July 2022 |
| **Codeset source** | DHHS | **Collection start date** | 2009 |

## 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 pregnancy  98 Unknown EPDS score  99 Not stated stated/inadequately described | | | |
| **Reporting guide** | Report the total score on the Edinburgh Postnatal Depression Scale derived at an antenatal care visit  This data may be self-reported or derived from medical information. | | | |
| **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**

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

## Episode identifier

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | An identifier, unique to the birth episode within the submitting organisation. Used to manage new/updated submitted information. | | |
| **Representation class** | Identifier | **Data type** | String |
| **Format** | A(9) | **Field size** | 9 |
| **Location** | Episode record | **Position** | 130 |
| **Permissible values** | Permissible characters: a–z and A–Z  numeric characters | | |
| **Reporting guide** | System generated.  Individual sites may use their own alphabetic, numeric or alphanumeric coding system.  For multiple births, a different Episode identifier is required for each baby.  An Episode identifier, once assigned, must never be reassigned to another episode/birth for this person (either mother or baby) or to another person. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | All birth episodes | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | Patient identifier – baby; Patient identifier – mother | | |
| **Related business rules (Section 4):** | \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Principal data users** | Not applicable | | | |
| **Definition source** | DHHS | **Version** | 1. January 2017 2. January 2019 3. January 2020 4. July 2022 | |
| **Codeset source** | DHHS | **Collection start date** | 2017 |

## 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 Yes  2 Not offered  3 Declined  9 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 Yes The woman was screened using a validated screening tool  Code 2 Not offered The woman was not offered screening using a validated screening tool  Code 3 Declined The woman declined screening using a validated screening tool | | | |
| **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**

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

## Gestation at first COVID19 vaccination during this pregnancy

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The earliest gestation during the current pregnancy at which a dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman | | |
| **Representation class** | Total | **Data type** | Number |
| **Format** | [N]N | **Field size** | 2 |
| **Location** | Episode record | **Position** | 153 |
| **Permissible values** | Range: 01 to 45 (inclusive)  **Code Descriptor**  88 Unknown gestation  99 Not stated / inadequately described | | |
| **Reporting guide** | The earliest gestation during the current pregnancy at which a dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.  If the woman receives one or more doses of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the first of those doses was received.  Report only COVID19 vaccines received during this pregnancy, that is, from the conception of this pregnancy to the birth of this baby.  If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has one or more further dose/s during this pregnancy, report in this field only the first dose received during this pregnancy.  Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.  Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated.  Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where:  - the woman received one or more doses of any COVID19 vaccine before conception of this pregnancy but none between the conception and the birth of this baby OR  - the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby.  Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or code 9 Not stated / inadequately described is reported. | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy | | |
| **Related business rules (Section 4):** | \*COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations; \*Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations | | |

**Administration**

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| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | Department of Health | **Version** | 1. July 2021 2. July 2022 |
| **Codeset source** | Department of Health | **Collection start date** | 1 July 2021 |

## Gestation at second COVID19 vaccination during this pregnancy

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The gestation during the current pregnancy when a ~~further~~ second dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman | | |
| **Representation class** | Total | **Data type** | Number |
| **Format** | [N]N | **Field size** | 2 |
| **Location** | Episode record | **Position** | 154 |
| **Permissible values** | Range: 01 to 45 (inclusive)  **Code Descriptor**  77 ~~Only one~~ No second dose received during this pregnancy  88 Unknown gestation  99 Not stated / inadequately described | | |
| **Reporting guide** | The gestation during the current pregnancy when a ~~further~~ second dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.  If the woman receives more than one dose of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the second of those doses was received.  Report only COVID19 vaccines received during this pregnancy.  If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has more than one dose during this pregnancy, report in this field only the second dose received during this pregnancy.  Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.  Report 77 in the following circumstances:  - if the woman received only one dose of a COVID19 vaccine during this pregnancy OR  - if a single-dose vaccine was received during this pregnancy OR  - if one dose of a COVID19 vaccine was received during the pregnancy, and the next dose was received after the birth of this baby but before the woman was discharged from this birth episode (report code 77 because the second dose was not received during the pregnancy; do not report the gestation at delivery in this instance).  Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where:  - the woman received one or more doses of any COVID19 vaccine before conception of this pregnancy but none between the conception and the birth of this baby OR  - the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby.  Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated.  Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or 9 Not stated / inadequately described is reported. | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy | | |
| **Related business rules (Section 4):** | \*COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations; \*Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations | | |

**Administration**

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| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | Department of Health | **Version** | 1. July 2021 2. July 2022 |
| **Codeset source** | Department of Health | **Collection start date** | 1 July 2021 |

## Gestation at third COVID19 vaccination during this pregnancy (new)

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The gestation during the current pregnancy when a third dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman | | |
| **Representation class** | Total | **Data type** | Number |
| **Format** | [N]N | **Field size** | 2 |
| **Location** | Episode record | **Position** | 155 |
| **Permissible values** | Range: 01 to 45 (inclusive)  **Code Descriptor**  77 No third dose received during this pregnancy  88 Unknown gestation  99 Not stated / inadequately described | | |
| **Reporting guide** | The gestation during the current pregnancy when a third dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.  If the woman receives more than one dose of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the third of those doses was received.  Report only COVID19 vaccines received during this pregnancy.  If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has more than one dose during this pregnancy, report in this field only the third dose received during this pregnancy.  Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.  Report 77 in the following circumstances:  - if the woman received one or two dose(s) of a COVID19 vaccine during this pregnancy, but not a third dose OR  - if a single-dose vaccine was received during this pregnancy OR  - if the woman received one or two dose(s) of a COVID19 vaccine during the pregnancy, and the next dose was received after the birth of this baby but before the woman was discharged from this birth episode (report code 77 because the third dose was not received during the pregnancy; do not report the gestation at delivery in this instance).  Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where:  - the woman received one or more doses of any COVID19 vaccine before conception of this pregnancy but none between the conception and the birth of this baby OR  - the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby.  Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated.  Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or 9 Not stated / inadequately described is reported. | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy | | |
| **Related business rules (Section 4):** | \*COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations; \*Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy and Gestation at second COVID19 vaccination during this pregnancy valid combinations | | |

**Administration**

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

## Head circumference – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The measurement of the circumference of the head of the baby | | |
| **Representation class** | Total | **Data type** | Number |
| **Format** | NN.N | **Field size** | 4 |
| **Location** | Episode record | **Position** | 129 |
| **Permissible values** | Range: ~~01.0 to 99.8~~10.0 to 40.0 (inclusive)  **Code Descriptor**  99.8 Unable to measure  99.9 Not stated  Blank Not applicable (eg stillbirths – but can be entered if measured) | | |
| **Reporting guide** | Head circumference should be measured prior to discharge (or within seven days if not admitted to a hospital, i.e. homebirth). This should be at the same time as the birthweight is measured, to maximise comparability of these two measures in percentile calculations.  Measurement is made in centimetres to one decimal place, e.g. 352 millimetres is expressed as 35.2 centimetres.  In the case of babies born before arrival at the hospital, the head circumference should be taken prior to discharge. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Mandatory to report for livebirth episodes.  Optional to report for stillbirths (can be left blank) | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | Birth Status | | |
| **Related business rules (Section 4):** | Birth status ‘Live born’ and associated conditionally mandatory data items | | |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | METeOR 568380 | **Version** | 1. January 2017 2. July 2022 |
| **Codeset source** | Not applicable | **Collection start date** | 2017 |

## 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 negative  2 Hepatitis serology (HBsAg) was positive  3 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. | | | |
| **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**

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

## Hypertensive disorder during pregnancy (new)

**Specification**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Definition** | Whether the woman has a hypertensive disorder during this pregnancy, based on a current or previous diagnosis, and if so, the type of hypertensive disorder | | | |
| **Representation class** | Code | **Data type** | Number | |
| **Format** | N | **Field size** | 1 (x3) | |
| **Location** | Episode record | **Position** | 163 | |
| **Permissible values** | **Code Descriptor**  1 Eclampsia 2 Pre-eclampsia  3 Gestational hypertension  4 Chronic hypertension  7 Hypertension, not further specified  8 No hypertensive disorder during this pregnancy 9 Not stated stated/inadequately described | | | |
| **Reporting guide** | Report any hypertensive disorder the woman has had during this pregnancy. Include hypertensive disorders controlled through treatment during this pregnancy.  **Code 1** **Eclampsia** Eclampsia is characterised by grand mal seizures, hypertension, proteinuria, oedema and may progress to coma. Before a seizure, a patient may experience a body temperature of over 40°C, anxiety, epigastric pain, severe headache and blurred vision. Complications of eclampsia may include cerebral haemorrhage, pulmonary oedema, renal failure, abruptio placentae and temporary blindness (NCCH 2000).  **Code 2** **Pre-eclampsia** Pre-eclampsia is a multi-system disorder characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis.  A diagnosis of pre-eclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following: renal involvement, haematological involvement, liver involvement, neurological involvement, pulmonary oedema, fetal growth restriction, placental abruption.  Includes HELLP syndrome (Haemolysis, Elevated Liver Enzymes, Low Platelet count), which is a variant of pre-eclampsia.  **Code 3 Gestational hypertension** Gestational hypertension is characterised by the new onset of hypertension after 20 weeks gestation without any maternal or fetal features of pre-eclampsia, followed by return of blood pressure to normal within 3 months post-partum.  **Code 4 Chronic hypertension** This may include essential or secondary hypertension. Essential hypertension is defined by a blood pressure greater than or equal to 140 mmHg systolic and/or greater than or equal to 90 mmHg diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause. It may also be diagnosed in females presenting early in pregnancy taking antihypertensive medications where no secondary cause for hypertension has been determined.  Important secondary causes of chronic hypertension in pregnancy include:   * chronic kidney disease, e.g. glomerulonephritis, reflux nephropathy, and adult polycystic kidney disease * renal artery stenosis * systemic disease with renal involvement, e.g. diabetes mellitus or systemic lupus erythematosus * endocrine disorders, e.g. phaeochromocytoma, Cushing's syndrome and primary hyperaldosteronism * coarctation of the aorta.   In the absence of any of the above conditions it is likely that a female with high blood pressure in the first half of pregnancy has essential hypertension.  For all other values, diagnosis is to be based on Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) Guideline for the Management of Hypertensive Disorders of Pregnancy (Lowe et al. 2014). If the clinician does not have information as to whether the above guidelines have been used, available information about diagnosis of hypertensive disorder is still to be reported.  The diagnosis is preferably derived from and substantiated by clinical documentation, which should be reviewed at the time of delivery. However, this information may not be available in which case the patient may self-report to the clinician that they have been diagnosed with a hypertensive disorder  **Code 7** **Hypertension, not further specified** Report only when the woman reports hypertension, but no further details are available about the type of hypertensive disorder or whether it arose during this pregnancy.  **Up to three (3) codes from the valid code set can be reported**:   * for a woman who has preeclampsia superimposed on chronic hypertension, report both Code 2 and Code 4; * for a woman who develops gestational hypertension which progresses to eclampsia, record both Code 1 and Code 3.   **Code 8 No hypertensive disorder during this pregnancy** Report if the woman does not have a hypertensive disorder during this pregnancy  **Codes 3 and 4 are not to be reported together.**  **Code 7 is not to be reported with code 3 or code 4.**  **Neither Code 8 nor Code 9 can be reported with any other code.**  **Report consistently with ICD-10-AM codes in clinicial data fields:**  Reporting hypertensive disorders in this ‘Hypertensive disorder during pregnancy’ data item does not preclude also reporting the same condition in one or more of the clinical data fields as an ICD-10-AM code.  For example, a woman has an unplanned caesarean due to developing severe pre-eclampsia: report both: code 2 Pre-eclampsia in this Hypertensive disorder during pregnancy field, and  ICD-10-AM code O141 in the Indication for operative delivery (main reason) – ICD-10-AM code field.  When reporting hypertensive disorders in any of the clinical data fields using ICD-10-AM codes, use the following codes to report hypertensive disorders consistently with the disorder(s) reported in this ‘Hypertensive disorder during pregnancy’ field:  **Code Hypertensive disorder ICD-10-AM code**  1Eclampsia in pregnancyO150  1Eclampsia in labourO151  1Eclampsia in the puerpiumO152  1Eclampsia, unspecified as to time periodO159  2 Mild to moderate pre-eclampsia O140  2 Severe pre-eclampsia O141  2 HELLP syndrome O142  2 Pre-eclampsia, unspecified O149  3 Gestational/pregnancy-induced hypertension O13  4 Chronic hypertension (without pre-eclampsia) O10  4 Pre-existing hypertension in pregnancy, childbirth and   the puerperium O10  7 Hypertension, not further specified O16  2 & 4 Pre-eclampsia superimposed on chronic hypertension O11  1 & 3 Eclampsia in labour following gestational hypertension O13 & O151  When reporting any of the above ICD-10-AM codes in any of the clinical data fields, the type of hypertensive disorder(s) must be reported consistently with the disorder(s) reported in this ‘Hypertensive disorder during pregnancy’ field, and in any other of the clinical data fields.  For example, do not report code O13 (Gestational hypertension) in Obstetric complications and O10 (Chronic hypertension) in Maternal medical conditions. Only combinations consistent with the combinations acceptable in this ‘Hypertensive disorders during pregnancy’ field are acceptable.  When code 8 No hypertensive disorder during this pregnancy is reported in this Hypertensive disorder during pregnancy field, none of the ICD-10-AM codes listed above may be reported in any of the clinical data fields reported as ICD-10-AM codes.  Valid combinations of codes in this field, and ICD-10-AM codes in clinical data fields, are set out in the business rule (see below). | | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | | |
| **Reported for** | All birth episodes | | |
| **Related concepts (Section 2):** | Hypertensive disorder during pregnancy | | |
| **Related data items (this section):** | 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 | | |
| **Related business rules (Section 4):** | ### 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; \*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 | **Version** | 1. July 2022 |
| **Codeset source** | AIHW (DHHS modified) | **Collection start date** | July 2022 |

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The main 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** | Codes relevant to this data element are listed in the 12~~11~~th edition ICD‑10‑AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@health.vic.gov.au](mailto:hdss.helpdesk@health.vic.gov.au).  A small number of additional codes have been created solely for VPDC reporting in this data element:  **Code Descriptor**  Z8751 Past history of shoulder dystocia  Z8752 Past history of third or fourth degree perineal tear | | |
| **Reporting guide** | Report ~~up to four~~ the main reason~~s~~ for operative delivery as an ICD-10-AM code. ~~in order from the most to least influential in making the decision.~~  Report the ‘main reason’ for the operative birth by reporting in this field a single ICD-10-AM code for each birth in which Method of birth code is reported as one of:  1Forceps   1. Planned caesarean – no labour 2. Unplanned caesarean – labour 3. Planned caesarean – labour 4. Unplanned caesarean – no labour 5. Vacuum extraction   10Other operative birth | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth | | |
| **Related concepts (Section 2):** | Operative delivery; Procedure | | |
| **Related data items (this section):** | Indications for operative delivery (other) – free text; Method of birth | | |
| **Related business rules (Section 4):** | Labour type ‘Failed induction’ conditionally mandatory data items; \*Method of birth, Indications for operative delivery (other) – free text and Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code valid combinations | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. January 1982  2. January 1999  3. January 2009  4. July 2015  5. January 2020  6. July 2022 |
| **Codeset source** | ICD-10-AM/ACHI 12~~11~~th edition plus CCOPMM additions | **Collection start date** | 1982 |

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

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | ~~The~~ Any other 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  A small number of additional codes have been created solely for VPDC reporting in this data element:  **Code Descriptor**  Z8751 Past history of shoulder dystocia  Z8752 Past history of third or fourth degree perineal tear | | |
| **Reporting guide** | Must report in the data item ‘Indication for operative delivery (main reason) a single ICD-10-AM code to indicate the ‘main reason’ for operative birth when Method of birth code is reported as one of:   1. Forceps   4Planned caesarean – no labour  5Unplanned caesarean – labour  6Planned caesarean – labour  7Unplanned caesarean – no labour  8Vacuum extraction  10Other operative birth  Report any other indications for operative delivery in this field, in order from the most to least influential in making the decision. ~~when there is no ICD-10-AM code available for selection in the software.~~ ~~Report up to four reasons for operative delivery in order from the most to least influential in making the decision.~~ | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | Indication~~s~~ for operative delivery (main reason) – 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~~ Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations | | |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. January 1982  2. January 2020.  3. July 2022 |
| **Codeset source** | Not applicable | **Collection start date** | 1982 |

## Influenza vaccination status

**Specification**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Representation class** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 |
| **Location** | Episode record | **Position** | 125 |

**Permissible values Code Descriptor**

1. Influenza vaccine(s) received at any time during this pregnancy
2. Influenza vaccine not received at any time during this pregnancy

9 Not stated / inadequately described

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

Report code 2 Influenza vaccine not received at any time during this pregnancy, if the vaccination was received prior to this pregnancy.

|  |  |
| --- | --- |
| **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 items |

**Administration**

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| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. July 2015 2. July 2022 |
| **Codeset source** | DHHS | **Collectionstartdate** | 1 July 2015 |

## 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 pregnancy  999994Planned homebirth with care from a registered private homebirth midwife  999997No antenatal care received by the woman for this pregnancy  988899Majority of antenatal care at a health service outside Australia  999999 Not stated stated/inadequately described | | | |
| **Reporting guide** | NNNNNN Report 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.  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.  999997 Report 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 midwife  988899 Report where the majority of antenatal care was provided by a health service outside Australia  999999 Not 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 | **Version** | 1. July 2022 |
| **Codeset source** | NHDD (DHHS modified) | **Collection start date** | 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 section  999994Planned homebirth with care from a registered private homebirth midwife  999997No antenatal care received by the woman for this pregnancy  988899Majority of antenatal care at a health service outside Australia  999999 Not stated stated/inadequately described | | | |
| **Reporting guide** | NNNNNN Report 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.  999997 Report 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 midwife  988899 Report where the plan at onset of labour or non-labour caesarean section had been provided by a health service outside Australia  999999 Not 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 | **Version** | 1. July 2022 |
| **Codeset source** | NHDD (DHHS modified) | **Collection start date** | 2022 |

## Patient identifier – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | An identifier, unique to the baby 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** | 6 |
| **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.  For planned births occurring outside the hospital system, enter the birth number or an equivalent number used to identify the mother. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Birth episodes where available | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | None specified | | |
| **Related business rules (Section 4):** | ### Patient identifier – baby not reported | | |

**Administration**

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| **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 |

## 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 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 2. July 2022 |
| **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** | Code | **Data type** | Number |
| **Format** | N | **Field size** | 1 (x~~2~~ 3) |
| **Location** | Episode record | **Position** | 86 |
| **Permissible values** | **Code Descriptor**  1 First degree laceration/tear/vaginal graze  2 Second degree laceration/tear  3 Third degree laceration /tear  4 Fourth degree laceration /tear  5 Labial / clitoral laceration/tear  6 Vaginal wall laceration/tear  7 Cervical laceration/tear  8 Other perineal laceration, rupture or tear  0 Laceration, rupture or tear of other genital tract location  9 Not stated / inadequately described | | |
| **Reporting guide** | Code 1 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, periurethral tissue (excluding involvement of urethra), vagina (low), skin and / or vulva.  Code 2 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. Excludes lacerations involving the anal sphincter.  Code 3 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.  Code 4 Fourth degree laceration: Perineal laceration, rupture or tear as in Code 3 occurring during delivery, also involving: anal mucosa and / or rectal mucosa.  Code 8 Other perineal laceration, rupture or tear: May include haematoma or unspecified perineal tear.  Code 0 Laceration, rupture or tear of other genital tract location: Other genital tract location not reported by other codes, including urethra  Where multiple perineal lacerations, ruptures or tears of different degrees are documented, assign the code for the highest (most severe) degree only. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred 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; Perineal laceration – repair | | |
| **Related business rules (Section 4):** | Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items~~; Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations~~ | | |

**Administration**

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| --- | --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | | |
| **Definition source** | NHDD (DHHS modified) | **Version** | 1. January 1999 2. July 2022 |
| **Codeset source** | DHHS | **Collection start date** | 1999 |

## Presence or history of mental health condition – indicator (new)

**Specification**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Definition** | Whether a woman is experiencing, or has previously experienced, a mental health condition | | | |
| **Representation class** | Code | **Data type** | Number | |
| **Format** | N | **Field size** | 1 | |
| **Location** | Episode record | **Position** | 158 | |
| **Permissible values** | **Code Descriptor**  1 Yes 2 No  9 Not stated stated/inadequately described | | | |
| **Reporting guide** | This data may be self-reported or derived from medical information.  Code 1 Yes The woman is currently experiencing, or has previously experienced, a mental health condition  Code 2 No The woman is not currently experiencing, and has not previously experienced, a mental health condition | | | |
| **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):** | Antenatal mental health risk screening status; Edinburgh Postnatal Depression Scale score | | |
| **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. July 2022 |
| **Codeset source** | NHDD (DHHS modified) | **Collection start date** | 2022 |

## Procedure – ACHI code

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium | | |
| **Representation class** | Code | **Data type** | Number |
| **Format** | NNNNNNN | **Field size** | 7 (x8) |
| **Location** | Episode record | **Position** | 56 |
| **Permissible values** | Codes relevant to this data element are listed in the 12~~11~~th edition ICD‑10‑AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at [hdss.helpdesk@health.vic.gov.au](mailto:hdss.helpdesk@health.vic.gov.au).  A small number of additional codes have been created solely for VPDC reporting in this data element:  **Code Descriptor**  1321505 ART – Donor Insemination  9619918 IV iron infusion | | |
| **Reporting guide** | ~~A procedure should only be coded once, regardless of how many times it is performed.~~  ~~Procedures that are reported in other data elements do not need to be reported in this field. These include anaesthesia or analgesia relating to the birth, augmentation or induction, caesarean section, forceps or vacuum extraction, suture/repair of tears, and allied health procedures.~~  ~~The order of codes should be determined using the following hierarchy, in accordance with the ICD-10-AM/ACHI Australian coding standards:~~   * ~~Procedure performed for treatment of the principal diagnosis~~ * ~~Procedure performed for treatment of an additional diagnosis~~ * ~~Diagnostic/exploratory procedure related to the principal diagnosis~~ * ~~Diagnostic/exploratory procedure related to an additional diagnosis.~~   A procedure should be reported only once, regardless of how many times it is performed.  Report procedures and operations performed during the current pregnancy, labour, delivery and the puerperium.  Give priority to invasive procedures and investigations.  Examples of procedures to report include cholecystectomy, ligation of vessels for twin-to-twin transfusion, hysterectomy, amniocentesis, cervical suture.  Procedures that are reported in other data elements (such as anaesthesia, augmentation or induction of labour, caesarean section, forceps or vacuum extraction, suture/repair of perineal laceration, episiotomy, allied health), do not need to be reported in the Procedure – ACHI code or Procedure – free text data fields.  Do not report activities such as providing brochures to the mother. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Birth episodes where a medical procedure and/or operation are performed and/or a procedure related to the pregnancy, including assisted reproductive technology, occurred during the pregnancy | | |
| **Related concepts (Section 2):** | Procedure | | |
| **Related data items (this section):** | Artificial reproductive technology – indicator; Procedure – free text | | |
| **Related business rules (Section 4):** | Artificial reproductive technology – indicator conditionally mandatory data items | | |

**Administration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | | |
| **Definition source** | DHHS | **Version** | 1. January 1982  2. January 2009  3. July 2015  4. January 2018  5. January 2020  6. July 2022 |
| **Codeset source** | ICD-10-AM/ACHI 12~~11~~th edition plus CCOPMM additions | **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.~~  A procedure should be reported only once, regardless of how many times it is performed.  Report procedures and operations performed during the current pregnancy, labour, delivery and the puerperium.  Give priority to invasive procedures and investigations.  Examples of procedures to report include cholecystectomy, ligation of vessels for twin-to-twin transfusion, hysterectomy, amniocentesis, cervical suture.  Procedures that are reported in other data elements (such as anaesthesia, augmentation or induction of labour, caesarean section, forceps or vacuum extraction, suture/repair of perineal laceration, episiotomy, allied health), do not need to be reported in the Procedure – ACHI code or Procedure – free text data fields.  Do not report activities such as providing brochures to the mother. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Birth episodes where a medical procedure and/or operation is performed and/or a procedure related to the pregnancy, including assisted reproductive technology, occurred during the pregnancy | | |
| **Related concepts (Section 2):** | Procedure | | |
| **Related data items (this section):** | Artificial reproductive technology – indicator; Procedure – ACHI code | | |
| **Related business rules (Section 4):** | Artificial reproductive technology – indicator conditionally mandatory data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. 1. January 1982 2. 2. January 2020 3. 3. July 2022 |
| **Codeset source** | Not applicable | **Collection start date** | 1982 |

## Separation date – baby

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date on which the baby is separated or transferred from the place of birth or on which they died | | |
| **Representation class** | Date | **Data type** | Date/time |
| **Format** | DDMMCCYY | **Field size** | 8 |
| **Location** | Episode record | **Position** | 119 |
| **Permissible values** | A valid calendar date  **~~Code Descriptor~~**  ~~99999999 Not stated / inadequately described~~ | | |
| **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.  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 and homebirth practitioners | | | |
| **Reported for** | All live birth episodes | | | |
| **Related concepts (Section 2):** | Separation | | | |
| **Related data items (this section):** | Reason for transfer out – baby; Separation status – baby; Transfer destination – 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; 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 | | |
| **Definition source** | DHHS | **Version** | 1. January 1982  2. January 2018  3. July 2022 |
| **Codeset source** | DHHS | **Collection start date** | 1982 |

## 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 | | | |
| **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** | DHHS | **Version** | 1. July 2022 |
| **Codeset source** | DHHS | **Collection start date** | 2022 |

## Time of rupture of membranes

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The time at which the mother’s membranes ruptured (spontaneously or artificially) 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** | 66 |
| **Permissible values** | A valid time value using a 24-hour clock (not 0000 or 2400)  **Code Descriptor**  7777 No record of rupture of membranes  8888 ~~No labour~~ Membranes ruptured at caesarean  9999 Not stated / inadequately described | | |
|  | | | |
| **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.  Code 7777 No record of rupture of membranes Use of code 7777 No record of rupture of membranes should be limited to situations where there is absolutely no evidence in the medical record to indicate the timing of the rupture of membranes.  If date of ROM is known but time of ROM is not, report the known date and report time as 7777 No record of rupture of membranes. ~~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 (77777777 and 7777 for Date and Time of ROM respectively) will be monitored and sites reporting a high frequency of ~~no record~~ those 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 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; 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 | **Version** | 1. January 2009 2. July 2022 |
| **Codeset source** | DHHS | **Collection start date** | 2009 |

## Version identifier

**Specification**

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Version of the data collection | | |
| **Representation class** | Identifier | **Data type** | Number |
| **Format** | NNNN | **Field size** | 4 |
| **Location** | Episode record, Header record | **Position** | 2 |
| **Permissible values** | **Code**  ~~2009~~  ~~2015~~  ~~2017~~  ~~2018~~  ~~2019~~  2020 (for births in the period 1 January 2020 to 30 June 2021 inclusive)  2021 (for births in the period 1 July 2021 to 30 June 2022 inclusive)  2022 (for births in the period 1 July 2022 to 30 June 2023 inclusive) | | |
| **Reporting guide** | Software-system generated.  A VPDC electronic submission file with a missing or invalid Version identifier will be rejected and the submission file will not be processed.  The Version identifier in each Episode record in a submission file must be the same as the Version identifier in the Header record of that submission file.  All Episode records in a submission file must have the same Version identifier. | | |
| **Reported by** | All Victorian hospitals where a birth has occurred and homebirth practitioners | | |
| **Reported for** | Each VPDC electronic submission file (Header record); Each VPDC electronic birth record (Episode record) | | |
| **Related concepts (Section 2):** | None specified | | |
| **Related data items (this section):** | None specified | | |
| **Related business rules (Section 4):** | \*Mandatory to report data items | | |

**Administration**

|  |  |  |  |
| --- | --- | --- | --- |
| **Principal data users** | Consultative Council on Obstetric and Paediatric Mortality and Morbidity | | |
| **Definition source** | DHHS | **Version** | 1. January 2009 2. July 2015 3. January 2017 4. January 2018 5. January 2019 6. January 2020 7. July 2021 8. July 2022 | | |
| **Codeset source** | DHHS | **Collection start date** | 2009 | |

# Update ICD-10-AM/ACHI codes from 11th to 12th edition

## ****Details of change/Additional background information provided by proposer****

Update all diagnosis/condition and procedure codes to the 12th edition of ICD-10-AM/ACHI codes.

This will involve the following data items:

* Congenital anomalies – ICD-10-AM code
* Events of labour and birth – ICD-10-AM code
* Indication for induction (main reason) – ICD-10-AM code
* Indications for operative delivery – ICD-10-AM code
* Maternal medical conditions – ICD-10-AM code
* Neonatal morbidity – ICD-10-AM code
* Obstetric complications – ICD-10-AM code
* Postpartum complications – ICD-10-AM code
* Procedure – ACHI code

The list of valid 12th edition ICD-10-AM/ACHI codes, including the limited number of codes created exclusively for use in VPDC reporting, will be available to health services and software vendors involved in submitting data to the VPDC early in 2022, following release by the IHPA. All VPDC stakeholders will be notified by email when this is available or contact the [HDSS HelpDesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>.

Any business rules that are altered as a result of changes to ICD-10-AM or ACHI codes will be notified separately.

# Section 4 Business rules

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

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

**Campuses with a SCN and/or NICU**

|  |  |  |  |
| --- | --- | --- | --- |
| **Campus Code** | **Campus Name** | **SCN** | **NICU** |
| 1660 | Albury Wodonga Health - Wodonga | Yes | No |
| 1590 | Angliss Hospital | Yes | No |
| 3020 | Bacchus Marsh campus of Western Health (formerly Djerriwarrh) | Yes | No |
| 2010 | Ballarat Health Services [Base Campus] | Yes | No |
| 6291 | Bays Hospital, The [Mornington] | Yes | No |
| 1021 | Bendigo Hospital, The | Yes | No |
| 1050 | Box Hill Hospital | Yes | No |
| 6511 | Cabrini Malvern | Yes | No |
| 3660 | Casey Hospital | Yes | No |
| 2060 | Central Gippsland Health Service [Sale] | Yes | No |
| 2111 | Dandenong Campus | Yes | No |
| 6470 | Epworth Freemasons | Yes | No |
| 6480 | Epworth Geelong | Yes | No |
| 7720 | Frances Perry House | Yes | No |
| 2220 | Frankston Hospital | Yes | No |
| 1121 | Goulburn Valley Health [Shepparton] | Yes | No |
| 8890 | Jessie McPherson Private Hospital [Clayton] | Yes | No |
| 2440 | Latrobe Regional Hospital [Traralgon] | Yes | No |
| 1160 | Mercy Hospital for Women | Yes | Yes |
| 1320 | Mercy Public Hospitals Inc [Werribee] | Yes | No |
| 8440 | Mitcham Private Hospital | Yes | No |
| 1170 | Monash Medical Centre [Clayton] | Yes | Yes |
| 2320 | New Mildura Base Hospital | Yes | No |
| 1150 | Northeast Health Wangaratta | Yes | No |
| 1280 | Northern Hospital, The [Epping] | Yes | No |
| 7390 | Northpark Private Hospital [Bundoora] | Yes | No |
| 6790 | Peninsula Private Hospital [Frankston] | Yes | No |
| 1230 | Royal Women’s Hospital [Carlton] | Yes | Yes |
| ~~1360~~ 1232 | Sandringham & District Memorial Hospital | Yes | No |
| 2160 | South West Healthcare [Warrnambool] | Yes | No |
| 6520 | St John of God Ballarat Hospital | Yes | No |
| 6030 | St John of God Bendigo Hospital | Yes | No |
| 6080 | St John of God Berwick Hospital | Yes | No |
| 6550 | St John of God Geelong Hospital | Yes | No |
| 6620 | St Vincent’s Private Hospital Fitzroy | Yes | No |
| 1390 | Sunshine Hospital | Yes | Yes |
| 2050 | University Hospital, Geelong | Yes | No |
| 6600 | Waverley Private Hospital [Mt Waverley] | Yes | No |
| 1580 | West Gippsland Healthcare Group [Warragul] | Yes | No |
| 2170 | Wimmera Base Hospital [Horsham] | Yes | No |

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

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

## ### Analgesia for 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

## Birth presentation conditionally mandatory data items

|  |  |
| --- | --- |
| If Birth presentation is: | the Birth presentation must be reported in at least one of the following data items: |
| 8 Other – specify | Events of labour and birth – free text or  Events of labour and birth – ICD-10-AM code |

Valid 12~~11~~th edition ICD-10-AM codes and descriptors for reporting a birth presentation in the Events of labour and birth – ICD-10-AM code data element include:

|  |  |
| --- | --- |
| 12~~11~~th edition ICD-10-AM code | Descriptor |
| O322 | Maternal care for transverse and oblique lie |
| ~~O640~~ | ~~Labour and delivery affected by incomplete rotation of fetal head~~ |
| O648 | Labour and delivery affected by other malposition and malpresentation |

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

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

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

**COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy, Gestation at third COVID19 vaccination during this pregnancy valid combinations**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If COVID19 vaccination status is:** | **and COVID19 vaccination during this pregnancy is:** | **then Gestation at first COVID19 vaccination during this pregnancy must be:** | **and Gestation at second COVID19 vaccination during this pregnancy must be:** | **and Gestation at third COVID19 vaccination during this pregnancy must be:** |
| 1 Yes | 1 Yes | 01 to 45 inclusive **or**  88 Unknown gestation | 01 to 45 inclusive **or**  77 No second ~~Only one~~ dose received during this pregnancy **or**  88 Unknown gestation | 01 to 45 inclusive **or**  77 No third dose received during this pregnancy **or**  88 Unknown gestation |
| 1 Yes | 2 No | Blank | Blank | Blank |
| 1 Yes | 7 Declined to answer | Blank | Blank | Blank |
| 1 Yes | 9 Not stated / inadequately described | 99 Not stated / inadequately described | 99 Not stated / inadequately described | 99 Not stated / inadequately described |
| 2 No | Blank | Blank | Blank | Blank |
| 7 Declined to answer | Blank | Blank | Blank | Blank |
| 9 Not stated/ inadequately described | 9 Not stated / inadequately described | 99 Not stated / inadequately described | 99 Not stated / inadequately described | 99 Not stated / inadequately described |

## 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 |
| 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 of completion of last pregnancy, Date of birth – baby and Estimated gestation valid combinations

|  |  |  |
| --- | --- | --- |
| **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 |

## ### Deceased baby conditionally mandatory data items

|  |  |
| --- | --- |
| **A record reporting:** | **Must also report:** |
| Separation status – baby = 2 Died | At least one code or condition in **at least one of**: Congenital anomalies – ICD-10-AM code **or**  Neonatal morbidity – free text **or**  Neonatal morbidity – ICD-10-AM code |

## ### Deceased mother conditionally mandatory data items

|  |  |
| --- | --- |
| **A record reporting:** | **Must also report:** |
| Separation status – mother = 2 Died | At least one code or condition in **at least one of:**  Events of labour and birth – free text **or**  Events of labour and birth – ICD-10-AM code **or**  Indication for induction (main reason) – ICD-10-AM code **or**  Indications for induction (other) – free text **or**  Indication for operative delivery (main reason) – ICD-10-AM code **or**  Indications for operative delivery (other) – free text **or**  Obstetric complications – free text **or**  Obstetric complications – ICD-10-AM code **or**  Postpartum complications – free text **or**  Postpartum complications – ICD-10-AM code |

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

|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 1 No diabetes mellitus during this pregnancy | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2492  O2493  O2494  O2499 | 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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|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 2 Pre-existing  Type 1 diabetes mellitus | O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth  – ICD-10-AM code **or**  Indication for induction (main reason)  – ICD-10-AM code **or**  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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|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 3 Pre-existing  Type 2 diabetes mellitus | O240  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth  – ICD-10-AM code **or**  Indication for induction (main reason)  – ICD-10-AM code **or**  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 |

|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 4 Gestational diabetes mellitus (GDM) | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth  – ICD-10-AM code **or**  Indication for induction (main reason)  – ICD-10-AM code **or**  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 |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 8 Other type of diabetes mellitus | O240  O2412  O2413  O2414  O2419  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459  O2492  O2493  O2494  O2499 | Events of labour and birth  – ICD-10-AM code **or**  Indication for induction (main reason)  – ICD-10-AM code **or**  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 |

|  |  |  |
| --- | --- | --- |
| **Diabetes mellitus during pregnancy – type** | **May not report any code below:** | **In any of the following data elements:** |
| Code 9 Not stated / inadequately described | O240  O2412  O2413  O2414  O2419  O2422  O2423  O2424  O2429  O2432  O2433  O2434  O2439  O2442  O2443  O2444  O2449  O2452  O2453  O2454  O2459 | Events of labour and birth  – ICD-10-AM code **or**  Indication for induction (main reason)  – ICD-10-AM code **or**  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 |

**Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy, ~~and~~ Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations**

| **Where Gestation at first COVID19 vaccination during this pregnancy is:** | **Then Gestation at second COVID19 vaccination during this pregnancy must be:** | **And Gestation at third COVID19 vaccination during this pregnancy must be:** | **And Estimated gestational age must be:** |
| --- | --- | --- | --- |
| In the range 01 to 45 inclusive | a number in the valid range that is greater than or equal to the value in Gestation at first COVID19 vaccination during this pregnancy | a number in the valid range that is greater than or equal to the value in Gestation at second COVID19 vaccination during this pregnancy | a number greater than or equal to the value in Gestation at ~~second~~ third COVID19 vaccination during this pregnancy |
| In the range 01 to 45 inclusive | 77 ~~Only one~~ No second dose received during this pregnancy | 77 No third dose received during this pregnancy | a number greater than or equal to the value in Gestation at first COVID19 vaccination during this pregnancy |
| In the range 01 to 45 inclusive | 88 Unknown gestation | a number in the valid range that is greater than or equal to the value in Gestation at first COVID19 vaccination during this pregnancy | a number greater than or equal to the value in Gestation at third COVID19 vaccination during this pregnancy |
| In the range 01 to 45 inclusive | a number in the valid range that is greater than or equal to the value in Gestation at first COVID19 vaccination during this pregnancy | 88 Unknown gestation | a number greater than or equal to the value in Gestation at second COVID19 vaccination during this pregnancy |
| In the range 01 to 45 inclusive | 88 Unknown gestation | 88 Unknown gestation | a number greater than or equal to the value in Gestation at first COVID19 vaccination during this pregnancy |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Where Gestation at first COVID19 vaccination during this pregnancy is:** | **Then Gestation at second COVID19 vaccination during this pregnancy must be:** | **And Gestation at third COVID19 vaccination during this pregnancy must be:** | **And Estimated gestational age must be:** |
| 88 Unknown gestation | In the range 01 to 45 inclusive | a number in the valid range that is greater than or equal to the value in Gestation at second COVID19 vaccination during this pregnancy | a number greater than or equal to the value in Gestation at third COVID19 vaccination during this pregnancy |
| 88 Unknown gestation | In the range 01 to 45 inclusive | 88 Unknown gestation | a number greater than or equal to the value in Gestation at second COVID19 vaccination during this pregnancy |
| 88 Unknown gestation | 88 Unknown gestation | In the range 01 to 45 inclusive | a number greater than or equal to the value in Gestation at third COVID19 vaccination during this pregnancy |
| 88 Unknown gestation | 88 Unknown gestation | 88 Unknown gestation | a number in the valid range |
| 88 Unknown gestation | 77 No second dose received during this pregnancy | 77 No third dose received during this pregnancy | a number in the valid range |

## Gravidity and related data items

|  |
| --- |
| **Gravidity must be less than or equal to the sum of:** |
| 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 (fetal deaths)  Total number of previous unknown outcomes of pregnancy  Plus one (for example, the current 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 3 Gestational hypertension | O10  O11  O12  O120  O121  O122  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 4 Chronic hypertension | O12  O120  O121  O122  O13  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 |

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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 | O10  O11  O12  O120  O121  O122  O13  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 |

|  |  |  |
| --- | --- | --- |
| **Hypertensive disorder during pregnancy** | **May not report any code below:** | **In any of the following data elements:** |
| Code 8 No hypertensive disorder during this pregnancy  **Or**  Code 9 Not stated/ inadequately described | O10  O11  O12  O120  O121  O122  O13  O14  O140  O141  O142  O149  O15  O150  O151  O152  O159  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 |

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

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

**Mandatory to report data items**

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

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

## Maternal alcohol use at less than 2~~1~~0 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 weeks or more valid combinations

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

## ### 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**  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**  988899 Majority of antenatal care at a health service in another country | Greater than 0 |
| 9999997 No antenatal care | 9999997 No antenatal care | 0 |
| 999999 Not stated/ inadequately described | 999999 Not stated/ inadequately described | 99 Not stated/ inadequately described |

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

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

## Method of birth and Labour type valid combinations

|  |  |
| --- | --- |
| **If Method of birth is:** | **Labour type must be:** |
| 1 Forceps **or**  3 Vaginal birth – non-instrumental **or**  5 Unplanned caesarean – labour **or**  6 Planned caesarean – labour **or**  8 Vacuum extraction **~~or~~**  ~~10 Other operative birth~~ | 1 Spontaneous **or**  2 Induced medical **or**  3 Induced surgical **or**  1 Spontaneous **and** 4 Augmented **or**  2 Induced medical **and** 3 Induced surgical |
| ~~4 Planned caesarean – no labour~~ | ~~5 No labour~~ |
| 4 Planned caesarean – no labour **or**  7 Unplanned caesarean – no labour **~~or~~**  ~~10 Other operative birth~~ | 5 No labour **or** 2 Induced medical **and** 5 No labour **or**  3 Induced surgical **and** 5 No labour **or**  2 Induced medical **and** 3 Induced surgical   **and** 5 No labour |
| 10 Other operative birth | 1 Spontaneous **or**  2 Induced medical **or**  3 Induced surgical **or**  1 Spontaneous **and** 4 Augmented **or**  2 Induced medical **and** 3 Induced surgical **or**  5 No labour **or** 2 Induced medical **and** 5 No labour **or**  3 Induced surgical **and** 5 No labour **or**  2 Induced medical **and** 3 Induced surgical   **and** 5 No labour |

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

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

## ### 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] |

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

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

|  |
| --- |
| **Single codes:** |
| 1 first degree laceration/tear |
| 2 second degree laceration/tear |
| 3 third degree laceration/tear |
| 4 fourth degree laceration/tear |

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

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

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

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

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

|  |
| --- |
| **Single codes:** |
| blank |
| 5 Labial/clitoral laceration/tear |
| 6 Vaginal wall laceration/tear |
| 7 Cervical laceration/tear |
| ~~8 Other~~ 0 Laceration, rupture or tear of other genital tract location |

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

## Validation level ‘Review required’ to be removed

## Validition of ICD-10-AM/ACHI codes checks for ~~11~~12th edition codes

All validations that check for ICD-10-AM/ACHI code(s) will do so for 12th edition codes, ie codes that were valid in 11th or earlier editions of ICD-10-AM/ACHI but are not valid in 12th edition, will be rejected.

# Section 5 Compilation and submission

**Table of Episode record data elements**

| **Position number** | **Data item name** | **Data type** | **Format** | **Field size** |
| --- | --- | --- | --- | --- |
| 1 | Collection identifier | String | AAAA | 4 |
| 2 | Version identifier | Number | NNNN | 4 |
| 3 | Transaction type flag | String | A | 1 |
| 4 | Hospital code (agency identifier) | Number | NNNN | 4 |
| 5 | Patient identifier – mother | String | A(10) | 10 |
| 6 | Patient identifier – baby | String | A(10) | 10 |
| 7 | Date of admission – mother | Date/time | DDMMCCYY | 8 |
| 8 | Surname / family name – mother | String | A(40) | 40 |
| 9 | First given name – mother | String | A(40) | 40 |
| 10 | Middle name – mother | String | A(40) | 40 |
| 11 | Residential locality | String | A(46) | 46 |
| 12 | Residential postcode | Number | NNNN | 4 |
| 13 | Residential road number – mother | String | A(12) | 12 |
| 14 | Residential road name – mother | String | A(45) | 45 |
| 15 | Residential road suffix code – mother | String | AA | 2 |
| 16 | Residential road type – mother | String | AAAA | 4 |
| 17 | Admitted patient election status – mother | Number | N | 1 |
| 18 | Country of birth | Number | NNNN | 4 |
| 19 | Indigenous status – mother | Number | N | 1 |
| 20 | Indigenous status – baby | Number | N | 1 |
| 21 | Marital status | Number | N | 1 |
| 22 | Date of birth – mother | Date/time | DDMMCCYY | 8 |
| 23 | Height – self-reported – mother | Number | NNN | 3 |
| 24 | Weight – self-reported – mother | Number | NN[N] | 3 |
| 25 | Setting of birth – intended | Number | NNNN | 4 |
| 26 | Setting of birth – intended – other specified description | String | A(20) | 20 |
| 27 | Setting of birth, actual | Number | NNNN | 4 |
| 28 | Setting of birth, actual – other specified description | String | A(20) | 20 |
| 29 | Setting of birth – change of intent | Number | N | 1 |
| 30 | Setting of birth – change of intent – reason | Number | N | 1 |
| 31 | Maternal smoking < 20 weeks | Number | N | 1 |
| 32 | Maternal smoking ≥ 20 weeks | Number | NN | 2 |
| 33 | Gravidity | Number | N[N] | 2 |
| 34 | Total number of previous live births | Number | NN | 2 |
| 35 | Parity | Number | NN | 2 |
| 36 | Total number of previous stillbirths (fetal deaths) | Number | NN | 2 |
| 37 | Total number of previous neonatal deaths | Number | NN | 2 |
| 38 | Total number of previous abortions – spontaneous | Number | NN | 2 |
| 39 | Total number of previous abortions – induced | Number | NN | 2 |
| 40 | Total number of previous ectopic pregnancies | Number | NN | 2 |
| 41 | Total number of previous unknown outcomes of pregnancy | Number | NN | 2 |
| 42 | Date of completion of last pregnancy | Date/time | {DD}MMCCYY | 6 (8) |
| 43 | Outcome of last pregnancy | Number | N | 1 |
| 44 | Last birth – caesarean section indicator | Number | N | 1 |
| 45 | Total number of previous caesareans | Number | NN | 2 |
| 46 | Plan for VBAC | Number | N | 1 |
| 47 | Estimated date of confinement | Date/time | DDMMCCYY | 8 |
| 48 | Estimated gestational age | Number | NN | 2 |
| 49 | Maternal medical conditions – free text | String | A(300) | 300 |
| 50 | Maternal medical conditions – ICD-10-AM code | String | ANN[NN] | 5 (X12) |
| 51 | Obstetric complications – free text | String | A(300) | 300 |
| 52 | Obstetric complications – ICD-10-AM code | String | ANN[NN] | 5 (x15) |
| 53 | Gestational age at first antenatal visit | Number | N[N] | 2 |
| 54 | Discipline of antenatal care provider | Number | N | 1 |
| 55 | Procedure – free text | String | A(300) | 300 |
| 56 | Procedure – ACHI code | Number | NNNNNNN | 7 (x8) |
| 57 | Deleted field |  |  |  |
| 58 | Deleted field |  |  |  |
| 59 | Deleted field |  |  |  |
| 60 | Artificial reproductive technology – indicator | Number | N | 1 |
| 61 | Date of onset of labour | Date/time | DDMMCCYY | 8 |
| 62 | Time of onset of labour | Date/time | HHMM | 4 |
| 63 | Date of onset of second stage of labour | Date/time | DDMMCCYY | 8 |
| 64 | Time of onset of second stage of labour | Date/time | HHMM | 4 |
| 65 | Date of rupture of membranes | Date/time | DDMMCCYY | 8 |
| 66 | Time of rupture of membranes | Date/time | HHMM | 4 |
| 67 | Labour type | Number | N | 1 (x3) |
| 68 | Labour induction/augmentation agent | Number | N | 1 (x4) |
| 69 | Labour induction/augmentation agent – other specified description | String | A(20) | 20 |
| 70 | Indications for induction (other) – free text | String | A(50) | 50 |
| 71 | Indication for induction (main reason) – ICD-10-AM code | String | ANN[NN] | 5 (X1) |
| 72 | Fetal monitoring in labour | String | NN | 2 (x7) |
| 73 | Birth presentation | Number | N | 1 |
| 74 | Method of birth | Number | NN | 2 |
| 75 | Indications for operative delivery (other) – free text | String | A(300) | 300 |
| 76 | Indication~~s~~ for operative delivery (main reason) – ICD-10-AM code | String | ANN[NN] | 5 (x4) |
| 77 | Analgesia for labour – indicator | Number | N | 1 |
| 78 | Analgesia for labour – type | Number | N | 1 (x4) |
| 79 | Anaesthesia for operative delivery – indicator | Number | N | 1 |
| 80 | Anaesthesia for operative delivery – type | Number | N | 1 (x4) |
| 81 | Events of labour and birth – free text | String | A(300) | 300 |
| 82 | Events of labour and birth – ICD-10-AM code | String | ANN[NN] | 5 (x9) |
| 83 | Prophylactic oxytocin in third stage | Number | N | 1 |
| 84 | Manual removal of placenta | Number | N | 1 |
| 85 | Perineal laceration – indicator | Number | N | 1 |
| 86 | Perineal / genital laceration – degree/type | Number | N | 1 (x~~2~~3) |
| 87 | Perineal laceration – repair | Number | N | 1 |
| 88 | Episiotomy – indicator | Number | N | 1 |
| 89 | Blood loss (ml) | Number | N[NNNN] | 5 |
| 90 | Blood product transfusion – mother | Number | N | 1 |
| 91 | Postpartum complications – free text | String | A(300) | 300 |
| 92 | Postpartum complications – ICD-10-AM – code | String | ANN[NN] | 5 (x6) |
| 93 | Discipline of lead intra-partum care provider | Number | N | 1 |
| 94 | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother | Number | N | 1 |
| 95 | Date of birth – baby | Date/time | DDMMCCYY | 8 |
| 96 | Time of birth | Date/time | HHMM | 4 |
| 97 | Sex – baby | Number | N | 1 |
| 98 | Birth plurality | Number | N | 1 |
| 99 | Birth order | Number | N | 1 |
| 100 | Birth status | Number | N | 1 |
| 101 | Birth weight | Number | NN[NN] | 4 |
| 102 | Apgar score at one minute | Number | N[N] | 2 |
| 103 | Apgar score at five minutes | Number | N[N] | 2 |
| 104 | Time to established respiration (TER) | Number | NN | 2 |
| 105 | Resuscitation method – mechanical | String | NN | 2 (x10) |
| 106 | Resuscitation method – drugs | Number | N | 1 (x5) |
| 107 | Congenital anomalies – indicator | Number | N | 1 |
| 108 | Deleted field |  |  |  |
| 109 | Deleted field |  |  |  |
| 110 | Deleted field |  |  |  |
| 111 | Neonatal morbidity – free text | String | A(300) | 300 |
| 112 | Neonatal morbidity – ICD-10-AM code | String | ANN[NN] | 5 (x10) |
| 113 | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby | Number | N | 1 |
| 114 | Hepatitis B vaccine received | Number | N | 1 |
| 115 | Breastfeeding attempted | Number | N | 1 |
| 116 | Formula given in hospital | Number | N | 1 |
| 117 | Last feed before discharge taken exclusively from the breast | Number | N | 1 |
| 118 | Separation date – mother | Date/time | DDMMCCYY | 8 |
| 119 | Separation date – baby | Date/time | DDMMCCYY | 8 |
| 120 | Separation status – mother | Number | N | 1 |
| 121 | Separation status – baby | Number | N | 1 |
| 122 | Transfer destination – mother | Number | NNNN | 4 |
| 123 | Transfer destination – baby | Number | NNNN | 4 |
| 124 | Number of antenatal care visits | Number | NN | 2 |
| 125 | Influenza vaccination status | Number | N | 1 |
| 126 | Pertussis (whooping cough) vaccination status | Number | N | 1 |
| 127 | Spoken English Proficiency | Numeric | N | 1 |
| 128 | Year of arrival in Australia | Number | NNNN | 4 |
| 129 | Head circumference | Number | NN.N | 4 |
| 130 | Episode identifier | String | A (9) | 9 |
| 131 | Fetal monitoring prior to birth – not in labour | String | NN | 2 (x5) |
| 132 | Reason for transfer out – baby | Number | N | 1 |
| 133 | Reason for transfer out – mother | Number | N | 1 |
| 134 | Congenital anomalies – ICD-10-AM code | String | ANN[NN] | 5 (x9) |
| 135 | Maternal alcohol use at less than 20 weeks | Number | N | 1 |
| 136 | Maternal alcohol volume intake at less than 20 weeks | Number | N | 1 |
| 137 | Maternal alcohol use at 20 or more weeks | Number | N | 1 |
| 138 | Maternal alcohol volume intake at 20 or more weeks | Number | N | 1 |
| 139 | Antenatal corticosteroid exposure | Number | N | 1 |
| 140 | Chorionicity of multiples | Number | N | 1 |
| 141 | Cord complications | String | ANN[NN] | 5 (x3) |
| 142 | Diabetes mellitus during pregnancy – type | Number | N | 1 |
| 143 | Diabetes mellitus – gestational – diagnosis timing | Number | NN | 2 |
| 144 | Diabetes mellitus – pre-existing – diagnosis timing | Number | NNNN | 4 |
| 145 | Diabetes mellitus therapy during pregnancy | String | N | 1 (x3) |
| 146 | Main reason for excessive blood loss following childbirth | Number | N | 1 |
| 147 | Blood loss assessment - indicator | Number | N | 1 |
| 148 | Category of unplanned caesarean section urgency | Number | N | 1 |
| 149 | Date of decision for unplanned caesarean section | Date/time | DDMMCCYY | 8 |
| 150 | Time of decision for unplanned caesarean section | Date/time | HHMM | 4 |
| 151 | COVID19 vaccination status | Number | N | 1 |
| 152 | COVID19 vaccination during this pregnancy | Number | N | 1 |
| 153 | Gestation at first COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 154 | Gestation at second COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 155 | Gestation at third COVID19 vaccination during this pregnancy | Number | [N]N | 2 |
| 156 | Antenatal mental health risk screening status | Number | N | 1 |
| 157 | Edinburgh Postnatal Depression Scale score | Number | N[N] | 2 |
| 158 | Presence or history of mental health condition – indicator | Number | N | 1 |
| 159 | Family violence screening status | Number | N | 1 |
| 160 | Hepatitis B antenatal screening – mother | Number | N | 1 |
| 161 | HIV antenatal screening – mother | Number | N | 1 |
| 162 | Syphilis antenatal screening – mother | Number | N | 1 |
| 163 | Hypertensive disorder during pregnancy | Number | N | 1 |
| 164 | Maternity model of care – antenatal | Number | NNNNNN | 6 |
| 165 | Maternity model of care – intrapartum | Number | NNNNNN | 6 |

## General information about managed file transfer (MFT) portal

The portion of Section 5 of the VPDC manual providing information about the MFT portal will be updated to include information about using the multifactor authentication (MFA) code, consistent with information released by email to all health services. The updated Section 5 will be released prior to 1 July 2022.

A [tutorial video](https://vimeo.com/629735934/8100600020) is also available to assist < https://vimeo.com/629735934/8100600020>.