Queensland Perinatal Data Collection Manual for the Completion of Perinatal Data

Statistical Collections and Integration Unit

2017-2018

Queensland Government

Queensland Perinatal Data Collection Manual for the Completion of Perinatal Data

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For more information contact:
Statistical Services Branch, Department of Health, GPO Box 48, Brisbane QLD 4001, email PERIMAIL@health.qld.gov.au, phone 07 3708 5667.

An electronic version of this document is available at
https://www.health.qld.gov.au/hsu/collections/pdc.asp

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GPO Box 48
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Email: PERIMAIL@health.qld.gov.au

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Manager
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Date	Release	Pages	Details
July 2011	Version 1.25	Numerous	Added diagnosed antenatally code and Toowoomba Birth Centre code.
July 2012	Version 1.26	Numerous	Amend thromboprophylaxis and non-pharmacological analgesia. Added total number of antenatal visits and hepatitis B immunoglobulin. Removed antenatal visits.
July 2013	Version 1.27	Numerous	Added perineal status and perineal code. Removed perineum, episiotomy and statistical local area.
July 2014	Version 2.0	Numerous	Amended perineum, presentation at birth, regular respirations and PPH volume. Added Gold Coast University Birth Centre code, assisted conception code, main reason for caesarean, first additional reason for caesarean and second additional reason for caesarean. Removed Gold Coast Birth Centre and reason for caesarean.
July 2015	Version 2.1	Numerous	Added antenatal screening performed for Edinburgh Depression Scale and range, antenatal screening performed for domestic violence, antenatal screening performed for alcohol use antenatal screening performed for illicit drug use, immunisation for influenza received during this pregnancy and at what gestation weeks, immunisation for pertussis received during this pregnancy and at what gestation weeks, assisted conception code, main reason for induction, reason for induction additional 1, reason for induction additional 2 Removed reason for induction
July 2016	Version 2.2	Numerous	Amend Division, Branch, Unit titles. Add gestation at first antenatal visit
July 2017	Version 2.3	Numerous	Amended dates and hyperlinks. Updated facilities in Neonatal Intensive Care Units, Special Care Nurseries for Public and Private Hospitals.

1. Introduction

This manual provides an overview for the completion of Perinatal Data Collection (PDC) and the data items that are collected. It is intended to be a reference for all public hospitals, private hospitals and private midwifery or medical practitioners who deliver babies outside hospitals, as well as Hospital and Health Services and Department of Health personnel who are involved in the collection and use of perinatal data.

For users completing, submitting and approving PDC online forms, this manual should be read in conjunction with the Perinatal Online User Manual.

1.1 Requirements

The *Health Act 1937–1988* was replaced by the *Public Health Act 2005*. Chapter 6, Part 1 - Perinatal Statistics includes a requirement that perinatal data be provided to the Chief Executive of Department of Health for every baby born in Queensland. The Queensland Perinatal Data Collection commenced in November 1986. All unit record information collected by Statistical Collections and Integration Unit is treated as strictly confidential. All information collected is used for statistical purposes only.

1.2 Australian Government Reporting Requirements

Australian Institute of Health and Welfare (AIHW)

The National Perinatal Data Collection (NPDC) is a national population-based cross sectional data collection of pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other staff, using information obtained from mothers and from hospital or other records, complete notification forms for each birth. Information is included in the NPDC on both live births and stillbirths of at least 400 grams birthweight or at least 20 weeks gestation. The NPDC is compiled annually by the Australian Institute of Health and Welfare.

The Perinatal National Minimum Data Set (NMDS) is a specification for perinatal data elements for mandatory collection and reporting at the national level, and depends on a national agreement to collect the data in a uniform way. This core set of data elements is agreed to and progressed by the National Perinatal Data Development Committee (NPDDC) and endorsed by the National Health Information Standards and Statistics Committee (NHISSC). The Perinatal NMDS was first specified in 1997. It includes data items relating to the mother, including demographic characteristics and factors relating to the pregnancy, labour and birth, and data items relating to the baby, including birth status, sex and birthweight. More data elements are included in the NPDC than are specified in the Perinatal NMDS. Definitions of all data elements in the Perinatal NMDS are included in the AIHW's online metadata registry, 'METeOR' .

2. The Perinatal Data Collection (PDC)

The aims of the PDC are to monitor patterns of obstetric and neonatal practice in the State and to provide statistical information on specific topics within these fields to assist with the planning of Department of Health services. It is also intended to be a basic source of information for research in obstetric and neonatal care and to be used in the education of students of midwifery and medicine.

In addition to information collected via the perinatal data forms and via electronic extracts, details from Certificates of Perinatal Death, Histopathology reports and post mortem reports supplement the Collection.

The Statistical Services Branch (SSB) releases an annual report presenting summary statistics based on the data collected via the PDC. This report is available on QHEPS:

http://qheps.health.qld.gov.au/hsu/publications.htm

or via the following website: http://www.health.qld.gov.au/hsu/

Through the AIHW, Queensland data is used in the compilation of Australia-wide figures and can be compared with perinatal statistics from other States and Territories.

Data are also available via request, on an adhoc or regular basis, from the Statistical Reporting and Coordination Unit (SRCU) within SSB. The release of data is governed by patient confidentiality legislation in the Public Health Act 2005. Requests for data should be made via e-mail to HlthStat@health.qld.gov.au or by phoning (07) 3234 1875. (Note that in some instances charges may apply – contact SRCT for further details).

2.1 Scope of the PDC

The Perinatal Data Collection Form (MR63D) is required to be completed (or in the case of hospitals providing electronic extracts, an extract is required) by all public hospitals, private hospitals, and private midwifery or medical practitioners who deliver babies outside hospitals, for all births occurring in Queensland. The scope of the Collection includes all live births, and stillbirths of at least 20 weeks gestation and/or at least 400 grams in weight.

Information relating to neonatal morbidity is collected up until the baby is discharged from the birth admission or up until the baby reaches 28 days of age. These forms or extract should be forwarded to the Statistical Collections and Integration Unit within 35 days of the birth of a baby.

The quality of information produced from the PDC depends on the accurate, consistent and timely completion of the forms. Completed forms and electronic extracts are validated and queries relating to missing, contradictory or ambiguous data are directed back to the hospital or independent practitioner.

2.2 Paper MR63D Forms

Paper MR63D forms are completed by a small number of hospitals and private midwifery practitioners and submitted to the PDC in this format. The form is designed to be an integral part of the obstetric record, both to reduce duplication of recording and to ensure optimum accuracy of data. The hospital copies can be used as a summary for the patient's chart and this includes some items which are not essential for the PDC but may be useful in hospitals. Items not needed specifically for the PDC but included for hospitals' use are not highlighted white on the hospital copies and have been marked with an asterisk (*) in this Manual.

2.3 Perinatal Online

Perinatal Online (PNO) is a web based application, developed by SCIU, which enables facilities to enter perinatal data for both the mother and the baby(s) and perform an electronic extract to SCIU to report PDC data.

Refer to the PNO Online User Manual for information on this application.

2.4 PDC Changes for 2017-2018

2.4.1 Mother Details

There are no NMDS or DSS changes required for this reporting period. There are changes to morbidity and procedures where a change to ICD-10-AM 10th edition is required.

2.4.2 PDC MR63D Form Changes for 2017-2018

There are no changes to the PDC Form (MR63D) for this period. The link to the latest MR63D form can be found at the following link –

https://www.health.qld.gov.au/hsu/collections/pdc

2.4.3 PDC Electronic File Format Changes for 2017-2018

There are minor changes to the PDC Electronic File Format for this period where a change to ICD-10-AM 10th edition is required and additions/amendments to facilities and names in the facility transfer lists. The link to the latest Electronic File Format can be found at the following link - https://www.health.qld.gov.au/hsu/collections/pdc

2.5 PDC Reporting Requirements

2.5.1 PDC Monthly & 6 Monthly Reporting Timeframes

All MR63D forms or electronic extract of births must be submitted to PDC by 35 days following the birth of the baby or reference month (e.g. for the reference month of September, PDC forms or extracts must be submitted by 4 November).

PDC data is required to be supplied to the AIHW 6 months following the end of the previous 6 months block of data.

Refer to the table below as an example of the 6 monthly reporting schedule:

Reporting Period	Birth Month	Due Date	Finalisation Date
July – December 2017	July	4 September	30 June 2018
	August	5 October	
	September	4 November	
	October	5 December	
	November	4 January	
	December	4 February	
January – June 2018	January	7 March	31 December 2018
	February	4 April	
	March	5 May	
	April	4 June	
	May	5 July	
	June	4 August	

2.6 Data Definitions

The Queensland Health Data Dictionary (QHDD) is available on the Queensland Health web page. The dictionary contains data definitions from a number of sources e.g., Qld Health, the National Health Data Dictionary, and some from the HL7 standard. It catalogues many definitions in 'current' use as well as listing those endorsed as standards by Qld Health.

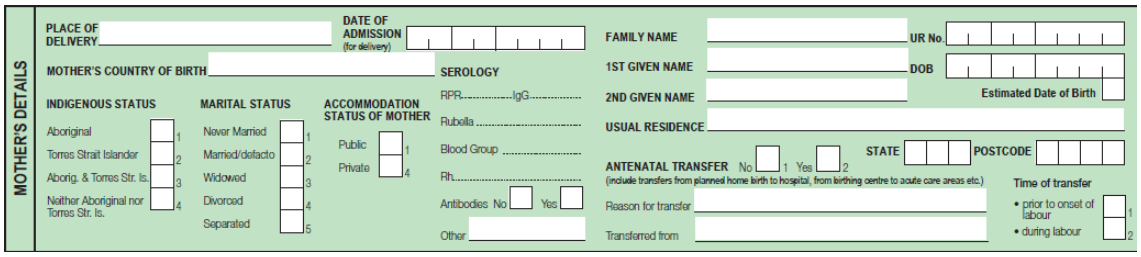
For more detail on any of the following data items please click on the link to the QHDD and follow the prompts.

https://www.health.qld.gov.au/__data/assets/pdf_file/0033/357864/qhdd-ourperf.pdf If you would like to obtain more information about the inventory of data elements please contact the Statistical Services Branch on email DQSTD@health.qld.gov.au.

3. Mothers Details

All items contained in this section of the form must be completed clearly. Wherever possible, it is preferred that printed labels be used to provide maternal details and to identify the MR63D forms, however this is not mandatory.

If used on the original and duplicate copies, labels should be placed in the upper right hand corner, ensuring that no other information is obscured. If an identification label is used only on the hospital copies (and not the duplicates), DO NOT FORGET to complete MOTHER'S USUAL RESIDENCE, DATE OF BIRTH, NAMES and UR NUMBER on the second duplicate (i.e. the Statistical Collections and Integration Unit copy).



3.1 Place of Delivery

The place of delivery for electronically submitted data is provided as a facility number and is a numerical code that uniquely identifies each Queensland Health care facility. For a full list of facility numbers refer to the Queensland Hospital Admitted Patient Data Collection Manual Appendix A.
https://www.health.qld.gov.au/hsu/collections/qhapdc.asp

For hospitals using the MR63D form, enter the name of the hospital where the birth occurred. For births notified by a hospital but not delivered in the hospital (e.g. Born before arrival (BBA) or home birth), enter the name of the hospital completing the form. If a home birth is notified by the accoucheur, write 'Home' and complete the details on the reverse side of the Statistical Collections and Integration copy.

This field allows the Statistical Collections and Integration Unit to follow up queries concerning missing or inconsistent data. It also enables individual hospitals to receive feedback on the data they record on the form.

3.2 Date of Admission

Enter the day, month and year of the date of admission of the mother for delivery using all boxes, e.g. 1 November 2017 should be entered as: 01112017.

For this Collection, record the date of admission for the birth to the facility where the birth takes place or in the case of a BBA the date the mother presents to the hospital post birth. For planned home births where the baby is not admitted to a hospital, this field is not required.

3.3 Mother's Country of Birth

Enter the country of birth of the mother. Be as specific as possible, e.g. enter South Korea or North Korea rather than Korea.

Ethnicity is an important concept, both in the study of disease patterns and the need for and provision of services. Country of birth is the most easily collected and consistently reported of possible ethnicity data items. It is recognised that country of birth is one of a number of surrogate measures for ethnicity.

3.4 Indigenous Status

Select the response (only one) that corresponds to the Indigenous Status of the mother.

Note that a mother's Indigenous status cannot be determined simply by observation and therefore this question must be asked of all mothers. For further information regarding determining Indigenous status, please refer to the 'Are you of Aboriginal or Torres Strait Islander origin?' pamphlet. If you require copies of this publication, please contact the Aboriginal and Torres Strait Islander Health Unit on (07) 3247 4893 or via email at cultural_pp@health.qld.gov.au

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which that person lives.

Definitions	
Aboriginal	Aboriginal but not Torres Strait Islander origin.
Torres Strait Islander	Torres Strait Islander but not Aboriginal origin.
Aboriginal and Torres Strait Islander	Both Aboriginal and Torres Strait Islander origin.
Neither Aboriginal nor Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander origin.

Given the gross inequalities in health status between Indigenous and Non-indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on Indigenous status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health.

3.5 Marital Status

Select the response (only one) that corresponds to the marital status of the mother.

Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is to establish the living arrangements of individuals, to

facilitate analysis of the association of marital status with the need for and use of services and for epidemiological analysis.

3.6 Accommodation Status of Mother

Select the response (only one) that corresponds to the type of ward accommodation the mother has elected to be accommodated in regardless of the method of payment for the hospital admission. This item does not indicate the insurance status of the mother.

For home births where the baby is not admitted to a hospital, this field is not required.

Definitions	
Public	A public patient is a person who: • elects to be treated as a public patient, and so cannot choose the doctor who treats them, or • is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority. A pubic patient who is allocated single room accommodation due to clinical need is still a public patient.
Private	A private patient is a person who elects to be treated by a doctor of their choice.

A patient who is ineligible for Medicare does not have access to hospital treatment 'free of charge'. Queensland Public Hospitals are to provide Medicare ineligible patients with a choice to be treated as a public or private patient. Different fees apply depending on the option chosen. Refer to the Queensland Health *Fees and Charges Register*.

A patient who is compensable (e.g. entitled to receive compensation for their hospital treatment) does not have access to treatment 'free of charge'. However, they do have the right to be treated either by a hospital nominated doctor ('public') or by a doctor of their choice ('private').

3.7 Serology

This field is not mandatory, however if results reported in this field affect the management of the pregnancy, please report the associated condition in Medical Conditions (see Section 5.11) or Pregnancy Complications (see Section 5.12).

Instructions	
RPR…….IgG …….	Enter 'Pos', '+' or 'Neg', '-' in both fields to show RPR and IgG status.
Rubella	Enter 'immune' or 'not immune'.

Blood Group	Enter blood group e.g. ‘O’, ‘A’, ‘B’ or ‘AB’.
Rh	Enter the Rhesus factor ‘+’ or ‘-‘.
Antibodies	Select the appropriate box for ‘Yes’ or ‘No’.
Other	Enter a text response for any other serology results not included in the above options.

3.8 Family Name

The mother’s full family name should be recorded.

If family name is not known or cannot be established, record UNKNOWN.

Some people do not have a family name and a given name and they have only one name by which they are known. If the mother has only one name, record it as the family name.

3.9 1st Given Name

A mother may have more than one given name. If so, the mother’s first given name should be recorded here. If first given name is not known or cannot be established, record UNKNOWN.

Some people do not have a family name and a given name and they have only one name by which they are known. If the mother has only one name, record it as the family name.

3.10 2nd Given Name

A mother may have more than one given name. If so, the mother’s second given name should be recorded here. If the mother does not have a second given name, then leave this field blank. If the second given name is not known or cannot be established, record UNKNOWN.

3.11 UR Number

Enter the Unit Record (UR) number assigned to the mother (if applicable).

For home births where the baby is not admitted to a hospital, this field is not required, however, if the private midwifery practitioner assigns a record number for administrative purposes it can be included.

Confidentiality of data is maintained through the storage of this data in a separate table by PDC, with limited access.

3.12 Date of Birth (Mother)

Record the date of birth of the mother using the full date (i.e. ddmmyyyy) and leading zeros where necessary. Example: 10 January 1985 should be entered as: 10011985

If the day of birth is unknown, use 15.

If the month of birth is unknown, use 06.

If the year of birth is unknown, estimate the year from the age of the mother.

If the age of the mother is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious mothers, use the year 1900)

Example: If a mother is admitted in 2015 and does not know her exact date of birth but knows that she is 30 years of age, record the date of birth as follows: 15061985

Although provision is made for recording an unknown date of birth (using 15/06/1900), every effort should be made during the course of the admission to determine (and record) the mother's actual date of birth. The mother's date of birth is an important requirement for the correct identification of the individual.

3.13 Estimated Date of Birth Flag (Mother)

The Estimated Date of Birth box indicates whether the mother's date of birth has been estimated. If an estimate has been used in place of either the day or the month or the year, then the Estimated Date of Birth box must be selected.

3.14 Usual Residence

The collection of the address details of a mother is critical for patient follow up and as a means of reporting information about the geographic location of the residence of a mother. A mother may have one address or many addresses. The last known usual residential address should be recorded.

3.14.1 Street name and Suburb

Enter the street number and street name into the first line of the usual address. Enter the suburb or town of where the mother usually resides (not postal address) into the second line of the usual address.

For interstate mothers, enter the street name and suburb of the mother's usual residence, not the address of a vacation premises or similar.

3.14.2 Postcode

Enter the postcode of where the mother usually resides (not postal address) into the postcode boxes.

If the mother is not a resident of Australia or an Australian External Territory, or has no fixed address, use one of the following supplementary codes as the postcode of usual residence.

Code	Description
9301	Papua New Guinea
9302	New Zealand
9399	Overseas other (not PNG or NZ)
9799	At Sea
9989	No fixed address
0989	Not stated or unknown

Please note that it is particularly important to record the country of residence accurately for patients from Papua New Guinea and New Zealand.

For Australian External Territory addresses, the actual postcode and State ID is to be used from 1 July 2005, rather than a supplementary postcode and State ID. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, and Norfolk Island.

3.15 Antenatal Transfer

Select 'Yes' or 'No' to indicate whether the mother has been transferred from a different location. This includes transfers from home births to hospital, from birthing centre to acute care area.

This does not include a mother who has had her antenatal care was received at a health care centre where there was no intention of birthing at that health care centre.

3.15.1 Reason for Transfer

Enter the reason for the transfer of the mother from the initial location, e.g. 'unavailability of medical services', 'premature rupture of membranes'.

3.15.2 Transferred From

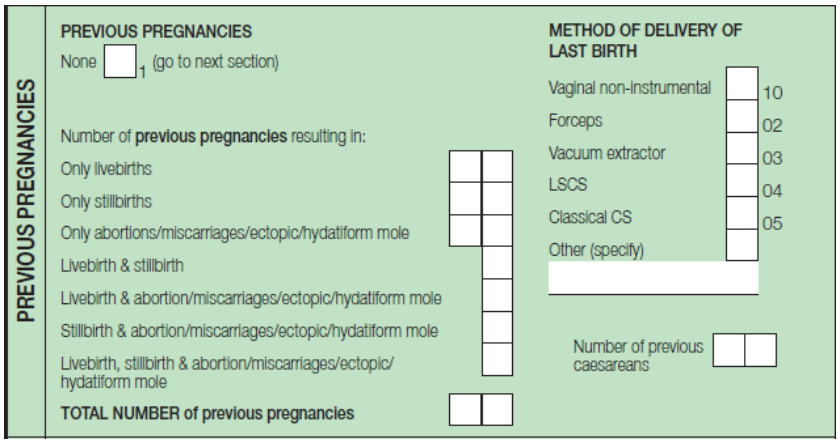
Enter the initial place of treatment that the mother has been transferred from. Enter the full name of the facility, including whether public or private where applicable, or where transferred from a home birth, enter 'Home'.

3.15.3 Time of Transfer

Select whether the mother was transferred 'prior to onset of labour' or 'during labour'.

4 Previous Pregnancies

This section refers to all previous pregnancies and therefore excludes the current pregnancy.



4.1 Previous Pregnancies

If the mother has had no previous pregnancies, select 'None' and go to the next section PRESENT PREGNANCY. **DO NOT** complete the remaining fields in this section.

If the mother has had previous pregnancies, complete all sections in Previous Pregnancies field (4.2 – 4.4).

4.2 Number of Previous Pregnancies

Enter the number of previous pregnancies (not number of previous babies) resulting in each of

- Only livebirths (Number of previous pregnancies resulting in livebirths only).
- Only stillbirths (Number of previous pregnancies resulting in stillbirths only).
- Only abortions/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in abortion/miscarriage/ectopic/hydatiform mole only).
- Livebirth & stillbirth (Number of previous pregnancies resulting in an outcome of livebirth and stillbirth in the same pregnancy).
- Livebirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of livebirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy).
- Stillbirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of stillbirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy).
- Livebirth, stillbirth & abortion/miscarriage/ectopic/hydatiform mole (Number of previous pregnancies resulting in an outcome of livebirth and stillbirth and abortion/miscarriage/ectopic/hydatiform mole in the same pregnancy).

The actual number of pregnancies must be recorded, even if that number is zero.

Note: This field refers to the number of pregnancies, not the number of babies born. Consequently, a pregnancy resulting in multiple births should be counted as only one pregnancy.

The total number of previous pregnancies should be entered at the bottom of the list of outcomes in the field provided. Note that the total number entered should be equal to the combined numbers entered as outcomes.

Definitions	
Livebirth	The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.
Stillbirth	A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation and/or of 400 grams or more birthweight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
Abortion/Miscarriage/ Ectopic/Hydatiform mole	Includes spontaneous abortion (less than 20 weeks gestation and less than 400 grams birthweight); induced abortion (termination of pregnancy before 20 weeks gestation and less than 400 grams); ectopic pregnancy; or molar pregnancy.

Note, that in the case of medical abortion or termination of pregnancy where gestation is 20 weeks or greater and/or birthweight 400g or greater, the pregnancy should be recorded as determined by the outcome (i.e. live birth or stillbirth).

4.3 Method of Delivery of Last Birth

Select the response(s) that correspond to the method of delivery of the last birth. If a previous multiple pregnancy resulted in two or more different outcomes (e.g. Vaginal non-instrumental and LSCS), select both boxes. This should be further clarified by noting in this section that a multiple pregnancy occurred.

This relates to the last birth, and therefore not necessarily the last pregnancy. For example, if the mother has had two previous pregnancies and the last pregnancy resulted in a spontaneous abortion while the pregnancy before that resulted in a lower segment caesarean birth then select ‘LSCS’.

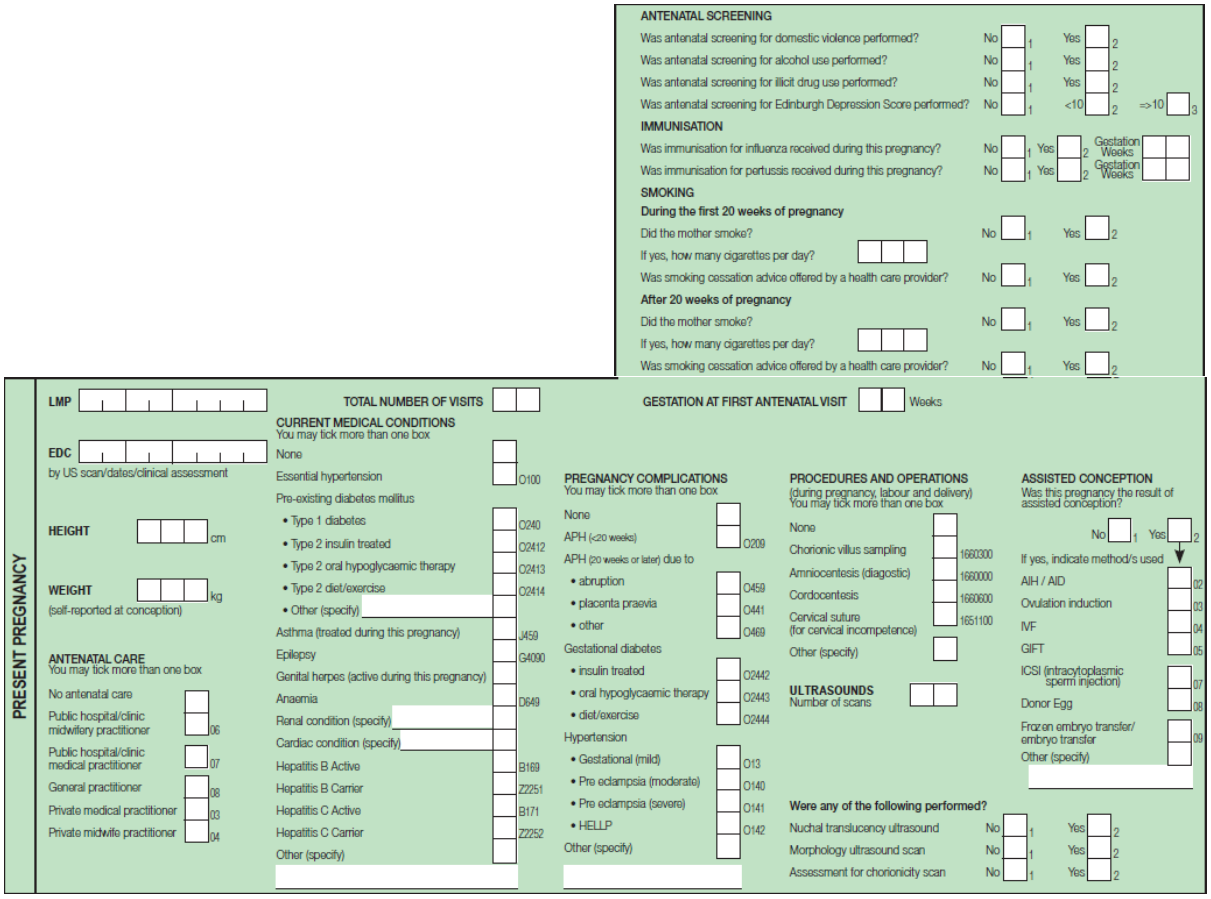
Method of delivery should only be provided for abortion/miscarriage when gestation is 20 weeks or greater and/or birthweight 400g or more.

(See Section 6.11 for definitions of Methods of Birth).

4.4 Number of Previous Caesareans

Enter the number of previous caesarean sections the mother has had. Enter zero if the mother has had no previous caesarean sections.

5 Present Pregnancy



5.1 Antenatal Screening

For additional information refer to the *National Antenatal Care Guidelines* (http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-antenatal-care-index and/or the *AIHW 2013 National Drug Strategy Household Survey Report* (http://www.aihw.gov.au/publication-detail/?id=60129549469)

Note: If the mother has had no antenatal care provided during the pregnancy, then the response to the Antenatal Screening questions must be 'No'. If the mother is screened at her first presentation to hospital for birth of the baby this is not included as an antenatal care visit.

5.1.1 Domestic Violence

Select the response that corresponds to the mother's antenatal screening status for domestic violence.

Violence poses serious health risks to pregnant women (including breast and genital injury, miscarriage, antepartum haemorrhage and infection, blunt or penetrating abdominal trauma and death) and babies (including fetal fractures, low birth weight, injury, suppressed immune system). Young women exposed to violence are more likely to have a miscarriage, stillbirth, premature birth or termination of pregnancy than other

young women. Women exposed to violence during pregnancy are more likely to develop depression in the postnatal period.

5.1.2 Alcohol Use

Select the response that corresponds to the mother's antenatal screening status for alcohol use.

High-level and/or frequent intake of alcohol in pregnancy increases the risk of miscarriage, stillbirth and premature birth. Alcohol crosses the placenta and nearly equal concentrations in the mother and fetus can be attained. Exposure of the fetus to alcohol may result in a spectrum of adverse effects, referred to collectively as fetal alcohol spectrum disorders (FASD).

5.1.3 Illicit Drug Use

Select the response that corresponds to the mother's antenatal screening status for illicit drug use.

Use of amphetamines, opiates and marijuana is associated with preterm birth. Illicit drugs include illegal drugs (such as cannabis, opiates, and certain types of stimulants), pharmaceutical drugs (such as pain-killers and tranquilisers) when used for non-medical purposes, and other substances used inappropriately (such as inhalants).

5.1.4 Edinburgh Postnatal Depression Scale

Select the response that corresponds to the mother's antenatal screening score range for the Edinburgh Postnatal Depression Scale.

Detecting symptoms of depression and anxiety during pregnancy relies on clinical judgement and experience. Use of the Edinburgh Postnatal Depression Scale complements this process. The aim is not to form a diagnosis, but to identify women who may benefit from further follow up.

5.2 Vaccination

5.2.1 Influenza

Select the response that corresponds to the mother receiving vaccination for influenza during this pregnancy.

If the mother was vaccinated for influenza during the pregnancy, record the gestation weeks at the time of the vaccination.

Pregnant women who contract influenza are up to three times more likely to be hospitalised or die compared with their non-pregnant female peers. Influenza vaccine for pregnant women is fully funded and provided free of charge as part of the National Immunisation Program – a program joint funded by the Commonwealth and State and Territory Governments.

5.2.2 Pertussis

Select the response that corresponds to the mother receiving vaccination for pertussis during this pregnancy.

If the mother was vaccinated for pertussis during the pregnancy, record the gestation weeks at the time of the vaccination.

Infants who contract pertussis in the first few weeks of life have a much higher risk of severe disease and death. The Queensland Immunisation Strategy 2014-17, launched by the Health Minister in July 2015, included a funded program for maternal pertussis vaccination. This program is not being offered in other States and Territories at present and is fully funded by the Queensland Government.

5.3 Smoking

5.3.1 Smoking during the first 20 weeks of pregnancy

Select the response that corresponds to the mother's smoking status during the first 20 weeks of pregnancy.

If the mother smoked at all during the first 20 weeks of pregnancy, record the number of cigarettes smoked per day.

Next, select the box that indicates whether the mother was offered smoking cessation advice by a health care provider at any time during the first 20 weeks of pregnancy. Smoking cessation advice can include anything from a stop smoking pamphlet included in an antenatal package/visit, through to a complete stop smoking program.

Cigarette smoking is the most important modifiable risk factor for preterm birth, which is the strongest predictor of perinatal death and disability.

5.3.2 Smoking after 20 weeks of pregnancy

Select the response that corresponds to the mother's smoking status after 20 weeks of pregnancy.

If the mother smoked at all after 20 weeks of pregnancy, record the number of cigarettes smoked per day.

Next, select the response that indicates whether the mother was offered smoking cessation advice by a health care provider at any time after 20 weeks of pregnancy. Smoking cessation advice can include anything from a stop smoking pamphlet included in an antenatal package/visit, through to a complete stop smoking program.

Cigarette smoking is the most important modifiable risk factor for preterm birth, which is the strongest predictor of perinatal death and disability.

5.4 LMP

Enter the day, month and year of the first day of the mother's last menstrual period (LMP) using all boxes. For example, a LMP of 1 November 2016 should be entered as: 01112016

If the exact day is unknown, enter month and year as: ??112016

If the date of the LMP is unknown, enter '99 99 9999'. This may occur in cases where there is a history of abnormal or irregular periods, or a delay of ovulation has occurred following the use of the contraceptive pill.

In the case of hospitals reporting this information electronically, if only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. The LMP Estimation Flag must be completed as an E for estimated. If the date is unknown, leave the field blank. LMP estimation flag can be found in the electronic file format.

5.5 EDC

Enter the day, month and year of the best-estimated date of confinement (EDC) for this pregnancy using all boxes. For example, an EDC of 1 November 2016 should be entered as: 01112016

If the exact day is unknown, enter month and year as: ??112017

Indicate how the EDC was determined by circling US scan, dates or clinical assessment.

If more than one EDC is available, (either by US scan, dates or clinical assessment), then record the one that has been deemed to be clinically the most reliable (i.e. the date used by the clinician, on which clinical decisions regarding the management of the pregnancy have been based).

In the case of hospitals reporting this information electronically, if only month and year are known, the day is entered as 01, 15 or 28 for early, mid or late in the month. The EDC Estimation Flag must be completed as an E for estimated. If the date is unknown, leave the field blank. EDC Estimation Flag can be found in the electronic file format

5.6 Height

Record the mother's height in total centimetres (round down if required). This can either be measured or self-reported. Height will be used in conjunction with self-reported weight for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

5.7 Weight

Record the mother's weight in total kilograms (round down if required). This will be the self-reported weight of the mother in the four to six weeks prior to or at conception. Weight will be used in conjunction with height for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

5.8 Antenatal Care

Select the response(s) that correspond to the antenatal care received for the current pregnancy. More than one box may be selected. If the mother received no antenatal care, select 'No antenatal care'.

Definitions	
No antenatal care	Mother received no antenatal care throughout her pregnancy.
Public hospital/clinic midwifery practitioner	Includes public hospital clinics, hospital based midwifery clinics and community based midwifery programs run by nursing staff.
Public hospital/clinic medical practitioner	Includes public hospitals and hospital based clinics attended by medical staff.
General practitioner	Includes a medical officer in general practice.
Private medical practitioner	Includes a private specialist medical practitioner in own private practice (for example private obstetrician).
Private midwifery practitioner	Includes registered midwives practicing in the community.

5.9 Total number of visits

Enter the total number of antenatal visits for the current pregnancy. This information can be obtained from the case notes (hospital clinic patients) or by asking the mother. The question is designed to measure the amount of supervision in the current pregnancy.

Note that if more than one type of antenatal care has been provided please report the total number of visits for the pregnancy, not just those provided at the reporting facility.

5.10 Gestation at first antenatal visit

Record the number of completed weeks of the current pregnancy when the mother had her first contact for antenatal care. The first contact for antenatal care is the first contact with a doctor or nurse where actual pre-birth maternity care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non pregnancy related issues.

5.11 Current Medical Conditions

Select the response(s) that correspond to any medical conditions the mother has which may significantly affect the current pregnancy or its management, or document the condition(s) in the space provided (see Appendix 2 – Examples of Conditions to Report

– Medical Conditions for examples). If the mother has no current medical conditions, select 'None'. Where 'Renal condition', 'Cardiac condition' or 'Other' is selected, please provide as much detail as possible to allow an appropriate morbidity code to be assigned.

Definitions	
Current medical condition	Includes pre-existing maternal conditions, hypertension or diabetes, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.
Pre-existing diabetes mellitus	Diabetes pre-existing prior to pregnancy. This can include either Type 1 diabetes or Type 2 diabetes. If Type 2 diabetes then indicate whether insulin treated, oral hypoglycaemic therapy treated or diet and exercise treated. Multiple treatment types may be selected.

5.12 Pregnancy Complications

Select the response(s) that correspond to any complications of the current pregnancy. If there are complications other than those listed, select 'Other' and specify the complication(s) in the space provided (see Appendix 2 – Examples of Conditions to Report – Pregnancy Complications for examples). If there are no pregnancy complications, select 'None'.

Definitions	
Pregnancy complications	Complications of pregnancy arising up to the period immediately preceding labour and delivery that are directly attributable to the pregnancy and may significantly affect care during the current pregnancy and/or the outcome.
APH (Antepartum haemorrhage)	• Abruption – An antepartum haemorrhage resulting from the placenta becoming totally or partially detached from the uterine wall whilst the fetus is still in utero. • Placenta praevia – An antepartum haemorrhage resulting from the placenta being located over or very near to the internal os. • Other – Any other antepartum haemorrhage, or cause unknown.

Gestational diabetes	Diabetes specifically occurring during pregnancy. Indicate whether insulin treated, oral hypoglycaemic therapy treated or diet and exercise treated. Multiple treatment types may be selected.
Hypertension	Hypertension specifically occurring during pregnancy. Multiple hypertension types may be selected. Indicate whether the hypertension is: • Gestational (mild) • Pre eclampsia (moderate) • Pre eclampsia (severe) • HELLP

5.13 Procedures and Operations

Select the response(s) that correspond to any medical or surgical procedures and/or operations that were performed on the mother or fetus during the current pregnancy. Please also include those performed during the labour and delivery. If a procedure and/or operation was performed other than those listed, select 'Other' and specify in the space provided (see Appendix 2 – Examples of Conditions to Report – Procedures and Operations).

If no procedure or operation was performed during this pregnancy, select 'None'. Where procedures are reported that may be performed via different approaches please provide as many details as possible. For example: cholecystectomy, which may be open or via laparoscope, please report as either 'open cholecystectomy' or 'laparoscopic cholecystectomy'.

5.14 Number of Ultrasound Scans

Enter the number of ultrasound scans performed during the current pregnancy. Enter zero if no ultrasound scans were performed.

This number indicates the total number of obstetric ultrasound scans performed during the current pregnancy. This will therefore include those performed by a radiographer in a recognised medical imaging unit and/or those performed by a health care professional(s) (e.g. Doctor or Midwife) in a variety of health care settings including hospital wards, community clinics or the premises of private practitioners.

Note that it does not include other non-obstetric ultrasounds (e.g. Maternal renal or gallbladder scan) and may necessitate asking the mother for confirmation of the number, as not all ultrasounds performed will have a written report.

5.15 Types Of Ultrasound Scans

5.15.1 Nuchal translucency scan

Indicate if a nuchal translucency scan was performed.

Definitions	
Nuchal translucency scan	An ultrasound to assess for major chromosomal abnormalities.

5.15.2 Morphology scan

Indicate if a morphology ultrasound scan was performed.

Definitions	
Morphology scan	An ultrasound to allow the early diagnosis of morphologic abnormalities.

5.15.3 Chorionicity scan

Indicate if an assessment for chorionicity scan was performed.

Definitions	
Chorionicity scan	An ultrasound to distinguish between twins who share a membrane. This will identify those multiples who share a chorion and are at risk of twin to twin transfusion syndrome.

5.16 Assisted Conception

Select ‘Yes’ or ‘No’ to indicate whether this pregnancy was achieved via assisted conception. If ‘Yes’, select the response(s) that correspond to the method(s) used to successfully assist conception for this pregnancy.

Definitions	
AIH/AID	Artificial Insemination using either the husband or male partner’s sperm or donor sperm. Includes Intrauterine Insemination (IUI), Intravaginal Insemination (IVI) or Intracervical insemination (ICI).

Ovulation induction	Ovulation is induced by pharmacological therapy such as Clomid.
IVF	In Vitro Fertilisation: Co-incubation of sperm and oocyte outside the body of the woman.
GIFT	Gamete Intrafallopian Transfer: A medical procedure of transferring an egg(s) and sperm to the body of the woman. Note: Zygote Intrafallopian Transfer (ZIFT) and Pronuclear Stage Tubal Transfer (PROST) are to be reported against this data item.
ICSI	Intracytoplasmic Sperm Injection: Involves the injection of a single sperm directly into the ovum, combined with IVF.
Donor Egg	The process by which a woman donates eggs for purposes of assisted reproduction. Egg donation typically involves in vitro fertilization technology, with the eggs being fertilized in the laboratory.
Frozen embryo transfer/embryo transfer	Embryo freezing gives more opportunity for a pregnancy for each hormone stimulation cycle and egg collection. Frozen embryo and fresh embryo transfer are used in conjunction with IVF. (IVF Australia)
Other	Indicate the type of method used, e.g. Assisted hatching, Blastocyst culture.

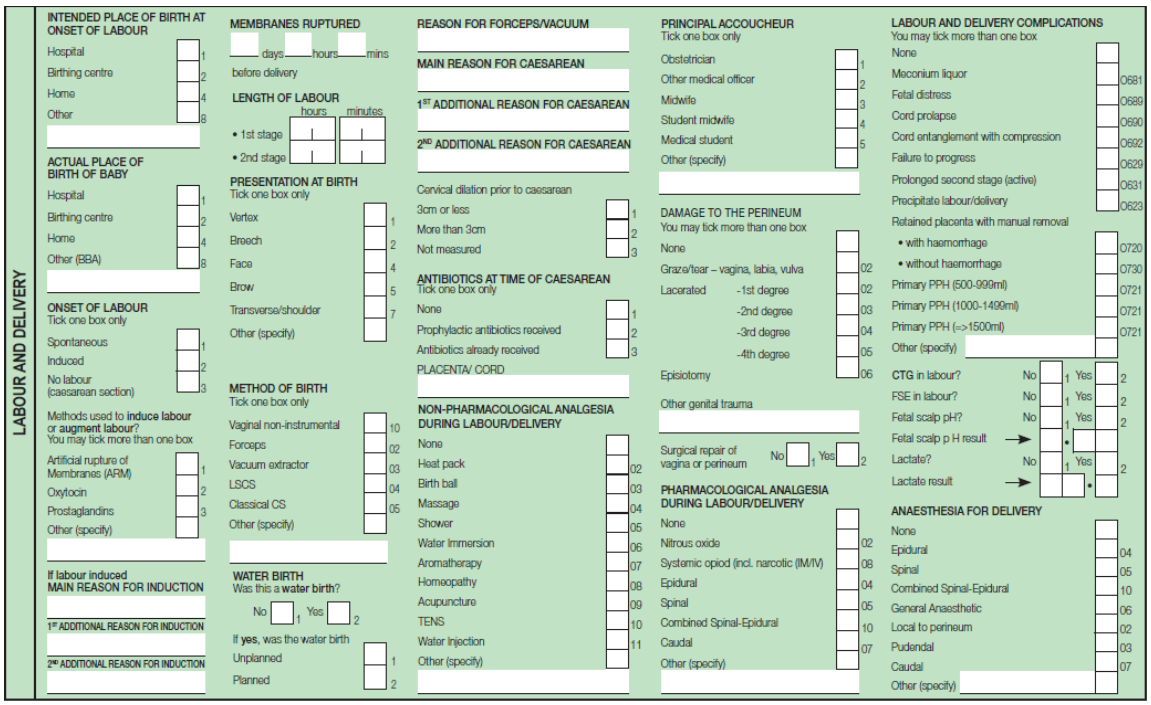
5.17 Did the same Midwife(s) who provided antenatal care also provide the woman's intrapartum and post discharge care (PNO Hospitals only)

Did the same Midwife(s) who provided antenatal care also provide the woman's intrapartum and post-discharge care? Answer 'yes' if **all** of the following occurred:

- The woman received antenatal care on a number of occasions by the named midwife or small group of 2 – 4 midwives to the extent that they could be considered 'known' by the woman;
- The woman was cared for in labour/birth by the named or one of the small group of midwives; and
- It is embedded in the maternity service that the named or one of the small group of midwives will provide the postnatal care to the woman after discharge.

If you require further assistance with this data field please contact the Office of the Chief Nursing and Midwifery Office Queensland via email on chiefnurse-office@health.qld.gov.au.

6 Labour and Delivery



6.1 Intended Place of Birth At Onset of Labour

Select the response (only one) that corresponds to the intended place of birth at onset of labour. If intended place of birth was other than those listed, select 'Other' and specify in the space provided.

Mothers who plan to give birth in birthing centres or at home usually have different risk factors compared to those who plan to give birth in hospital.

Definitions	
Hospital	A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

Birthing Centre	A facility where women are able to birth in an environment which: • Is free-standing or physically separate from a labour ward but has access to emergency or medical facilities for both mother and child if required; and • Has home-like atmosphere; and • Focuses on a model of care (e.g. Midwifery model) which ensures continuity of care/caregiver; a family-centred approach; and informed client participation related to the management of care.
Home	Home may be the mother's own home or where the baby is born in a home environment where 'home' may actually be that of a midwifery practitioner or any other person and attended by a midwifery practitioner.

6.2 Actual Place of Birth of Baby

Select the response (only one) that corresponds to the actual place where the birth of the baby occurred (see Section 6.1 for definitions). If the actual place of birth of the baby was other than those listed, select 'Other' and specify in the space provided, e.g. hospital car park, on the way to hospital in an ambulance etc.
Note that if the mother at the onset of labour intended to have her baby in a hospital but actually delivered at home, this should be reported as 'Other (BBA)' in this field.'

This field is used in conjunction with the 'Intended Place of Birth at Onset of Labour' field. It identifies mothers who intend to deliver at hospital but deliver at home, compared to those mothers who intend to deliver at home and do so.

This information is used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of birth was planned.

6.3 Onset of Labour

Select the response (only one) that corresponds to how labour commenced. 'No labour' can only be associated with a caesarean section.

Note that when a failed induction of labour (labour is not established) results in a caesarean, 'No labour (caesarean section)' should be selected and the reason for caesarean should be reported as failed induction of labour.

The onset of labour is closely associated with type of delivery and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are indicators of obstetric intervention.

Definitions	
Spontaneous	Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation and is distinct from spurious labour or spontaneous pre-labour rupture of membranes.
Induced	Medical and/or surgical procedure performed for the purpose of stimulating and establishing labour in a woman who has not commenced labour spontaneously.
No labour (caesarean section)	Indicates the absence of labour, as in caesarean section performed before the onset of labour or a failed induction.

6.4 Methods Used to Induce Labour or Augment Labour

If the labour was induced in onset, select the response(s) that correspond to the method used. If a method used was other than those listed, select 'Other' and specify in the space provided, e.g. Foley's catheter.

If the labour was spontaneous in onset and subsequently augmented, select the response(s) that correspond to the method used. If a method used was other than those listed, select 'Other' and specify in the space provided, e.g. Foley's catheter.

6.5 Main Reason for Induction

If labour was induced, specify the main reason for induction in the space provided, e.g. rupture of membranes > 24 hours before delivery, post-term etc. If the main reason for induction was a social reason, specify the actual reason(s) rather than writing 'social reasons'.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid main reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid main reason for induction as augmentation is any medical or surgical intervention that assists with the continuation of a labour that has had a spontaneous or induced onset, e.g. ARM, administration of oxytocins.

Where a failed induction of labour has occurred, ensure that 'No labour' (caesarean section)' has been selected. The main reason the induction was attempted should be reported in the appropriate field (e.g. medical conditions or pregnancy complications).

6.6 1st Additional Reason for Induction

If labour was induced and there is more than one reason indicated, specify the 1st additional reason for induction in the space provided, e.g. rupture of membranes > 24 hours before delivery, post-term etc.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid 1st additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid 1st additional reason for induction as augmentation is any medical or surgical intervention that assists with the continuation of a labour that has had a spontaneous or induced onset, e.g. ARM, administration of oxytocins.

6.7 2nd Additional Reason for Induction

If labour was induced and there are more than two reasons indicated, specify the 2nd additional reason for induction in the space provided, e.g. rupture of membranes > 24 hours before delivery, post-term etc.

Note that 'failure to progress', or any other conditions that pertain to labour, are not valid 2nd additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid 2nd additional reason for induction as augmentation is any medical or surgical intervention that assists with the continuation of a labour that has had a spontaneous or induced onset, e.g. ARM, administration of oxytocins.

6.8 Membranes Ruptured

Enter the number of days, hours and minutes before delivery the membranes were ruptured. If membranes ruptured at delivery, then record 'at delivery' or enter '0'. If a 'no labour' caesarean section occurs, it cannot be assumed that the membranes ruptured at delivery so record 'at delivery' or enter '0' as above.

6.9 Length of 1st and 2nd Stage of Labour

Enter in the length of each of 1st stage and 2nd stage of labour in hours and minutes.

Where the labour is interrupted (e.g. by caesarean section) and therefore either stage1 or 2 are interrupted, completed as follows:

- If stage 1 is complete and stage 2 is interrupted then report total length of stage 1 in hours and minutes and enter 'not completed' for stage 2
- If neither stage is compete then indicate be writing 'not completed' in both sections of the field.

Please note that if quantitative measurement has not been performed then clinical judgement based on subjective observation is appropriate (i.e. vaginal examination to confirm dilation is not mandatory). Use of other clinical observations used to manage labour are appropriate indications of stages of labour.

Where length of stages is unknown please write 'unknown'.

Definitions	
Stage 1	Begins with the onset of regular uterine contractions and is complete when the cervix is fully dilated (10cms).
Stage 2	Begins when the cervix is fully dilated (10cms) and is complete with the birth of the baby.

6.10 Presentation at Birth

Select the response (only one) that corresponds to the presentation of the fetus at birth. If the presentation at birth is other than those listed, select 'Other' and specify the presentation in the space provided.

If the presentation is unknown, for example due to extreme prematurity or macerated fetus, document this in the space provided.

Definitions	
Vertex	Presentation is where the occiput is the point of reference.
Breech	Presentation includes breech with extended legs, breech with flexed legs, footling and knee presentations.
Face	Presentation where the fetal head is hyperextended and the areas of the head below the root of the nose and the orbital ridges is at the uterine cervix.
Brow	Presentation where the fetal head is partly extended and the area of the head between the anterior fontanelle and the root of the nose is at the uterine cervix.
Transverse/shoulder	Transverse presentation – the long axis of the baby's body is across the long axis of the mother's body. Shoulder presentation – the fetal head is in the iliac fossa and the shoulder is at the uterine cervix.
Other	Examples include compound presentations.

Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

6.11 Method of Birth

Select the response (only one) that corresponds to the method of birth of the baby, i.e. the method of complete expulsion or extraction from its mother of a product of conception. If the method of birth was other than those listed, select 'Other' and specify the method in the space provided.

Note that a vaginal breech with forceps to the after coming head should be recorded as 'Forceps'. Forceps used to assist delivery at caesarean should be reported as a caesarean.

Definitions	
Vaginal non-instrumental	A birth which is achieved solely by the mother's expulsive efforts requiring no mechanical or surgical assistance.
Forceps	Where forceps are applied to assists the delivery process, including rotation forceps, liftout, etc.
Vacuum Extractor	An assisted birth using a suction cap applied to the baby's head, including rotation vacuum, also known as Ventousse Extractor.
LSCS	Lower segment caesarean section, includes hysterotomy.
Classical CS	Classical caesarean section.
Other	Includes birth methods not classified above.

6.12 Water Birth

Select the response to indicate if this birth was a water birth.

If the birth was a water birth, select the response to indicate if it was an unplanned or planned water birth.

For a birth to be considered a water birth, the baby's head must remain submerged under water until after the body is born.

6.13 Reason for Forceps or Vacuum

If forceps or vacuum were used as the method of birth, specify the reason in the space provided, e.g. 'prolonged active 2nd stage', 'Direct OP'.

6.14 Main Reason for Caesarean

If caesarean section was performed as the method of birth, specify the main reason in the space provided, e.g. ‘repeat caesar’, ‘fetal distress’, ‘prolonged labour’, etc.

6.15 1st Additional Reason for Caesarean

If caesarean section was performed as the method of birth, and there is more than one reason, specify the 1st additional reason in the space provided, e.g. ‘repeat caesar’, ‘fetal distress’, ‘prolonged labour’, etc.

6.16 2nd Additional Reason for Caesarean

If caesarean section was performed as the method of birth, and there are more than two reasons, specify the 2nd additional reason in the space provided, e.g. ‘repeat caesar’, ‘fetal distress’, ‘prolonged labour’, etc.

6.17 Cervical Dilatation Prior to Caesarean

If a caesarean was performed, select the response (only one) that corresponds to the level of dilatation of the cervix prior to the caesarean. If the cervical dilatation was not measured, select ‘Not measured’.

Note this field is mandatory when the method of birth is a caesarean, including no labour caesarean.

6.18 Antibiotics at Time of Caesarean

When the method of birth is either a lower segment caesarean section or a classical caesarean section, select the response (only one) that corresponds to the administration of antibiotics to the mother in relation to the caesarean.

If antibiotics were not received at the time of LSCS or classical caesarean section, select the ‘None’ box.

If antibiotics have been received for prophylaxis of infection specifically associated with the caesarean, select the ‘Prophylactic antibiotics received’ box.

If antibiotics have been received for a known condition (e.g. chorioamnionitis, pneumonia, etc) at the time of LSCS or classical caesarean, select the ‘Antibiotics already received’ box. This does not include antibiotic prophylaxis.

This information is used to assist the identification of adverse outcomes in relation to maternal health and wellbeing.

6.19 Principal Accoucheur

Select the response (only one) that corresponds to the principal person who assisted the mother in the birth of the baby. If the principal accoucheur is other than those listed, select ‘Other” and specify the accoucheur in the space provided,

Definitions	
Obstetrician	A medical doctor who is qualified in the field of obstetrics.
Other medical officer	Includes registrar, junior house officer, resident, general practitioner, etc.
Midwife	A registered nurse who is qualified in the field of midwifery.
Student Midwife	A registered nurse training to obtain qualifications in the field of midwifery.
Medical Student	A student training to obtain qualifications to become a medical doctor.
Other	Includes a registered nurse without midwifery qualifications, doulas, ambulance officer, self, husband/partner, other patient etc.

6.20 Damage to the Perineum

Select the response(s) that corresponds to the damage to the perineum following delivery. Note that more than one box may be selected to indicate if there is multiple damage to the perineum.

If both a 2nd degree tear and an episiotomy occurred, please select both corresponding boxes.

If an episiotomy is extended to a 3rd or 4th degree tear, select both corresponding boxes (i.e. episiotomy as well as either 3rd or 4th degree tear).

Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and to some extent intervention rates.

Definitions	
None	There is no damage to the perineum following delivery.
Graze/Tear – vagina, labia, vulva	A slight abrasion to the vagina, labia, vulva following delivery.

Lacerated	• 1st degree – Tear or laceration involving one of the fourchette, hymen, labia, skin, vagina or vulva. • 2nd degree – Tear or laceration involving the pelvic floor or perineal muscles or vaginal muscles. • 3rd degree – Tear or laceration involving the anal sphincter or recto vaginal septum. • 4th degree – third degree tear or laceration also involving the anal mucosa or rectal mucosa.
Episiotomy	Surgical incision into the perineum and vagina to assist delivery.

6.21 Other Genital Trauma

Specify any other genital trauma experienced by the mother in the space provided including high vaginal tears where the perineum is not damaged, cervical tears, urethral tears etc.

6.22 Surgical Repair of the Vagina or Perineum

Select 'Yes' or 'No' to indicate whether the vagina or perineum was surgically repaired. Note that if an episiotomy has been performed, then corresponding surgical repair would be expected.

6.23 Non-pharmacological Analgesia during Labour/Delivery

Select the response(s) under the Non-Pharmacological Analgesia during Labour/Delivery heading that correspond to the non-pharmacological analgesia administered to the mother during labour and delivery. If non-pharmacological analgesia was used other than those listed, select 'Other' and specify the non-pharmacological analgesia in the space provided. If non-pharmacological analgesia was not administered, select 'None'.

Definitions	
Heat Pack	Includes the use of electronic heat pads, heat wheat packs and gel packs.
Water Immersion	The labouring woman places her body into water or other liquid so that it is completely covered by the liquid.
TENS	An electronic device that delivers small electrical impulses to the body via electrodes placed on the skin.

Other	Includes the use of visualisation and hypnotherapy.

6.24 Pharmacological Analgesia During Labour/Delivery

Select the response(s) under the Pharmacological Analgesia heading that correspond to the pharmacological analgesia administered to the mother during labour and delivery. If a pharmacological analgesia other than those listed was used, select 'Other' and specify the pharmacological analgesia in the space provided. If pharmacological analgesia was not administered, select 'None'.

Definitions	
Pharmacological analgesia	Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.
Nitrous Oxide	Gas providing light anaesthesia delivered in various concentrations with oxygen.
Systemic Opioid (inc.. narcotic (IM/IV))	Opioid analgesics that acts on the patient's central nervous system. This includes drugs which have an agonist action at the opioid receptor on the cell.
Epidural	Injection of a local anaesthetic into the epidural space of the spinal column.
Spinal	Injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord, also called the Subarachnoid Block Anaesthesia.
Combined Spinal-Epidural	Needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column.
Caudal	Injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.

6.25 Labour and Delivery Complications

Select the response(s) that correspond to any complications that arose during labour and delivery. If complications arose other than those listed, select 'Other' and specify the complication(s) in the space provided (see Appendix 2 – Examples of Conditions to Report – Labour and Delivery Complications). If no complications were experienced, select 'None'.

Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Definitions	
Labour and delivery complication	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

6.26 CTG in Labour

Select 'Yes' or 'No' to indicate whether Cardiotocography (CTG) monitoring was performed during labour. Any external trace (including 'routine baseline' traces) recorded during labour, regardless of the duration of recording (i.e. continuous or intermittent) should be reported. A baseline trace recorded prior to labour commencing should not be included.

A CTG prior to a 'no labour caesarean' should not be reported.

6.27 FSE in Labour

Select 'Yes' or 'No' to indicate whether Fetal Scalp Electrode (FSE) monitoring was performed during labour.

6.28 Fetal Scalp pH and Result

Select 'Yes' or 'No to indicate whether fetal scalp pH was measured or not.

If the fetal scalp pH was taken then record the fetal scalp pH result.

6.29 Lactate and Result

Select 'Yes' or 'No to indicate whether fetal scalp lactate was measured.

If the fetal scalp lactate was taken, record the fetal scalp lactate result.

6.30 Anaesthesia for Delivery

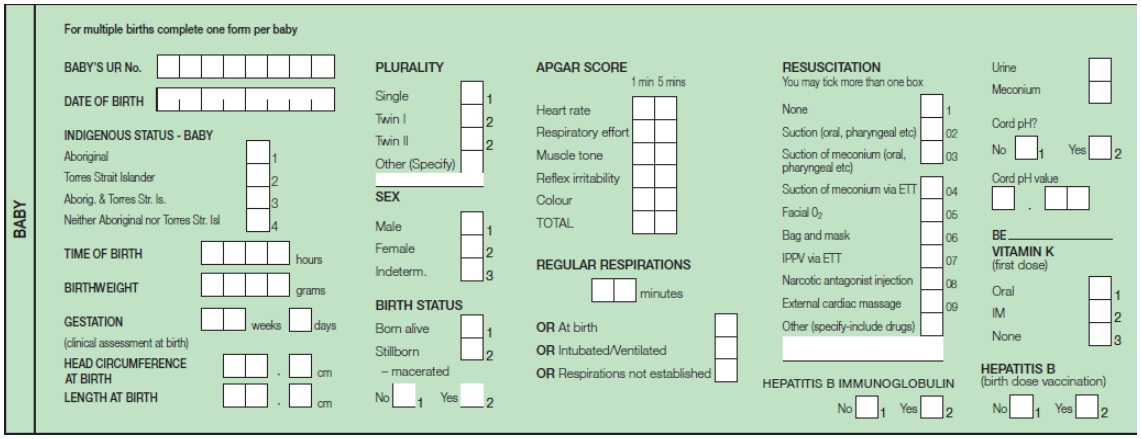
Select the response(s) under the Anaesthesia heading that correspond to the anaesthesia administered to the mother for delivery. If the anaesthesia used was other than those listed, select 'Other' and specify the anaesthesia used in the space provided. If anaesthesia was not administered, select 'None'.

Please note that a response is required in non-pharmacological analgesia, pharmacological analgesia and anaesthesia fields, e.g. if delivery is by elective caesarean section, and non-pharmacological or pharmacological analgesia are not used, then 'None' should be selected in both fields.

Note also that local to the perineum administered following delivery and for the sole purpose of repair of tear or episiotomy is not considered anaesthetic for delivery, and therefore should not be included.

Definitions	
Anaesthesia	Agents administered to the mother for the operative/instrumental delivery of the baby (caesarean section, forceps or vacuum delivery).
Epidural	Injection of a local anaesthetic into the epidural space of the spinal column.
Spinal	Injection of an analgesic drug or anaesthetic drug into the subarachnoid space of the spinal cord, also called the Subarachnoid Block Anaesthesia.
Combined Spinal-Epidural	Needle-through-needle injection of an analgesic drug or anaesthetic drug into both the epidural space and the subarachnoid space of the spinal column.
General Anaesthetic	Various anaesthetic agents given primarily by inhalation or intravenous injection.
Local to Perineum	Infiltrating the perineum with local anaesthetic.
Pudendal	Injection of local anaesthetic to the pudendal nerves.
Caudal	Injection of a local anaesthetic agent into the caudal portion of the spinal canal through the sacrum.

7 Baby



7.1 Baby's UR Number

Enter the Unit Record (UR) number assigned to the baby (if applicable).

For home births where the baby is not admitted to a hospital, this field is not required, however if the private midwifery practitioner assigns a record number for administrative purposes it can be included.

7.2 Date of Birth

Enter the day, month and year of the baby's date of birth using all boxes.

7.3 Indigenous Status – Baby

Select the response (only one) that corresponds to the Indigenous Status of the baby.

Note that a baby's Indigenous status cannot be determined simply by observation and therefore this question must be asked of all mothers. For further information regarding determining Indigenous status, please refer to the 'Are you of Aboriginal or Torres Strait Islander origin?' pamphlet. If you require copies of this publication, please contact the National Centre for Aboriginal and Torres Strait Islander Statistics (Australian Bureau of Statistics) on the free call number 1800 223 919 or nidisc@aihw.gov.au.

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which that person lives.

Definitions	
Aboriginal	Aboriginal but not Torres Strait Islander origin.
Torres Strait Islander	Torres Strait Islander but not Aboriginal origin.

Aboriginal and Torres Strait Islander	Both Aboriginal and Torres Strait Islander origin.
Neither Aboriginal nor Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander origin.

Given the gross inequalities in health status between Indigenous and Non-Indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on Indigenous status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health.

7.4 Time of Birth

Enter the time of birth of the baby using the 24 hour clock, e.g. 2.30pm should be entered as 14:30 hours. If the time of birth of the baby is midnight, this should be recorded as 00:00 hours to indicate the start of the day.

7.5 Birthweight

Enter the first weight of the fetus or baby obtained after birth in grams, e.g. 3500 grams. Weight should preferably be measured on the day of birth.

7.6 Gestation

Enter the estimated gestational age of the baby in completed weeks and days, as determined by clinical assessment after birth. Do not use ‘T’ for term, or ‘K’.

Gestational age is a key outcome of pregnancy and an important risk factor for neonatal outcomes

7.7 Head Circumference at Birth

Enter the head circumference of the baby at birth in centimetres, to the nearest one decimal place. Head circumference should preferably be measured on the day of birth.

7.8 Length at Birth

Enter the length of the baby at birth in centimetres, to the nearest one decimal place. Length at birth should preferably be measured on the day of birth.

7.9 Plurality

Select one response only to indicate whether this pregnancy has resulted in a ‘Single’ birth, or for a multiple birth, select the response for which baby the form is being completed. For example, if the form relates to the second twin, select ‘Twin II’.

For the first baby of triplets or higher, select ‘Other’ and write, for example, ‘Triplet I’ in the space provided.

Note: The plurality refers to the total number of births resulting from this pregnancy. If the pregnancy commences as a twin pregnancy but one foetus is miscarried/aborted before 20 weeks and less than 400 grams, the plurality would be single.

7.10 Sex

Select the response (only one) that corresponds to the sex of the baby. If the sex of the baby cannot be determined, select ‘Indeterm’.

7.11 Birth Status

Select the response that corresponds to the result of the birth. If the baby was born alive, select ‘Born alive’. If the baby was not born alive, select ‘Stillborn’.

If the baby was stillborn, indicate whether the baby was macerated by selecting ‘Yes’ or ‘No’.

Note that maceration status should only be completed in the case of stillbirths, and should not be used to indicate ‘peeling skin’ associated with a post term infant.

Definitions	
Live birth	The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.
Stillbirth	A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 grams or more birthweight. The death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
Macerated	Softening and breaking down of skin caused by prolonged exposure to amniotic fluid in a deceased foetus.

7.12 APGAR Score

Enter the 1 minute and 5 minute APGAR scores in the boxes for each of the conditions listed.

Enter the total APGAR scores in the boxes provided.

The APGAR score is a numerical score to evaluate the baby's condition at 1 minute and 5 minutes after birth. It is an indicator of the health of the baby, particularly after complications of pregnancy and/or labour and birth. It is useful in deciding the need for and adequacy of resuscitation.

Definitions	
Appearance	Blue or pale skin tone = 0 Pink body but blue fingers and toes = 1 Completely pink = 2
Pulse	No heart rate detected = 0 Slow heart rate (below 100 beats/minute) = 1 Fast heart rate (more than 100 beats/minute) = 2
Grimace	No response when the sole of the foot is stimulated = 0 Baby grimaces when the foot is stimulated = 1 Baby cries when the foot is stimulated = 2
Activity	Baby is limp = 0 Baby shows some muscle flexing in the feet and hands = 1 Baby is active and can flex the muscles in its feet and hands = 2
Respiration	There are no signs of the baby's breathing = 0 Baby has only a weak cry and can't seem to get enough air into its lungs = 1 Baby is breathing well and can cry strongly = 2

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7.13 Regular Respirations

Enter, to the nearest minute, the time the baby took to establish regular, spontaneous breathing. If respirations were established 30 to 59 seconds after birth, record as 1 minute.

If the baby established respirations spontaneously select the ‘at birth box’; if the baby was ventilated, select the ‘intubated/ventilated’ box; if respirations were never established, select the ‘respirations not established’ box.

7.14 Resuscitation

Select the response(s) that correspond to the method of resuscitation used. If resuscitation methods were used other than those listed, select ‘Other’ and specify the method(s) used in the space provided, e.g. tactile stimulation. Include other drugs used for resuscitation, e.g. adrenalin, etc. If resuscitation was not required, select ‘None’.

This information is required to analyse the need for resuscitation after complications of labour and delivery and to evaluate level of services required for different birth settings.

Definitions	
Suction (oral, pharyngeal, etc)	Routine aspiration of the airways only.
Suction of meconium (oral, pharyngeal, etc)	Meconium is cleared from the airway with a suction catheter.
Suction of meconium via ETT	Meconium is cleared from the airway via insertion of an endotracheal tube.
Facial O_2	Oxygen is administered via a mask, funnel, nasal prongs, head box, bag and mask without ventilation.
Bag and mask	Intermittent positive pressure ventilation via a bag and mask, with or without laryngeal mask.
IPPV (via ETT)	Intermittent positive pressure ventilation via an endotracheal tube.
Narcotic antagonist injection	Administration of the drug Narcan (Naloxone).

7.15 Cord pH and Value

Select ‘Yes’ or ‘No’ to indicate whether pH of the umbilical cord was measured.

If the Cord pH was measured provide the cord pH value.

Record the Base Excess (BE) level if measured. Note: The BE is not mandatory.

7.16 Vitamin K (first dose)

Select the response (only one) that corresponds to the method of administration for first dose of Vitamin K was administered. If Vitamin K was not administered, select ‘None’.

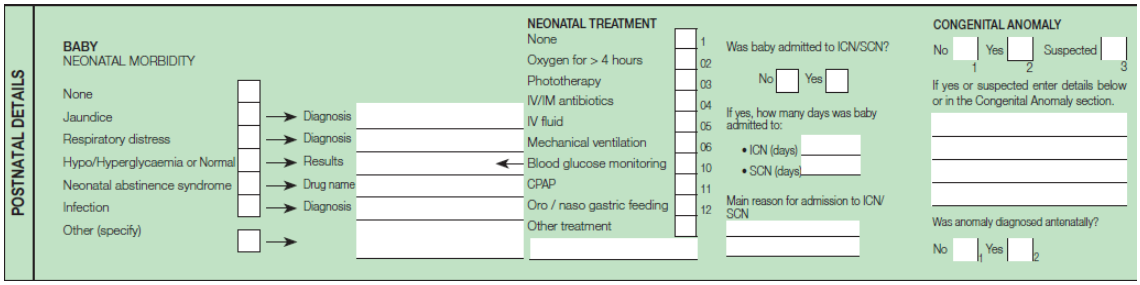
7.17 Hepatitis B Vaccination (birth dose)

Select the response (only one) that corresponds to whether or not the birth dose Hepatitis B vaccination was given. Note that this is not exclusive to the dose given immediately after birth or whilst still within the delivery room, and therefore includes the dose given prior to discharge. This field does not refer to administration of Hepatitis B Immunoglobulin.

7.18 Hepatitis B Immunoglobulin

Select the response (only one) that corresponds to whether or not Hepatitis B Immunoglobulin was given. Note that this is not exclusive to a dose given immediately after birth or whilst still within the delivery room, and therefore includes any dose given prior to discharge. This field does not refer to administration of Hepatitis B Vaccination.

8 Postnatal Details



8.1 Neonatal Morbidity

Select the response(s) that correspond to the conditions/diseases/illnesses/birth traumas experienced by the baby up to the time of discharge or when the baby reaches 28 days of age. Document the diagnosis in the space provided. If a condition is present other than those listed, select 'Other' and specify the condition(s) in the space provided. If there is no neonatal morbidity, select 'None' (See Appendix 2 – Examples of Conditions to Report – Neonatal Morbidity).

Definitions	
Jaundice	Physiological, ABO incompatibility, etc. (Indicate whether phototherapy was used to treat the jaundice).
Respiratory distress	Transient tachypnoea of the newborn, respiratory distress syndrome, etc.
Hypo/Hyperglycaemia or Normal	When blood glucose monitoring has been reported, please supply the outcome of the observation (hypoglycaemia, hyperglycaemia or normal).
Neonatal abstinence syndrome	Please specify the name of the drug used by the mother.
Infection	Cytomegalovirus, septicaemia, eye infection, etc. and also specify the name of the bacteria where applicable.

8.2 Neonatal Treatment

Select the response(s) that correspond to any neonatal treatments given up to the time of discharge or when the baby reached 28 days of age. If a treatment is used other than those listed, select 'Other' and specify the treatment(s) in the space provided. If treatment(s) were not required, select 'None'.

Note that if a treatment has been specified, ensure that a corresponding morbidity has also been specified (e.g. If phototherapy is selected, jaundice should also be selected in morbidities. If blood glucose monitoring is indicated, then the reason for the monitoring and the outcome of the monitoring should be specified).

8.3 Admitted to ICN/SCN

Information about ***Neonatal Services*** see the ***Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.2*** can be found at: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/default.asp or by contacting:

Public health sector
Health Protection Unit
Phone: (07) 3708 9049
Email: cscf@health.qld.gov.au

Private health sector
Private Heath Regulatory Unit
Phone: (07) 3708 5325
Email: Private.Health@health.qld.gov.au

A neonatal service can provide a range of care from well infant care to highly specialised care. This includes care for sick, low birth weight and/or premature infants, and/or infants born with congenital conditions or other conditions compromising their health and survival. Regardless of the level of neonatal service provided, it is essential neonatal staff are skilled in neonatal resuscitation, stabilisation and examination.

Maternal health directly affects the physical and psychological health of the baby, and continues to affect their health during the childhood and adult years. Therefore, high-quality neonatal services should be integrated into a continuum of care with maternal and child health services.

Neonatal care is provided across six service levels. Neonatal services at Levels 1, 2 and 3 primarily care for well infants. Infants who need intensive medical attention and specialised diagnosis and treatment are admitted into a special care neonatal service at Levels 4, 5 and 6 - the level required depends on the infant's gestational age, risk factors and level of clinical care required. Health services at Levels 4 and 5 provide neonatal care as an integral component of general children's services. At Level 6, neonatal paediatric specialist staff deliver complex care to infants.

Specialised neonatal services may provide:

- antenatal consultation and planned management of birth with maternal fetal medicine (MFM) services where neonatal illness / abnormality is expected
- consultation and assessment of infants post-birth (including well newborn assessment)
- specialised transport services for infants requiring special or intensive care
- follow-up and ongoing care after discharge from the neonatal service

SOURCE: *Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.2* (2014)

Select 'Yes' or 'No' to indicate it the baby was admitted to Intensive Care Nursery (ICN) (level 4 and 5) or Special Care Nursery (SCN) (level 6). Specify the type of nursery the baby was admitted to by entering the number of days the baby was admitted to ICN and/or SCN, including 0 if the baby was not admitted. Reporting in this field is only required for those facilities where approval is current. Note that admissions to a neonatal service level 1, 2 and 3 (primarily for well infants) should not be reported.

SOURCE: Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.2 (2014)

For further information in regards to nursery details see the QHAPDC Manual or MAC Manual located at:

https://www.health.qld.gov.au/hsu/collections/dchome.asp

8.4 Main Reason for Admission to ICN/SCN

If the baby was admitted to either an ICN (level 4 and 5) or SCN (level 6), enter one main reason for admission in the space provided. The reason should be a condition, not a treatment, e.g. 'prematurity' rather than 'tube feeding', or 'respiratory distress' rather than 'oxygen therapy or observation'. The treatment should be included in the Neonatal Treatment field.

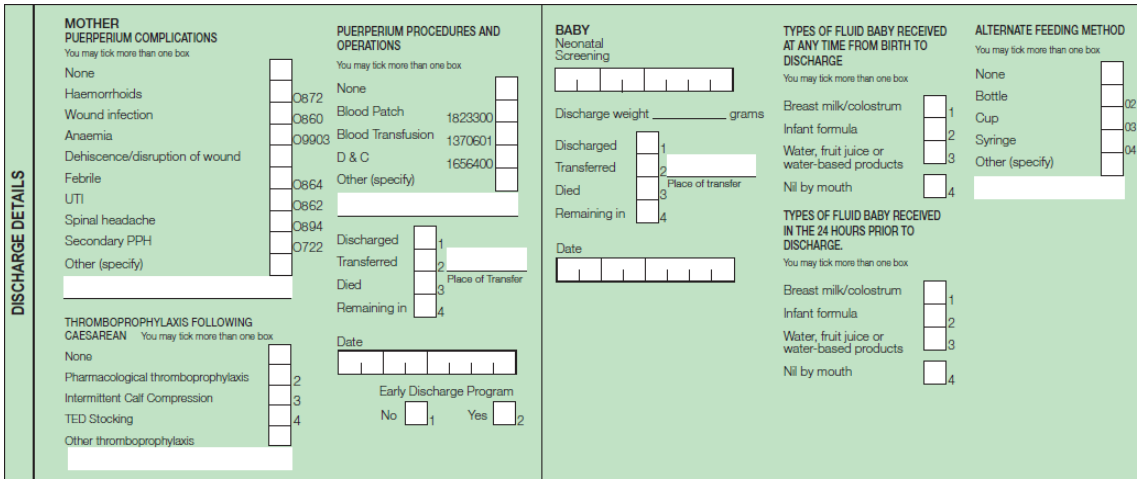
8.5 Congenital Anomaly

Select 'Yes', 'No' or 'Suspected' to indicate whether a congenital anomaly is present or suspected. Congenital anomalies are abnormalities (including deformities) that were present at birth and detected prior to separation from care (See Appendix 2 for examples of congenital anomalies).

In the case of a diagnosed or suspected anomaly, enter a brief description in the space provided then ensure that the Additional Congenital Anomaly Data section of the form is completed. The medical practitioner responsible for the baby should complete the Congenital Anomaly section, which can be updated up to 28 days after the birth.

Perinatal Data Collection will be reporting against each congenital anomaly whether or not the congenital anomaly was diagnosed prior to birth.

9 Discharge Details



9.1 Discharge Details of the Mother

9.1.1 Puerperium Complications

Select the response(s) that correspond to the puerperium complications experienced by the mother. If a complication is experienced other than those listed, select 'Other' and specify the complication(s) in the space provided (see Appendix 2 – Examples of Conditions to Report – Puerperium Complications). If no complications are experienced, select 'None'.

This field should reflect conditions, not treatments or procedures. For example, a spinal headache would be reported in this field, but if it required intervention such as a blood patch, the treatment would be reported in the puerperium procedures and operations field.

Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Definitions	
Puerperium Complication	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

9.1.2 Thromboprophylaxis Following Caesarean

When the method of birth is either a lower segment caesarean section or a classical caesarean section, select the response(s) that correspond to any puerperium thromboprophylaxis administered following caesarean section.

If Thromboprophylaxis following LSCS or classical caesarean section was not administered, select the 'None' box.

If Thromboprophylaxis following LSCS or classical caesarean was via other thromboprophylaxis methods, select the 'Other (specify)' box and record the method(s) used in the space provided.

This information is used to assist the identification of adverse outcomes in relation to maternal health and wellbeing.

9.1.3 Puerperium Procedures and Operations

Select the response(s) that correspond to any medical or surgical procedures and/or operations that were performed on the mother during the puerperium. If a procedure and/or operation was performed other than those listed, select 'Other' and specify in the space provided (see Appendix 2 for examples). If no procedures or operations were performed during the puerperium, select 'None'.

Where procedures are reported that may be performed via different approaches please provide as many details as possible. For example: ligation of fallopian tubes, which may be via laparotomy or laparoscopy, please report as either 'open abdominal ligation' or 'laparoscopic ligation'.

9.1.4 Discharge Details

Select the response (only one) that corresponds to whether the mother was discharged, or transferred to another facility, remaining in hospital or died during the current admission.

If the mother was transferred to another facility, enter the full name of the other facility in the space provided. In cases such as Mater Mother's Hospital indicate whether the transfer was to the public or private facility. For PDC purposes, a patient transferred from unit to unit within the same facility (e.g. maternity to intensive care) is not considered a transfer or discharge.

A patient transferred from a birth centre to the labour ward or maternity ward is a transfer from one facility to another facility.

Enter the day, month and year the mother was discharged, transferred or died using all boxes. If the mother is remaining in after 28 days select the remaining in box and provide the discharge date when available.

Note that if the baby had an extended stay in hospital and the mother was registered as a boarder so that she could be near her baby, enter the date she was formally discharged as an admitted patient, i.e. the day she changed from an admitted patient to a boarder.

Homebirths only: do not complete the discharge details field unless the mother was transferred to a facility following delivery.

9.1.5 Early Discharge Program

Select the 'Yes' box if the mother was released from hospital to an Early Discharge or other similar program. Note there is currently no standard definition available that constitutes an early discharge program. Please report whatever individual facilities regard as an early discharge program.

9.2 Discharge Details of the Baby

9.2.1 Neonatal Screening

Enter the day, month and year when the neonatal screening was performed using all boxes, e.g. if the neonatal screening was performed.

Note that this is not a mandatory field on the form, and subsequently no information is stored by PDC from this field.

For enquires regarding neonatal screening tests please contact the Neonatal Screening Unit on 3636 7171 or 3636 7051.

9.2.2 Discharge Weight

Enter the weight of the baby on discharge in grams.

Note that this is not a mandatory field on the form and subsequently no information is stored by PDC from this field.

9.2.3 Discharge Details

Select the response (only one) that corresponds to whether the baby was discharged or transferred to another facility, remaining in hospital or died during the admission. If the baby was transferred to another facility, enter the full name of the other facility in the space provided. In cases such as Mater Mother's Hospital indicate whether the transfer was to the public or private facility. For PDC purposes, a baby transferred from unit to unit within the same facility (e.g. Level 3 Nursery to Level 2 Nursery) is not considered a transfer or discharge. A patient transferred from a birth centre to a nursery is a transfer from one facility to another facility.

Enter the day, month and year the baby was discharged, transferred or died using all boxes. If the baby is remaining in after 28 days select the 'Remaining in' box and provide the discharge date when available.

Homebirths only: do not complete the discharge details field unless the baby was transferred to a facility following delivery.

9.2.4 Fluid Baby Received at any time from Birth to Discharge

Select the response(s) that applies to the type of fluid the baby received at any time from birth to discharge. More than one box may be selected. This field may be used as an indicator for the Baby Friendly Health Initiative.

Definitions	
Breast milk/colostrum	Includes breast milk/colostrum received directly from the breast as well as expressed breast milk/colostrum received by but not limited to syringe, cup or enteral tube.
Infant formula	Refers to commercially prepared formulas that adequately meet the nutritional needs of the newborn.
Water, fruit juice or water-based products	Other types of fluid includes but is not limited to water, fruit juice, herbal tea or flavoured water.

9.2.5 Fluid Baby Received in the 24 Hours Prior to Discharge

Select the response(s) that applies to the type of fluid the baby received in the 24 hours prior to discharge (or part thereof). More than one box may be selected. This field may be used as an indicator for the Baby Friendly Health Initiative.

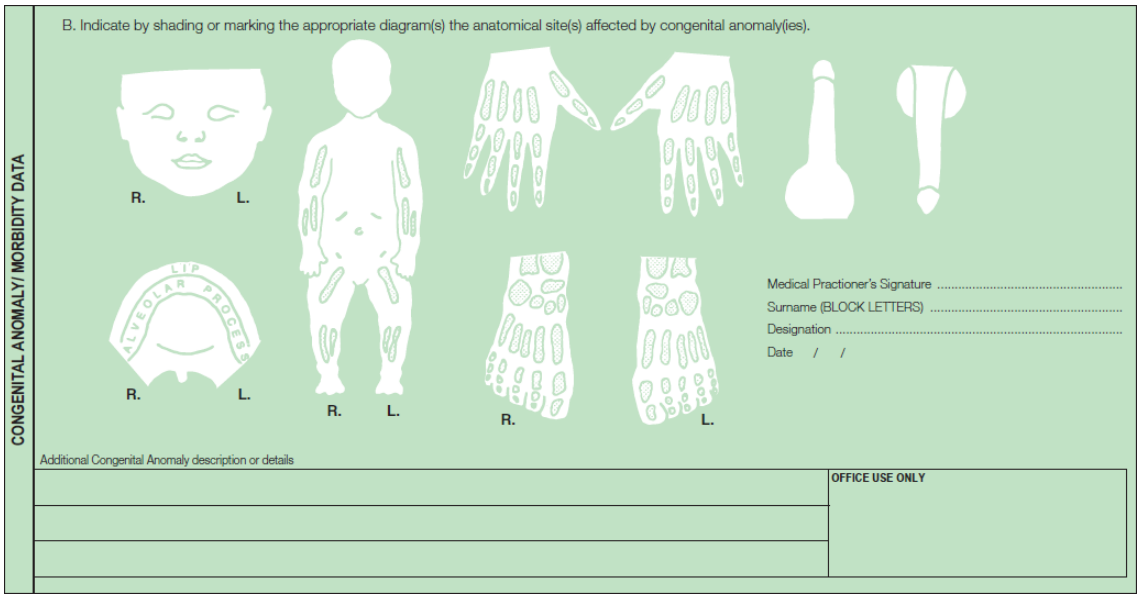
NOTE: If the baby has received a type of fluid in the 24 hours prior to discharge, that type of fluid must also be selected in the types of fluid the baby received at any time from birth to discharge. See section 9.2.4. For definitions see section 9.2.4.

9.2.6 Alternate Feeding Method

Select the response(s) that apply to the type of alternate methods used to feed the baby from birth to discharge (or part thereof). More than one box may be selected.

This includes babies who are fed expressed breast milk/colostrum via an alternate feeding method. This will enable a broader understanding of bottle usage by reducing association with infant formula and consideration of other liquids such as expressed breast milk. This may be an indicator for the Baby Friendly Health Initiative.

10 Additional Congenital Anomaly Data (MR63D only)



10.1 Indicate by shading or marking the appropriate diagram(s)

In the case of congenital anomaly(ies) with apparent physical defects, indicate by shading or marking the anatomical site(s) affected on the appropriate diagram(s).

10.2 Additional Congenital Anomaly Description or Details

Extra space is provided for a more detailed description of any congenital anomaly which does not fit in the space provided in the postnatal details section of the form.

10.3 Medical Practitioner's Signature

This form should be signed by the medical practitioner in charge of the neonatal care of the baby.

10.4 Surname

Enter the surname of the medical practitioner as it may be necessary to elicit further details at a later date.

10.5 Designation

Enter the position/designation of the medical practitioner.

10.6 Date

Enter the date the medical practitioner signed the form.

Appendix 1. Dispatch Instructions

Part 3 of the Public Health Regulation 2005, provides for the compulsory completion of a return in the approved format, of information relating to all births, hospital and non-hospital, in Queensland. This enables the compilation of a comprehensive base of perinatal statistical data for Queensland. All completed information (either paper based form or electronic extract) is required to be forwarded to Statistical Collections and Integration Unit within 35 days of the birth of a baby. Hospitals should dispatch the returns on a fortnightly or monthly basis unless there are no births for the month.

DISPATCH: The forms and the batch cover sheet are to be forwarded to Statistical Collections and Integration Unit using the confidential envelopes provided. Otherwise the address as below should be used:

CONFIDENTIAL

Perinatal Data Collection
Statistical Collections and Integration Unit
Statistical Services Branch
Department of Health
GPO Box 48
Brisbane QLD 4001

YOUR CO-OPERATION: It is appreciated that the prompt dispatch of forms for all births is no easy task. However, to achieve the objectives of the Collection, accurate and timely information must be supplied.

CONFIDENTIALITY: All information collected is used for statistical purposes only and will not be published in any form which might enable the identification of an individual.

QUERIES: If you have any queries concerning the dispatch of these forms, please contact the Perinatal Data Collection via email at PERIMAIL@health.qld.gov.au.

The batch cover sheet can be found at the following location:

https://www.health.qld.gov.au/hsu/collections/pdc.asp

Appendix 2. Examples of Conditions to Report

Medical Conditions

The following is a list of examples of medical conditions, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

Abnormal Papanicolaou smear
AIDS
Alcoholism
Anaemia (pre-existing)
Anomalies of the reproductive system – please specify
Appendicitis
Asthma
Cardiac conditions - please specify
Cervical dysplasia, e.g. CIN I, II etc.
Coagulation disorders – please specify
Cystic Fibrosis
Diabetes mellitus (pre-existing) - Specify if insulin, oral hypoglycaemic agent and/or diet and exercise treated
Domestic violence (physical, emotional, threatened, etc.)
Drug abuse – dependent, non-dependent (specify which drug/s)
Epilepsy
Essential hypertension
Fracture of coccyx/sacrum or pelvis
Gastrointestinal disorders – please specify, e.g. Crohn's Disease, Cholecystitis
Hepatitis – Specify type and infection status (e.g. A, B, C, carrier, infectious/active)
Hyperthyroidism
Hypothyroidism
Infection, Streptococcus, Group B
Liver disorders– please specify
Musculoskeletal disorders – please specify, e.g. Carpal Tunnel Syndrome, Back pain, Scoliosis
Obesity
Paraplegia, quadriplegia
Past history rheumatic fever
Previous infertility, e.g. IVF, GIFT, Clomid-induced pregnancy
Psychiatric disorders – please specify
Renal disease– please specify
Respiratory disorders– please specify
Sexually transmitted diseases – if active and affect the management of the current pregnancy (e.g. syphilis, gonorrhoea, chlamydia, donovaniasis, genital herpes, genital warts, etc.)
Systemic lupus erythematosus (SLE)
Thalassaemia
TORCH conditions – please specify
Urinary incontinence
Uterine disorders– please specify
Viral infections – please specify

Pregnancy Complications

The following is a list of examples of pregnancy complications, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

Abdominal pain
Abnormal glucose tolerance test
Admission for social reason/assessment of pregnancy
Amnionitis, Chorioamnionitis
Anaemia (of pregnancy)
APH - 20 weeks or more
Cervical incompetence
Cephalopelvic/fetopelvic disproportion – please specify
Deep vein thrombosis
Eclampsia
False (spurious) labour
Gestational diabetes – specify if insulin, oral hypoglycaemic agent or diet and/or exercise treated
Grand multiparity
High head at term
Hyperemesis gravidarum
Hypertension – gestational (mild)
- Pre eclampsia (moderate)
- Pre eclampsia (severe)
- HELLP

Infection of genito-urinary tract
Intrauterine fetal death
Intrauterine growth retardation
Iso-immunisation - Rh, ABO
Malpresentation – please specify
Placenta praevia – specify with or without haemorrhage, include grade or degree
Placental abruption
Polyhydramnios/Oligohydramnios
Premature labour
Premature rupture of membranes (spontaneous rupture of membranes before the onset of contractions)
Premature, prolonged rupture of membranes (PPROM)
Previous caesarean section
Prolonged rupture of membranes (>24 hours)
Prolonged pregnancy
Threatened miscarriage/abortion
Threatened premature labour
Unstable lie
Vomiting in late pregnancy

Procedures and Operations

The following is a list of examples of procedures and operations, which should be reported to the Perinatal Data Collection. **This is not a past history and only includes procedures and operations performed during the present pregnancy, labour and delivery**. Note that this is not an exhaustive list.

Appendicectomy – specify open or laparoscopic
Amniocentesis
Amnioscopy
Blood transfusion
C.A.T. scan
CTG in labour
Cervical suture
Cholecystectomy – specify open or laparoscopic
Chorionic villi sampling
Doppler studies
Drainage of abscess – specify site
External cephalic version, specify combined internal/external version
Fetal blood sampling
FSE in labour
Intrauterine transfusion
Mechanical ventilation
Ultrasound pelvimetry

Labour and Delivery Complications

The following is a list of examples of labour and delivery complications, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

Amniotic fluid embolism
Cephalo-pelvic disproportion
Cervical tear
Compound presentation
Cord entanglement
Cord presentation
Cord prolapse
Deep transverse arrest
Failed instrumental delivery – specify type
Failure to progress
Fetal distress
High head at term
Incoordinate uterine action
Intra-partum haemorrhage
Maternal pyrexia
Malpresentation – please specify
Meconium liquor
Obstructed labour – specify type
Perineal Tears (1st, 2nd, 3rd, 4th degree)
Placental abruption
Placenta accreta
Precipitate labour/delivery
Primary post-partum haemorrhage – within first 24 hours
Prolonged labour
Prolonged second stage
Prolapsed uterus
Pulmonary embolus
Retained placenta/membranes – indicate whether manual removal performed
Rupture of uterus
Septicaemia
Shoulder dystocia
Uterine scar – previous caesarean section
Vaginal haematoma
Vaginal tear

Neonatal Morbidity

The following is a list of examples of neonatal morbidity conditions, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

ABO incompatibility
Anaemia
Apnoea
Birth asphyxia
Birth injury/trauma e.g. # clavicle, cephalohaematoma
Broncho-pulmonary dysplasia
Cerebral haemorrhage
Eye infection
Feeding problem
Hydrocephalus
Hyaline membrane disease
Hyperglycaemia
Hypoglycaemia
Hypothermia
Infant of diabetic mother
Infection - specify site/organism e.g. septicaemia, cytomegalovirus, eye infection
Intra Uterine Growth Retardation (IUGR)
Jaundice - physiological
- ABO incompatibility
- Rhesus incompatibility
- biliary atresia etc.
Large for gestational age
Meconium aspiration
Necrotising enterocolitis
Neonatal abstinence syndrome
Physiological jaundice
Pneumonia
Pneumothorax
Pneumomediastinum
Polycythaemia
Pulmonary haemorrhage
Pulmonary hypertension
Respiratory distress - specify condition e.g. Transient tachypnoea of the newborn,
Respiratory distress syndrome
Retained fetal lung fluid
Rhesus incompatibility
Seizures
Septicaemia
Small for gestation age

Congenital Anomalies

The following is a list of examples of congenital anomalies, which should be reported to the Perinatal Data Collection if they are present or suspected. Note that this is not an exhaustive list.

Chromosomal	Trisomy 18 (Edward's syndrome) Trisomy 21 (Down's syndrome) Turner's syndrome
Central nervous system	Anencephaly Meningocele Spina bifida
Alimentary	Cleft lip and/or cleft palate Biliary Atresia Tracheo-oesophageal fistula Hirschsprung's Disease Oesophageal atresia and/or Stenosis Imperforate anus Gastroschisis Hernia – umbilical, diaphragmatic Duodenal atresia
Genito-urinary tract	Renal agenesis Atresia and stenosis of urethra or bladder neck Polycystic kidney(s) Exstrophy of bladder Hypospadias Indeterminate sex Undescended testes at term
Cardio-vascular system	Transposition of the great vessels Fallot's Tetralogy Ventricular septal defect Patent ductus arteriosus at term Coarctation of the aorta
Skeletal	Talipes equinovarus (club foot) Polydactyly Congenital dislocation of hip Achondroplasia Phocomelia Syndactyly
Muscular	Exomphalos

Puerperium Complications

The following is a list of examples of puerperium complications, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

Anaemia
Baby for adoption
Breast – any disorders of the breast and lactation (specify whether with or without attachment difficulties) e.g. breast engorgement, cracked nipples, suppressed lactation
Deep vein thrombosis
Eclampsia
Febrile
Haemorrhoids
Infection of genito-urinary tract
Mastitis - breast infection
Post natal depression
Post-partum thyroiditis
Pregnancy induced hypertension – specify severity
Puerperal psychosis
Pulmonary embolism
Pyrexia
Retained products of conception, with or without haemorrhage
Secondary post-partum haemorrhage
Septicaemia
Spinal headache
Thrombophlebitis
Urinary retention
Urinary tract infections
Vaginal/vulval haematoma
Wound disruption – breakdown or infection (specify if vaginal or abdominal)

Puerperium Procedures and Operations

The following is a list of examples of procedures and operations that were performed during the puerperium, which should be reported to the Perinatal Data Collection. Note that this is not an exhaustive list.

Appendicectomy
Blood patch, spinal or epidural
Blood transfusion
C.A.T. scan
Cholecystectomy – specify open or laparoscopic
Curette (D and C) post-partum
Doppler studies
Drainage of abscess – specify site
Evacuation of haematoma – specify site e.g. Vulva
Hysterectomy
Haemorrhoidectomy
Laparoscopy – specify reason
Magnetic Resonance Imaging (MRI) of pelvis etc.
Manual exploration of uterus
Manual removal of placenta
Mechanical ventilation
Resuture of perineum (following breakdown of perineal repair)
Tubal Ligation

Appendix 3. Neonatal Intensive Care Units and Special Care Nurseries

Neonatal Intensive Care Units (Level 6)

CODE	FACILITY NAME
00936	GOLD COAST UNIVERSITY HOSPITAL
00003	MATER MOTHERS' HOSPITAL
00318	MATER WOMEN'S & CHILDREN'S PRIVATE HEALTH SERVICES
00201	ROYAL BRISBANE & WOMEN'S HOSPITAL
00200	THE TOWNSVILLE HOSPITAL

Special Care Nurseries – Public Hospitals (Level 4 & 5)

CODE	FACILITY NAME
00062	BUNDABERG BASE HOSPITAL
00030	CABOOLTURE HOSPITAL
00214	CAIRNS HOSPITAL
00936	GOLD COAST UNIVERSITY HOSPITAL
00069	HERVEY BAY HOSPITAL
00015	IPSWICH HOSPITAL
00029	LOGAN HOSPITAL
00172	MACKAY BASE HOSPITAL
00246	MOUNT ISA BASE HOSPITAL
00049	NAMBOUR GENERAL HOSPITAL
00016	REDCLIFFE HOSPITAL
00028	REDLAND HOSPITAL

00141	ROCKHAMPTON HOSPITAL
00201	ROYAL BRISBANE & WOMEN'S HOSPITAL
00032	SUNSHINE COAST UNIVERSITY HOSPITAL
00200	THE TOWNSVILLE HOSPITAL
00104	TOOWOOMBA HOSPITAL

Special Care Nurseries – Private Hospitals (Level 4 & 5)

CODE	FACILITY NAME
00420	CAIRNS PRIVATE HOSPITAL
00391	GREENSLOPES PRIVATE HOSPITAL
00441	JOHN FLYNN PRIVATE HOSPITAL
00401	MATER MISERICORDIAE HOSPITAL MACKAY
00380	MATER MISERICORDIAE HOSPITAL ROCKHAMPTON
00003	MATER MOTHERS' HOSPITAL
00318	MATER WOMEN'S & CHILDREN'S PRIVATE HEALTH SERVICES
00411	MATER WOMEN'S AND CHILDREN'S HOSPITAL HYDE PARK
00332	NAMBOUR SELANGOR PRIVATE HOSPITAL
00320	NORTH WEST PRIVATE HOSPITAL
00331	PINDARA PRIVATE HOSPITAL
00313	ST ANDREW'S - IPSWICH PRIVATE HOSPITAL
00366	ST VINCENT'S HOSPITAL TOOWOOMBA
00317	SUNNYBANK PRIVATE HOSPITAL
00334	THE SUNSHINE COAST PRIVATE HOSPITAL
00316	THE WESLEY HOSPITAL

The responsibility for implementing, monitoring, complying with and notifying changes in service levels in public health facilities will rest with HHS Chief Executive Officers.

Please direct any queries regarding the CSCF v3.2 and licensing within the private health sector to Private.Health@health.qld.gov.au or phone 07 3708 5325.

Please direct any other queries regarding the CSCF v3.2 to CSCF@health.qld.gov.au or phone 07 3708 9049.
The full document can be found at the following web address:
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/maintenance-development/default.asp

Abbreviations

AID	Artificial Insemination using Donor sperm
AIH	Artificial Insemination using the Husband or male partner's sperm
AIHW	Australian Institute of Health and Welfare
BBA	Born Before Arrival
BE	Base Excess
BMI	Body Mass Index
CPAP	Continuous Positive Airway Pressure
CTG	Cardiotocography
CSCF	Clinical Services Capability Framework
EDC	Estimated Data of Confinement
ETT	Endotracheal Tube
FET/ET	Frozen Embryo Transfer/Embryo Transfer
FSE	Fetal Scalp Electrode
GIFT	Gamete Intra Fallopian Transfer
HELLP	Hemolysis/Elevated Liver enzymes/Low Platelet count
HHS	Hospital and Health Services
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICI	Intracervical Insemination
ICN	Intensive Care Nursery
ICSI	Intracytoplasmic Sperm Injection
IM	Intramuscular
IPPV	Intermittent Positive Pressure Ventilation
IUI	Intrauterine Insemination
IV	Intravenous
IVF	In Vitro Fertilisation
IVI	Intravaginal Insemination
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean Section
MR63D	Queensland Perinatal Data Collection Form
NHDD	National Health Data Dictionary
NICU	Neonatal Intensive Care Unit
NHISSC	National Health Information Standards and Statistics Committee
NPDC	National Perinatal Data Collection
NPDDC	National Perinatal Data Development Committee
PDC	Perinatal Data Collection

PNO	Perinatal Online Form
PPH	Post-Partum Haemorrhage
QHDD	Queensland Health Data Dictionary
SCIU	Statistical Collections and Integration Unit
SCN	Special Care Nursery
SRCU	Statistical Reporting and Coordination Unit
SSB	Statistical Services Branch
UR	Unit Record Number
US	Ultrasound