

Queensland Perinatal Data Collection (QPDC) Manual

2019-2020

Version 1.01



Queensland Perinatal Data Collection (QPDC) Manual 2019-2020 Collection Year

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

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1. Introduction

This manual provides an overview for the completion of the Queensland Perinatal Data Collection (QPDC) 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 QPDC 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 (QPDC)

The aims of the QPDC 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 QPDC. 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 one off 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) 3708 5702. (Note that in some instances charges may apply – contact SRCU for further details).

2.1 Scope of the QPDC

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 QPDC 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 QPDC 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 QPDC but may be useful in hospitals. Items not needed specifically for the QPDC but included for hospitals' use are not highlighted white on the hospital copies.

2.3 Perinatal Online

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

Refer to the [PNO Online User Manual](#) for information on this application.

2.4 QPDC Changes for 2019-2020

For additional information on the QPDC File Format refer to:

<https://www.health.qld.gov.au/hsu>

Change Description	File Format Reference Page/s
1. Update of ICD-10-AM 10th edition to ICD-10-AM 11th edition The Independent Hospitals Pricing Authority engaged the Australian Consortium for Classification Development to conduct public consultation and develop the ICD-10-AM/ACHI/ACS Eleventh Edition for use in all Australian States and Territories for births occurring from 1 July 2019.	3
2. Add data quality and compliance statement to the Introduction A paragraph has been added to the Introduction advising hospitals that data reported to the Statistical Services Branch (SSB) must be of high quality and clarifying the process to manage data of poor quality. Note: Data containing high numbers of validation errors will not be accepted by SSB.	3, 5
3. Amend the Descriptions to add further clarity to the following Data Items: <ul style="list-style-type: none">• Last Menstrual Period estimation indicator• Estimated Date of Confinement estimation indicator• Mother's Date of Birth estimation indicator Clarification that the indicator is to only be supplied as 'E' when any part of the date (the day, month or year) was intentionally estimated by a clinician. Systems should not default to 'E' in any circumstance.	3, 28, 38
4. Add new response value of 'declined to answer' to: <ul style="list-style-type: none">• Cigarette smoking during the first 20 weeks indicator	4, 36, 37, 40, 41

Change Description	File Format Reference Page/s
<ul style="list-style-type: none"> • Cigarette smoking after 20 weeks indicator • Antenatal screening performed for illicit drug use indicator • Antenatal screening using Edinburgh Postnatal Depression Scale indicator • Amend validations to include new value of 3 <p>This change is required to assist in meeting the Australian Institute of Health and Welfare (AIHW) Compliance requirements to reduce the percentage of 'Not Stated/inadequately described' responses.</p>	
<p>5. Closure of the Antenatal Screening for Domestic Violence indicator and addition of new Antenatal Screening performed for Family Violence indicator</p> <p>This change is required to align with the revised <i>Clinical Practice Guidelines – Pregnancy Care</i>.</p> <p>The new Antenatal Screening performed for Family Violence indicator is to be used for births occurring from 1 July 2019.</p>	4, 39, 42
<p>6. Closure of Antenatal Screening for Alcohol Use and addition of new Alcohol items below:</p> <ul style="list-style-type: none"> • Alcohol consumption in the first 20 weeks of pregnancy indicator • Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy • Alcohol consumption frequency in the first 20 weeks of pregnancy • Alcohol consumption after 20 weeks of pregnancy indicator • Number of standard drinks consumed when drinking alcohol after 20 weeks of pregnancy • Alcohol consumption frequency after 20 weeks of pregnancy <p>As part of the National Indigenous Reform Agreement (NIRA), the Council of Australian Governments (COAG) agreed to the enhancement of perinatal data to capture additional information in relation to antenatal care and alcohol use during pregnancy. COAG provided funding to the Australian Institute of Health and Welfare (AIHW) to facilitate the development of data items for inclusion in the Perinatal National Minimum Data Set through Schedule F of the NIRA. This data item has been modelled on the AUDIT-C tool which is already used in the Pregnancy Health Record.</p> <p>The new Alcohol items are to be used for births occurring from 1 July 2019.</p>	4, 39, 42, 43, 44
<p>7. Add the following new response values to Resuscitation Methods:</p> <ul style="list-style-type: none"> • 13 - CPAP ventilation • 14 - Intubation <p>The inclusion of these baby resuscitation methods will ensure that Queensland meets the national agreement to collect and provide high quality and nationally consistent data. This will assist in monitoring the incidence of resuscitation immediately after birth, perinatal outcomes of babies requiring resuscitation and the intensity of resuscitation required.</p>	4, 82

Change Description	File Format Reference Page/s
The new resuscitation methods are to be used for births occurring from 1 July 2019.	
<p>8. Update Terminology to conform to QHDD and METeOR</p> <p>Wording in the <i>2019-2020 QPDC File Format</i> document has been updated to align with Queensland Health Data Dictionary (QHDD) terminology and the Australian Institute of Health and Welfare's repository for national metadata standards (METeOR).</p>	Throughout document

2.4.1. QPDC MR63D Form Changes for 2019-2020

There are changes to the QPDC (MR63D) for this period in-line with the changes described in the section above.

The link to the latest MR63D form can be found at the following link (note will be available from August 2019- <https://www.health.qld.gov.au/hsu>)

2.4.2. QPDC Electronic File Format Changes for 2019-2020

The QPDC electronic file format has changes associated with the QPDC changes for 2019-2020, as shown in the section above.

The link to the latest Electronic File Format can be found at the following link - <https://www.health.qld.gov.au/hsu>

2.5 QPDC Reporting Requirements

2.5.1. QPDC Reporting Timeframes

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

Refer to the table below for the reporting schedule:

Reporting Period	Finalised Data Due Date All Hospitals
July	4 September
August	5 October
September	4 November
October	5 December
November	4 January
December	4 February
January	7 March (6 in a leap year)
February	4 April

March	5 May
April	4 June
May	5 July
June	4 August

2.5.2. Data Quality

Hospitals should ensure that the following principals guide the collection and reporting of data to the Queensland Department of Health (DoH) via the Statistical Services Branch (SSB):

- Trustworthy - data is accurate, relevant and timely;
- Valued - data is a core strategic asset;
- Managed - collection of data is actively planned, managed and compliant; and
- Quality – data provided is complete, consistent, undergoes regular validation and is of sufficient quality to enable the DoH to perform regulatory functions such as monthly performance reports, fulfil legislative requirements, deliver accountabilities to state and commonwealth governments, monitor and promote improvements in the safety and quality of health services.

To ensure the DoH can fulfil its regulatory functions, hospitals must ensure that data submitted to SSB are of high quality. SSB cannot accept data containing a high number of validation errors.

Should data submitted contain a high number of validation errors, SSB will advise the hospital accordingly to review the quality of the data submitted for correction and re-submission. For SSB to accept data submitted any validation errors identified must be addressed (on the relevant information system) to ensure that erroneous data is not submitted to SSB.

For private facilities, under the *Private Health Facilities Act 1999* (the Act) private facilities must comply with the requirements of the Act. In particular, the submission of reports to enable the State to give information to the Commonwealth under an agreement with the Commonwealth and prescribed under section 7(4)(c) of the *Private Health Facilities Regulation 2000* (the Regulations).

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 view the Queensland Health Data Dictionary to obtain more information about the inventory of data elements please contact the Principal Data Standards Officer, Statistical Services Branch on email DQSTD@health.qld.gov.au.

3. Mothers Details

3.1 Place of Delivery

A valid facility code from the Corporate Reference Data System (CRDS) Facility data set maintained by Statistical Standards and Strategies Unit (SSSU), SSB.

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/Select 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/Select 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

Date on which an admitted patient commences a hospital stay. For the QPDC submission record, this is the admission date for the birthing episode.

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

The country in which a person was born.

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

Whether a person identifies as being of Aboriginal or Torres Strait Islander origin. In this case, 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 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.

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

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

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.

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 Reister](#).

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 (MR63D form only)

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 or Pregnancy Complications.

Instructions

RPR/IgG	Enter +/- in both fields to show RPR and IgG status.
---------	------------------------------------------------------

Rubella	Enter immune/not immune
---------	-------------------------

Blood Group	Enter blood group e.g. O/A/B/AB
-------------	---------------------------------

Rh	Enter the Rhesus factor +/-
Antibodies	Enter the appropriate box for Yes/No.
Other	Enter a text response for any other serology results not included in the above options.

3.8 Family Name

The part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given 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 First Given Name

The person's first or most common identifying name within the family group or by which the person is uniquely socially identified.

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 Second Given Name

The person's second or least used identifying name within the family group or by which the person is uniquely socially identified.

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.

3.11 UR Number

A unique number used to identify a patient within a facility. In this case, the mother.

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 unique number for administrative purposes it can be included.

3.12 Date of Birth (Mother)

The date of birth of an individual. In this case, the mother.

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 2019 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: 15061989

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 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. Do not use a post office box address for any part of the usual residence details.

3.13.1. Street number and name

The street number and name of usual residential address of person, or equivalent in rural areas.

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

If unknown, leave this field blank.

3.13.2. Suburb

The name of the suburb/town/locality of usual residential address of person.

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

If not stated or unknown record the suburb as 'Not stated or unknown'

3.13.3. Postcode

The postcode aligned with the suburb/town/locality of usual residence of a person.

For interstate mothers, use the postcode of the mother's usual residence, not the address of a vacation premises or similar.

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/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. Australian External Territories include the following: Christmas Island, Cocos (Keeling) Islands, Jervis Bay and Norfolk Island.

Unknown postcode

If a postcode is unknown (e.g. an unconscious patient is unable to provide the information), record code **0989 Not stated or unknown**. Do not leave the field blank.

Although provision is made for recording 0989 Not stated or unknown, every effort should be made during the course of the admission to determine (and record) a patient's postcode.

3.14 Antenatal Transfer

An indicator of whether the mother was transferred antenatally.

This includes transfers from planned home births to hospital, from birthing centre to acute care area or where the mother has been transferred from a different location.

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

3.14.1. Reason for Transfer

A code which describes the reason for the mother being transferred prior to the delivery.

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

3.14.2. Transferred From

The identifier for the facility from which the person is transferred.

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

3.14.3. Time of Transfer

Whether the mother was transferred prior to onset of labour or during labour.

Record 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

Indicator of whether the female was previously pregnant.

If the mother has had no previous pregnancies, record no or 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

4.2.1. Previous pregnancies all outcomes were livebirths

The total number of previous pregnancies where all outcomes were livebirths.

Record the number of previous pregnancies (not number of previous babies) resulting in only livebirths.

4.2.2. Previous pregnancies all outcomes were stillbirths

The total number of previous pregnancies where all outcomes were stillbirths.

Record the number of previous pregnancies (not number of previous babies) resulting in only stillbirths.

4.2.3. Previous pregnancies all outcomes were abortion/miscarriage/ectopic/hydatiform moles

The total number of previous pregnancies where all outcomes were only abortion/miscarriage/ectopic /hydatiform moles.

Record the number of previous pregnancies (not number of previous babies) resulting in only abortions/miscarriage/ectopic /hydatiform moles.

4.2.4. Previous pregnancies all outcomes livebirth and stillbirth

The total number of previous pregnancies where all outcomes resulted in a combination of only livebirth and stillbirth.

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only livebirth and stillbirth.

4.2.5. Previous pregnancies all outcomes livebirth and abortion/miscarriage/ectopic /hydatiform mole

The total number of previous pregnancies where all outcomes resulted in a combination of only livebirth and abortion/miscarriage/ectopic /hydatiform mole.

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only livebirth and abortion/miscarriage/ectopic /hydatiform mole.

4.2.6. Previous pregnancies resulting in stillbirth and abortion/miscarriage/ectopic /hydatiform mole

The total number of previous pregnancies where all outcomes resulted in a combination of only stillbirth and abortion/miscarriage/ectopic /hydatiform mole.

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of only stillbirth and abortion/miscarriage/ectopic/hydatiform mole.

4.2.7. Previous pregnancies resulting in livebirth, stillbirth and abortion/miscarriage/ectopic /hydatiform mole

The total number of previous pregnancies where all outcomes resulted in a combination of livebirth and stillbirth and abortion/miscarriage/ectopic /hydatiform mole.

Record the number of previous pregnancies (not number of previous babies) resulting in a combination of livebirth and stillbirth and abortion/miscarriage/ectopic/hydatiform mole.

4.2.8. Total number of previous pregnancies

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.

Note, that in the case of medical abortion or termination of pregnancy where gestation is 20 weeks or greater and/or birthweight 400 grams 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

The method of complete expulsion or extraction from its mother of a product of conception for the last birth.

Record 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), report both. 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 report 'LSCS'.

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

4.4 Number of Previous Caesareans

The number of previous caesarean sections performed on the woman.

In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born. Exclude the current birth if by caesarean section

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

5. Present Pregnancy

5.1 Antenatal Screening

For additional information refer to The Department of Health - Maternity Services.

<https://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-pdb-maternity>

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. Family Violence

An indicator of whether a female has received family violence screening during the antenatal stage of the pregnancy.

Record the response that corresponds to the mother's antenatal screening status for family violence.

Family violence has become a significant policy priority across Australia. The term 'Family Violence' has replaced 'Domestic Violence' in keeping with clinical practice guidelines. Family violence is the preferred term used to identify experiences of violence as it encompasses the broad range of extended family and kinship relationships in which violence may occur.

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). Women exposed to violence are more likely to have a miscarriage, stillbirth, premature birth or termination of pregnancy than other women. Women exposed to violence during pregnancy are more likely to develop depression in the postnatal period.

5.1.2. Illicit Drug Use

An indicator of whether screening for illicit drug use was performed during the antenatal stage of the pregnancy.

Record 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).

5.1.3. Edinburgh Postnatal Depression Scale indicator

Indicates if Edinburgh Postnatal Depression Scale (EPDS) was assessed as part of antenatal screening during the pregnancy.

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

5.1.4. Edinburgh Postnatal Depression Scale Score

The score for the Edinburgh Postnatal Depression Scale (EPDS) assessed as part of antenatal screening during the pregnancy.

The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a pregnant woman has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. (Beyond Blue: <http://www.beyondblue.org.au/resources/for-me/pregnancy-and-early-parenthood/edinburgh-postnatal-depression-scale>).

5.2 Vaccination

5.2.1. Influenza vaccination indicator

An indicator of whether an influenza vaccine was administered to the pregnant woman during the pregnancy. An influenza vaccine may be administered at any stage of the pregnancy.

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. Influenza – gestation weeks administered

The number of weeks of pregnancy when the influenza vaccine was administered to the pregnant woman, in completed weeks.

5.2.3. Pertussis vaccination indicator

An indicator of whether a pertussis vaccine was administered to the pregnant woman during the pregnancy. A pertussis vaccine may be administered at any stage of the pregnancy. Pertussis is also known as whooping cough.

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 2017-2022, includes a funded program for maternal pertussis vaccination.

5.2.4. Pertussis – gestation weeks administered

The number of weeks of pregnancy when the pertussis vaccine was administered to the pregnant woman, in completed weeks.

5.3 Smoking

5.3.1. Smoking during the first 20 weeks of pregnancy indicator

An indicator of whether a female smoked tobacco during the first 20 weeks of pregnancy.

Tobacco cigarette smoking refers to tobacco delivered to the user in the form of a cigarette and does not include pipes or cigars.

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. Number of tobacco cigarettes smoked per day during the first 20 weeks of pregnancy

The total number of cigarettes usually smoked daily by a female during the first 20 weeks of pregnancy until the birth.

5.3.3. Tobacco cigarette smoking cessation advice during the first 20 weeks of pregnancy indicator

An indicator of whether a pregnant woman was given tobacco cigarette smoking cessation advice from a health care provider 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.

5.3.4. Smoking after 20 weeks of pregnancy indicator

An indicator of whether a female smoked tobacco after 20 weeks of pregnancy until the birth.

Tobacco cigarette smoking refers to tobacco delivered to the user in the form of a cigarette and does not include pipes or cigars.

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

5.3.5. Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy

The total number of cigarettes usually smoked daily by a female after 20 weeks of pregnancy until the birth.

5.3.6. Tobacco cigarette smoking cessation advice after 20 weeks of pregnancy indicator

An indicator of whether a pregnant woman was given tobacco cigarette smoking cessation advice from a health care provider 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.

5.4 Alcohol

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).

5.4.1. Alcohol consumption in the first 20 weeks of pregnancy indicator

An indicator of whether a female consumed alcohol in the first 20 weeks of pregnancy.

This data item is self-reported and to ensure consistency of results, this data element should be collected after the first 20 weeks of pregnancy.

5.4.2. Number of standard drinks consumed when drinking alcohol in the first 20 weeks of pregnancy

The total number of standard drinks consumed on a typical day when drinking alcohol by a female in the first 20 weeks of pregnancy.

Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the national Health and Medical Research Council (NHMRC) 2009 guidelines.

This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the NHMRC, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

Note: Occasional drinking (less than one) should be reported as 998 in the electronic extract.

5.4.3. Alcohol consumption frequency in the first 20 weeks of pregnancy

The frequency of alcohol consumption by a female in the first 20 weeks of pregnancy.

This data item is self-reported and to ensure consistency of results, this data element should be collected after the first 20 weeks of pregnancy.

5.4.4. Alcohol consumption after 20 weeks of pregnancy indicator

An indicator of whether a female consumed alcohol after 20 weeks of pregnancy until the birth.

This data item is self-reported and to ensure consistency of results, this data element should be collected after the birth.

5.4.5. Number of standard drinks consumed when drinking alcohol after 20 weeks of pregnancy

The total number of standard drinks consumed on a typical day when drinking alcohol by a female after 20 weeks of pregnancy.

Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol. The numbers of Australian standard drinks in common containers of various alcoholic beverages is presented in the national Health and Medical Research Council (NHMRC) 2009 guidelines.

This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the NHMRC, consumed per day. When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

Note: Occasional drinking (less than one) should be reported as 998 in the electronic extract.

5.4.6. Alcohol consumption frequency after 20 weeks of pregnancy

The frequency of alcohol consumption by a female after 20 weeks of pregnancy until the birth.

This data item is self-reported and to ensure consistency of results, this data element should be collected after the birth.

5.5 Last Menstrual Period (LMP)

Date of the first day of the mother's last menstrual period.

If the date of the LMP is unknown leave the field blank/null. 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. A value of E should then be reported in the LMP Estimated field.

5.6 Estimated Date of Confinement (EDC)

Estimated date of delivery as indicated by ultrasound scan, date of last menstrual period 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. A value of E should then be reported in the EDC Estimated field.

5.7 Height

A person's height, measured in centimetres.

Record the mother's height in total centimetres (round down if required).

Height will be used in conjunction with self-reported weight for Body Mass Index (BMI) assessment to assist in identifying pregnancies at risk.

5.8 Weight (self-reported)

A person's self-reported weight (body mass)

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.

5.9 Antenatal care indicator

Indicator of whether antenatal care was received for the current pregnancy.

5.10 Antenatal care type

The type of service provider delivering the antenatal care during the pregnancy.

More than one may be reported to indicate the different antenatal care service provider types providing care during the pregnancy. If the mother received no antenatal care then No should be reported.

5.11 Total number of antenatal visits

The total number of antenatal care visits attended by a pregnant female.

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

The number of antenatal care visits is an indicator of access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants.

Receiving antenatal care at least four times, as recommended by World Health Organization (WHO), increases the likelihood of receiving effective maternal health interventions during antenatal visits (WHO 2015).

5.12 Gestation at first antenatal visit

The estimated duration of a pregnancy in total completed weeks, on the day of the first visit for antenatal care.

The date of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided. It does not include a visit where the sole purpose of contact is to confirm the pregnancy, or those contacts that occurred during the pregnancy that related solely to non-pregnancy related issues. It does not include a first contact after the onset of labour.

Antenatal care visits are attributed to the pregnant woman. The duration of the pregnancy on that day is the same as the gestational age of the fetus or baby on that day.

5.13 Current Medical Condition

Pre-existing maternal diseases, conditions 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.

Such conditions are those regarded by the clinician to affect the management of the pregnancy. Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the fetus and perinatal morbidity

See [Appendix 2 – Examples of Conditions to Report – Medical Conditions](#) for examples.

5.14 Pregnancy Complication

Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is not arbitrary limit on the number of complications specified.

Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

See [Appendix 2 – Examples of Conditions to Report – Pregnancy Complications](#) for examples.

5.15 Procedures and Operations

A procedure or operation performed on a female during the pregnancy, labour or delivery.

Note: procedure or operations performed after the birth of the baby are reported in Puerperium Procedures and Operations.

See [Appendix 2 – Examples of Conditions to Report – Procedures and Operations](#).

5.16 Number of Ultrasound Scans

Total number of ultrasound scans performed in the current pregnancy.

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.

5.17 Types Of Ultrasound Scans

5.17.1. Nuchal translucency scan

Indicates whether a nuchal translucency ultrasound was performed on the mother during the pregnancy.

A nuchal translucency ultrasound is performed during pregnancy to assess for major chromosomal abnormalities.

5.17.2. Morphology scan

Indicates whether an assessment for morphology ultrasound was performed on the mother during the pregnancy.

A morphology ultrasound is performed during pregnancy to allow the diagnosis of morphologic abnormalities.

5.17.3. Chorionicity scan

Indicates whether an assessment for chorionicity ultrasound was performed on the mother during the pregnancy.

An assessment for chorionicity ultrasound is performed during pregnancy 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.

5.18 Assisted Conception

A method used to increase the chance of conception due to an infertile or subfertile woman and/or man.

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.

6. Labour and Delivery

6.1 Intended Place of Birth at Onset of Labour

The intended place of birth at the onset of labour (or immediately prior to no labour caesarean section).

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 (Note: all Birth Centres in Queensland currently are Birth centre, attached to hospital)	A facility where women are able to birth in an environment which: <ul style="list-style-type: none">• 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.
Freebirth	Freebirth is a birth where no medical professional who is trained to direct the birth process is in attendance. This code is only for use by the QPDC team.

6.2 Actual Place of Birth of Baby

The actual place where the birth occurred.

Record 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 (BBA)' and specify in the space provided, e.g. hospital car park, on the way to hospital in an ambulance etc. 'Other (BBA)'.

If the baby was born inside the hospital building (Emergency Department, Outpatient Clinic, hallway, bathroom etc then this should be reported as in the Hospital.

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

The manner in which labour started in a birth event.

Record 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 dilation 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

The method used to induce labour in a birth event.

If the labour was induced in onset, report 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

The main indication for an induction of labour being performed to commence a birth event.

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 First Additional Reason for Induction

The first additional indication for an induction of labour being performed to commence a birth event.

If labour was induced and there is more than one reason indicated, specify the first 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 first additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid first 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 Second Additional Reason for Induction

The second indication for an induction of labour being performed to commence a birth event.

If labour was induced and there are more than two reasons indicated, specify the second 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 second additional reasons for induction as labour has not yet commenced. Also note that 'augmentation' is not a valid second 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

The number of hours before delivery, the membranes ruptured.

Record the number of days, hours and minutes before delivery the membranes were ruptured. If membranes ruptured at delivery, then record 'at delivery' or Record '0'. If a 'no labour' caesarean section occurs, it cannot be assumed that the membranes ruptured at delivery so record 'at delivery' or Record '0' as above. Note: recorded as the total number of hours in electronic databases.

6.9 Length of First Stage of Labour

The duration of the first stage of labour, in minutes.

Stage 1 begins with the onset of regular uterine contractions and is complete when the cervix is fully dilated (10cms).

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

Code	Description
00000	Interrupted
99998	Not measured
99999	Not stated/Unknown

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. Note: recorded as the total number of minutes in electronic databases.

6.10 Length of Second Stage of Labour

The duration of the second stage of labour, in minutes.

Stage 2 begins when the cervix is fully dilated (10cms) and is complete with the birth of the baby.

Where the labour is interrupted and therefore stage 2 is interrupted, completed as follows:

Code	Description
00000	Interrupted
99998	Not measured
99999	Not stated/Unknown

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. Note: recorded as the total number of minutes in electronic databases.

6.11 Presentation at Birth

The part of the fetus which lies in the lower segment of the uterus, over the cervical os, at birth.

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

Definitions

Vertex	Presentation at birth is the upper back part of the fetal head. This is, the occiput is the point of reference.
Breech	Presentation at birth is the buttocks or legs. Includes breech with extended legs, breech with flexed legs, footling and knee presentations.
Face	Presentation at birth is the face. That is, the fetal head is hyper-extended and the area of the head below the root of the nose and the orbital ridge is at the cervical os.
Brow	Presentation at birth is the brow. That is, 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 cervical os.
Transverse/shoulder	Presentation at birth is either transverse or shoulder. Transverse: the long axis of the fetal body is across the long axis of the mother's body. Shoulder: the fetal head is in the iliac fossa and the shoulder is at the cervical os.
Other	Presentation at birth is none of the above. For example, compound presentations.

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

6.12 Method of Birth

The method of complete expulsion or extraction of a product of conception from the female in a birth event.

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 Ventouse Extractor.
LSCS	Lower segment caesarean section, includes where a hysterotomy is performed to extract the product of conception.
Classical CS	Classical caesarean section.
Other	Includes birth methods not classified above.

6.13 Water Birth indicator

An indicator of whether the birth was a 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.

6.14 Water Birth planned indicator

An indicator of whether the water birth was planned or unplanned

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

6.15 Reason for Forceps or Vacuum

If forceps or vacuum were used as the method of birth, specify the reason for this.

For example, 'prolonged active 2nd stage', 'Direct OP'.

6.16 Main Reason for Caesarean

The primary reason for why a caesarean section is performed during a birth event.

For example, 'repeat caesarean', 'fetal distress', 'prolonged labour', etc.

6.17 First Additional Reason for Caesarean

The first additional reason for why a caesarean section is performed during a birth event.

For example, 'repeat caesarean', 'fetal distress', 'prolonged labour', etc.

6.18 Second Additional Reason for Caesarean

The second additional reason for why a caesarean section is performed during a birth event.

For example, 'repeat caesarean', 'fetal distress', 'prolonged labour', etc.

6.19 Cervical Dilation Prior to Caesarean

The level of dilation of the cervix (in cm) prior to the caesarean section.

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

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

6.20 Antibiotics at Time of Caesarean

Whether antibiotics were administered at the time of caesarean section.

No antibiotics administered: If antibiotics were not received at the time of LSCS or classical caesarean section.

Antibiotics administered – Prophylactic: If antibiotics have been received for prophylaxis of infection specifically associated with the caesarean.

Antibiotics administered – therapeutic: If antibiotics have been received for a known condition (e.g. chorioamnionitis, pneumonia, etc) at the time of LSCS or classical caesarean. This does not include antibiotic prophylaxis.

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

6.21 Principal Accoucheur

The principal person assisting the mother in the birth of the baby.

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.

6.22 Damage to the Perineum

The state of the perineum following a birth event.

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	<ul style="list-style-type: none"> • 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.

6.23 Surgical Repair of the Vagina or Perineum

Indicator of whether there was a surgical repair to the perineum or vagina.

Note that if an episiotomy has been performed, then corresponding surgical repair would be expected.

6.24 Non-pharmacological Analgesia during Labour/Delivery

The type of non-pharmacological analgesia administered to or used by a female to relieve pain during a birth event.

If non-pharmacological analgesia was not used report this as No.

6.25 Pharmacological Analgesia During Labour/Delivery

Type of pharmacological agents administered to the mother by injection or inhalation to relieve pain during labour and/or delivery.

The use of pharmacological analgesia may influence the duration of labour, may affect the health status of the baby and is an indicator of obstetric intervention.

If pharmacological analgesia was not used report this as No.

6.26 Labour and Delivery Complications

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

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.

6.27 Cardiotocography (CTG) in Labour indicator

An indicator of whether Cardiotocography (CTG) monitoring was performed during the 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.

6.28 Fetal Scalp Electrode (FSE) in Labour indicator

Indicates if Fetal Scalp Electrode (FSE) monitoring was performed during labour.

Internal fetal monitoring involves placing an electrode directly on the fetal scalp through the cervix. This test is performed to evaluate fetal heart rate and variability between beats, especially in relation to the uterine contractions of labour.

6.29 Fetal Scalp pH indicator

Indicator of whether the fetal scalp pH was measured.

6.30 Fetal Scalp pH Result

A numerical score determined from a sample of blood taken from the fetal scalp during labour. Valid range from 6.49 to 7.50.

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

This data element is used to indicate fetal wellbeing during labour.

6.31 Fetal Scalp Lactate indicator

Indicator of whether the fetal scalp lactate was measured.

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

6.32 Fetal Scalp Lactate result

A numerical score allocated during the birth event to assess lactate levels of the newborn. Valid range 00.0 to 30.9.

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

The fetal scalp lactate measured result can help to determine if the newborn did not receive enough oxygen during the birth event.

6.33 Anaesthesia for Delivery indicator

An indicator of whether anaesthesia was administered to the mother for during a birth event.

6.34 Type of Anaesthesia administered

The type of anaesthesia administered to a female during a birth event.

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

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

Anaesthetic use may affect the health status of the baby and is an indicator of obstetric intervention.

When more than one type of anaesthesia was used, record all types administered.

7. Baby

7.1 Baby's UR Number

A unique number used to identify a patient within a facility. In this case, the baby.

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 unique number for administrative purposes it can be included.

7.2 Date of Birth

The date of birth of an individual. In this case, the baby.

7.3 Indigenous Status – Baby

Whether a person identifies as being of Aboriginal or Torres Strait Islander origin. In this case, 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

Aboriginal and Torres Strait Islander Health Unit 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.

7.4 Time of Birth

The time of the baby's birth.

Record 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

The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth (e.g. BBA), measured in grams.

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

If the baby was a stillbirth, the birthweight must be ≥ 400 grams or the gestation at least 20 weeks to be within the scope of the collection. Stillbirths less than 20 weeks gestation and less than 400 grams in weight are outside the scope of the QPDC. All livebirths are within scope, regardless of weight or gestation.

7.6 Gestation

The gestational age of the baby in completed weeks determined by clinical assessment after birth. Valid range 00 to 46.

Must be in completed weeks, for example, 40 weeks and 5 days is rounded down to 40 weeks.

Stillbirths less than 20 weeks gestation and less than 400 grams in weight are outside the scope of the QPDC. All livebirths are within scope, regardless of weight or gestation.

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

7.7 Gestational age after birth, completed days

The days component of a baby's gestational age determined by clinical examination after birth. Valid range 0 to 6.

Gestational days at birth is used in conjunction with gestational weeks at birth and does not represent the total gestational days. For example, for a baby with a gestational age of 35 weeks and 3 days, record '3'. is a key outcome of pregnancy and an important risk factor for neonatal outcomes.

7.8 Head Circumference at Birth

The head circumference of the baby at birth, measured in centimetres.

This metadata item applies to newborn babies. It enables the calculation of growth centiles which requires the measurement of head circumference and birth weight and/or length. Baby head circumference together with other anthropometric measurements assist with determining whether a baby is small for gestational age or has experienced intrauterine growth restriction. In addition, head circumference measurement enables identification of newborns with microcephaly, either primary or as an association with other pathology, for example, Fetal Alcohol Syndrome.

Head circumference should preferably be measured in the first hour of life at the same time as the birthweight is measured, to maximise comparability of these two measures in percentile calculations. A narrow, flexible, inelastic tape measure with clearly legible intervals and labels should be used.

Ideally the circumference should be plotted on a percentile chart to ensure it is within the 10th-90th percentile curves and consistent with the length and weight percentile.

7.9 Length at Birth

The length of the baby at birth, in centimetres.

This metadata item applies to newborn babies. It enables the calculation of growth centiles which requires the measurement of head circumference and birth weight and/or length.

Length at birth should preferably be measured on the day of birth.

7.10 Plurality

The total number of births (live births and stillbirths) resulting from this pregnancy.

Plurality at birth is determined by the total number of live births and stillbirths that result from the pregnancy. Stillbirths, including those where the fetus was likely to have died before 20 weeks gestation, should be included in the count of plurality. To be included, they should be recognisable as a fetus and have been expelled or extracted with other products of conception where pregnancy ended at 20 or more weeks gestation. Fetuses aborted before 20 completed weeks and less than 400 grams are excluded. If the pregnancy commences as a twin pregnancy but one fetus is miscarried/aborted before 20 weeks and 400 grams, the plurality is single.

7.11 Sex

Sex refers to a person's biological characteristics. A person's sex is usually described as being either male or female. A person may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics.

Male - Persons who have male or predominantly masculine biological characteristics, or male sex assigned at birth

Female - Persons who have female or predominantly feminine biological characteristics, or female sex assigned at birth.

Other - Persons who have mixed or non-binary biological characteristics (if known), or a non-binary sex assigned at birth.

The label 'Other' is used because a more descriptive term has not been widely agreed within the general community.

Sex refers to the chromosomal, gonadal and anatomical characteristics associated with biological sex. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.

7.12 Birth Status

The status of the baby at birth.

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

Stillbirth (fetal death) - Stillbirth is 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 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. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

7.13 Macerated indicator

Indicator of whether a stillborn baby was macerated.

Maceration is the softening and breaking down of skin from prolonged exposure to amniotic fluid in a deceased fetus.

Note: 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.

7.14 APGAR Score at 1 minute

Numerical score used to indicate the baby's condition at 1 minute after birth.

The score is based on the assessment of 5 characteristics of the baby. Heart rate, respiratory condition, muscle tone, reflex irritability and skin colour. Each characteristic is given a score of between 0 and 2 points with a maximum total Apgar score of 10 points.

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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7.15 APGAR Score at 5 minutes

Numerical score used to indicate the baby's condition at 5 minutes after birth.

The score is based on the assessment of 5 characteristics of the baby. Heart rate, respiratory condition, muscle tone, reflex irritability and skin colour. Each characteristic is given a score of between 0 and 2 points with a maximum total Apgar score of 10 points.

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.

See table at 7.14 APGAR Score at 1 minute for details.

7.16 Regular Respirations

The time (in minutes) to establish regular respirations for a live born baby.

Record to the nearest minute, the time the baby took to establish regular, spontaneous breathing. For example, record 20 seconds as 01, record 1 minute 12 seconds as 02, and so on.

If the baby established respirations spontaneously the time recorded would be 00.

If the baby was intubated or ventilated record as 'intubated/ventilated'.

If respirations were never established, record as 'respirations not established'.

7.17 Active Resuscitation indicator

Indication of whether active measures were taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

This does not include any drug therapy.

7.18 Active Resuscitation method

Method of active measure taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Resuscitation also includes routine oral suction and intubation. Required to analyse need for resuscitation after complications of labour and delivery, and to evaluate level of services needed for different birth settings. IPPV is also known as intermittent positive pressure respiration. More than one method may be recorded for each baby.

Intubation or laryngeal mask ventilation may be added at any stage of the resuscitation/ The timing will often depend on the familiarity and skill of the clinician with the procedure. For a skilled and experienced clinician, intubation will normally occur earlier in the resuscitation

7.19 Cord pH measured indicator

Indicates whether the umbilical cord pH was measured.

Only applicable for live births. Stillbirth should be recorded as Not measured.

7.20 Cord pH Result

Numerical result determined after delivery to assess blood gases of the newborn which can determine if the newborn did not receive enough oxygen during labour.

Lower limit of 6.49 and upper limit of 7.50

7.21 Vitamin K administered method (first dose)

The method of administration for the first dose of vitamin K to the baby.

7.22 Hepatitis B Vaccination administered status (birth dose)

The status of whether the birth dose of Hepatitis B vaccination was administered to the baby.

This field does not refer to administration of Hepatitis B Immunoglobulin.

7.23 Hepatitis B Immunoglobulin administered status

The Hepatitis B immunoglobulin administered status of the baby at birth.

This field does not refer to administration of Hepatitis B Vaccination.

8. Postnatal Details

8.1 Neonatal Morbidity indicator

Indicator of whether any neonatal morbidity (conditions or diseases of the baby) were present up to the time of the discharge or when the baby reaches 28 days of age.

Only applicable to live births. Still births are recorded as no neonatal morbidity.

8.2 Neonatal Morbidity

Neonatal morbidity (conditions or diseases of the baby) present prior to discharge, transfer or death.

Only applicable to live births.

See [Appendix 2 – Examples of Conditions to Report – Neonatal Morbidity](#)

8.3 Neonatal Treatment indicator

Indicator of whether any neonatal treatment was given up to the time of discharge or when the baby reached 28 days of age.

Only applicable to live births. Still births are recorded as no neonatal treatment.

8.4 Neonatal Treatment type

The type of neonatal treatment given during the birth episode.

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).

Only applicable to live births.

8.5 Number of days in Intensive Care Nursery

Number of whole days the baby was present in the intensive care nursery (ICN).

If baby in the ICN for less than 24 hours report this as 001.

If baby was not in ICN report this as 000.

Intensive Care Nursery: A Specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

Neonatal Intensive Care Unit: must be capable of providing complex, multi-system life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of similar nature.

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>

For information about **Neonatal Services** see the **Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.2**, available 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 5325
Email: cscf@health.qld.gov.au

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

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>

8.6 Number of days in Special Care Nursery

Number of whole days the baby was present in the special care nursery (SCN).

If baby in the SCN for less than 24 hours report this as 001.

If baby was not in SCN report this as 000.

Special Care Nursery: A nursery that monitors and cares for newborns suffering from illness or disability at birth requiring specialist medical care, nursing attention and hospital treatment. Facilities include humidicribs, cardiorespiratory monitoring, IV fluid therapy, tube feeds and phototherapy.

For more information in relation to Special Care Nursery see 8.6.

8.7 Main Reason for Admission to ICN/SCN

The reason as to why the baby was admitted to an intensive care nursery or special care nursery.

If the baby was admitted to either an ICN (level 6) or SCN (level 4 and 5), 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.

8.8 Congenital Anomaly indicator

Indicates whether an anatomical defect or chromosomal abnormality was present at birth and detected prior to separation from care.

8.9 Congenital Anomaly

An anatomical defect or chromosomal abnormality that is present at birth and detected prior to separation.

See [Appendix 2](#) for examples of congenital anomalies.

8.10 Congenital Anomaly position

The laterality of the structural abnormalities (including deformations) present at birth.

Record for each congenital anomaly.

8.11 Congenital Anomaly status

Indicates whether an anatomical defect or chromosomal abnormality was confirmed or suspected.

8.12 Congenital Anomaly diagnosed prior to birth indicator

Indicator of whether congenital anomaly was diagnosed prior to 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

A medical/obstetric complication of the mother occurring during the postnatal period up to the time of separation from care.

See [Appendix 2 – Examples of Conditions to Report – Puerperium Complications](#).

Record all puerperium complications.

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.

9.1.2. Puerperium Thromboprophylaxis administered

The type of puerperium thromboprophylaxis administered/used following caesarean section.

When more than one puerperium thromboprophylaxis is administered, record all types administered. Only valid when the method of birth is a LSCS or classical caesarean.

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

A procedure or operation performed on a female during the puerperium.

See [Appendix 2 – Examples of Conditions to Report – Procedures and Operations](#).

9.1.4. Discharge Status of mother

The mode of formal separation of the mother.

This item refers to formal separations, that is, discharge, transfer to another facility (see 9.1.5 discharge facility transferred to), or death. It does not refer to statistical separation/episode of care type changes.

If the mother is remaining in after 28 days select remaining in 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, Record 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. Discharge facility transferred to

The unique code that identifies the facility to which the mother was transferred after birth.

This data element is applicable when the mother has been transferred to another hospital after birth.

9.1.6. Discharge Date of mother

Date on which the mother was discharged, transferred or died.

9.1.7. Early Discharge Program

Indicates 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

The date when neonatal screening was performed.

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

9.2.2. Discharge Weight

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 QPDC from this field.

9.2.3. Discharge Status of baby

The mode of formal separation of the baby.

This item refers to formal separations, that is, discharge, transfer to another facility (see 9.2.4 discharge facility to), or death. It does not refer to statistical separation/episode of care type changes.

If the baby is remaining in after 28 days select remaining in 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. Discharge facility transferred to

The unique code that identifies the facility to which the baby was transferred after birth.

This data element is applicable when the baby has been transferred to another hospital after birth.

9.2.5. Discharge Date of baby

Date on which the baby was discharged, transferred or died.

9.2.6. Fluid Baby Received at any time from Birth to Discharge

The type of fluid ingested by the baby at any time prior to discharge, transfer or death. More than one type may be selected.

Breast milk/colostrum includes breast milk/colostrum received directly from the breast as well as expressed breast milk/colostrum received by syringe, cup or enteral tube.

Infant formula refers to commercially prepared formulas that adequately meet the nutritional needs of the newborn.

Other types of fluid include, but is not limited to, water, fruit juice, herbal tea or flavoured water.

This field may be used as an indicator for the Baby Friendly Health Initiative to obtain accreditation from World Health Organisation.

9.2.7. Fluid Baby Received in the 24 Hours Prior to Discharge

The type of fluid ingested by the baby in the 24 hours prior to discharge, transfer or death. More than one type may be selected.

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 9.2.6. For definitions see section 9.2.6.

9.2.8. Alternate Feeding Method

The type of alternative feeding method used other than breast feeding (mouth to nipple feeding only) prior to discharge. More than one method 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

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

10.5 Designation

Record the position/designation of the medical practitioner.

10.6 Date

Record the date the medical practitioner signed the form.

11. 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 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>

12. Examples of Conditions to Report

12.1 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

12.2 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.

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

12.3 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

12.4 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

12.5 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

12.6 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.

<u>Chromosomal</u>	Trisomy 18 (Edward's syndrome) Trisomy 21 (Down's syndrome) Turner's syndrome
<u>Central nervous system</u>	Anencephaly Meningocele Spina bifida
<u>Alimentary</u>	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
<u>Genito-urinary tract</u>	Renal agenesis Atresia and stenosis of urethra or bladder neck Polycystic kidney(s) Exstrophy of bladder Hypospadias Indeterminate sex Undescended testes at term
<u>Cardio-vascular system</u>	Transposition of the great vessels Fallot's Tetralogy Ventricular septal defect Patent ductus arteriosus at term Coarctation of the aorta
<u>Skeletal</u>	Talipes equinovarus (club foot) Polydactyly Congenital dislocation of hip Achondroplasia Phocomelia Syndactyly
<u>Muscular</u>	Exomphalos

12.7 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)

12.8 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

13. Neonatal Intensive Care Units and Special Care Nurseries

13.1 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

13.2 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
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13.3 Special Care Nurseries–Private Hospitals (Level 4&5)

CODE	FACILITY NAME
00420	CAIRNS PRIVATE HOSPITAL
00391	GREENSLOPES PRIVATE HOSPITAL
00375	GOLD COAST 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	BUDERIM 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 5325.

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>

14. Abbreviations

CODE	FACILITY NAME
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	Haemolysis/Elevated Liver enzymes/Low Platelet count
HHS	Hospital and Health Services
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10 th 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
NPDC	National Perinatal Data Collection
NPDDC	National Perinatal Data Development Committee
QPDC	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

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Department of Health
Queensland Perinatal Data Collection (QPDC) Manual 2019-2020