Queensland Perinatal Data Collection Perinatal Online User Guide

2019-2020

Version 1.0

Queensland Government

Queensland Perinatal Data Collection Perinatal Online User Guide 2019-2020

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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 user guide is specifically for users of Perinatal Online (PNO) which supports the collection of perinatal statistics via a Perinatal Data Collection (QPDC) Online form.

This user guide has been designed as a user-friendly document. It is structured to lead you through some of the frequently used processes of the QPDC online form step by step, providing you with the ability to successfully operate the application and reference its functions. Screen shots are from the pre-production environment so may differ slightly from production.

For a full description and definition of all the data items collected as part of the Queensland Perinatal Data Collection (QPDC), users should refer to the *Queensland Perinatal Data Collection (QPDC) Manual* at https://www.health.qld.gov.au/hsu/collections/QPDC.asp for the completion and notification of perinatal data.

The QPDC online form will undergo re-design and maintenance to existing functions from time to time. The user guide will be reviewed annually therefore information in this user guide may change to describe new functionality and new pages may be included. Please contact the Perinatal Data Collection if you have any issues or queries regarding the content within this user guide via PERIMAIL@health.qld.gov.au

1.1 Requirements

The provision of perinatal data for all births at health facilities is a requirement of the Public Health Act 2005 and Hospital and Health Service, service agreements. 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.

1.2 Scope of the QPDC

The Perinatal Data Collection Perinatal Online form (PNO) is required to be completed by all registered users in public hospitals and private hospitals who deliver babies, 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 online forms should be extracted to the Statistical Collections and Integration Unit within 35 days of the birth of a baby.

The quality of information produced from PNO depends on the accurate, consistent and timely completion of the QPDC online form. Completed QPDC online forms and subsequent extracts are validated and queries relating to missing, contradictory or ambiguous data are directed back to the hospital.

1.3 Confidentiality

Information collected using the QPDC online form relates to the pregnancy of mothers and birth of their babies. All data collected using the QPDC online form is strictly confidential and is only to be used for statistical purposes. All persons involved in the collection, processing, management and use of this information must ensure that patient confidentiality is maintained at all times.

1.4 Security

The QPDC online form contains highly sensitive and confidential information. Access to the PNO system is strictly controlled through the use of usernames and passwords. Users are issued with a Log on username that is unique and identifiable to the individual and a system generated unique password for their first Log on.

To ensure that PNO system conforms to the Queensland Department of Health security guidelines, user passwords require a combination of upper case and lower case letters, numbers and symbols and must be at least 8 characters in length. For example 'Pa$$word15'.

Users will be locked out after three unsuccessful attempts at logging on. Contact your local Primary User or Deputy User at your facility to unlock your account. Once unlocked, the user will then receive a new system generated email containing a new system generated password. If your password becomes compromised, you must immediately change your password. The QPDC online form has an 8 minute lock out. If the system is left unattended for 8 minutes, you will automatically be locked out. Any unsaved data will be lost when you log back in.

1.5 The Perinatal Data Collection online form

The QPDC online form is an electronic version of the current MR63D paper form. A mother can be entered and details updated at any stage throughout the pregnancy and birth.

There are currently four main screens to the form

1. **MOTHER** details which contains demographic information, previous pregnancy history, her current pregnancy information and discharge details
2. **LABOUR AND DELIVERY** details relating to both mother and baby
3. **BABY BIRTH DETAILS** relating to baby, and
4. **POSTNATAL AND DISCHARGE DETAILS** relating to postnatal information for baby and mother and discharge details.

The record can be updated, saved and validated at any time throughout the pregnancy and birth. To reduce the number of validations prior to each extract, it is advisable to validate the record once information has been entered in each screen e.g. validate the labour and delivery section of the form after the birth and prior to transfer to postnatal ward. Records are unable to be submitted with any blank fields. If information is unknown

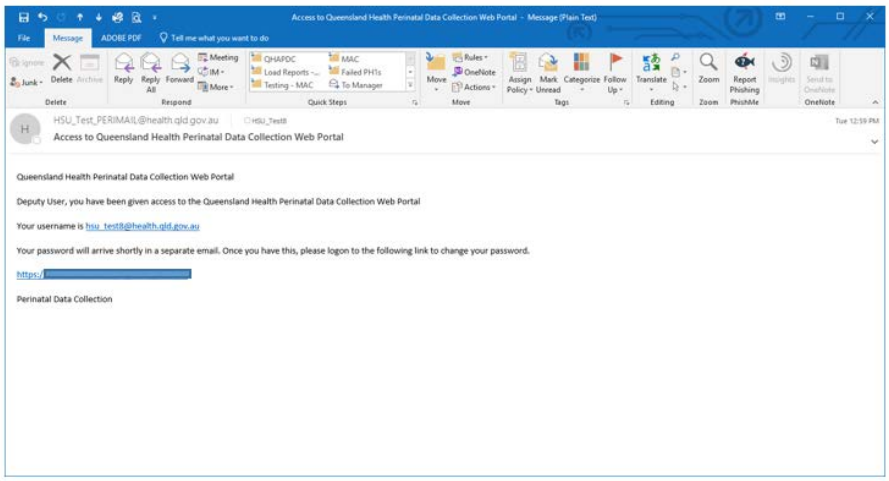
e.g. Apgar's with a BBA, please use the override functionality and put in a reason for unknown values.

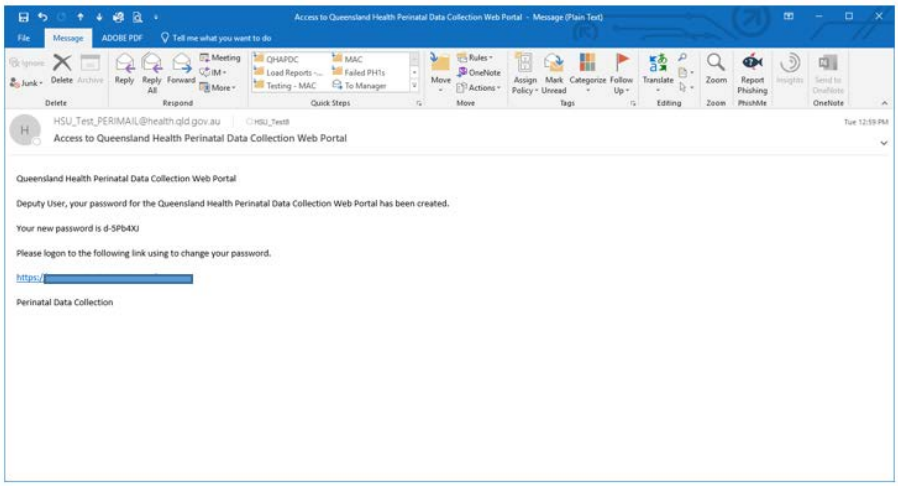
1.6 Access/Registration to PNO system

All users must be registered and granted access to the PNO system to access the QPDC online form. For registration/access to the PNO system contact the Primary User or Deputy Users of your hospital, or QPDC contact via PERIMAIL@health.qld.gov.au

After system registration you will receive two notification emails (see below). If you do not receive these emails within 1 hour please notify the person who has registered your account or the QPDC.

- The notification email contains (screen shot one) your username (email address) and the link to the PNO system site (not shown) to be opened using Internet Explorer version 8 or above. Note: other browsers may work however Internet Explorer is the preferred browser.
- The password email contains (screen shot two) your initial password (this password must be changed on your first logon) and link to the PNO system site (not shown) to be opened using your internet browser.





1.7 PNO system and QPDC online form support

Users of the PNO system should contact their Primary User or Deputy Users for any system issues in the first instance. Should the Primary User or Deputy User not be available, or not able to assist, then users should contact the QPDC, Statistical Collections and Integration Unit (SCIU), Statistical Services Branch.

Office hours for the QPDC are 8:15 am to 5:00 pm Monday to Friday.

Phone: (07) 3708 5666 or (07) 3708 5668

Email: PERIMAIL@health.qld.gov.au

1.8 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: • Last Menstrual Period estimation indicator • Estimated Data 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: • Cigarette smoking during the first 20 weeks indicator • 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	**4, 36, 37, 40, 41**

Change Description	File Format Reference Page/s
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.	
5. Closure of the Antenatal Screening for Domestic Violence indicator and addition of new Antenatal Screening performed for Family Violence indicator This change is required to align with the revised *Clinical Practice Guidelines – Pregnancy Care*. The new Antenatal Screening performed for Family Violence indicator is to be used for births occurring from 1 July 2019.	**4, 39, 42**
6. Closure of Antenatal Screening for Alcohol Use and addition of new Alcohol items below: • 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 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. The new Alcohol items are to be used for births occurring from 1 July 2019.	**4, 39, 42, 43, 44**
7. Add the following new response values to Resuscitation Methods: • 13 - CPAP ventilation • 14 - Intubation 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. The new resuscitation methods are to be used for births occurring from 1 July 2019.	**4, 82**
8. Update Terminology to conform to QHDD and METeOR Wording in the *2019-2020 QPDC File Format* document has been updated to align with Queensland Health Data Dictionary (QHDD) terminology and the	Throughout document

Change Description	File Format Reference Page/s
Australian Institute of Health and Welfare's repository for national metadata standards (METeOR).	

1.9 Data definitions

The Queensland Health Data Dictionary (QHDD) is available on the Queensland Health web page. The dictionary contains data definitions from a number of sources e.g., Qld Health, the National Health Data Dictionary, and some from the HL7 standard. It catalogues many definitions in current use as well as listing those endorsed as standards by Qld Health. For more detail on any of the following data items please click on the link to the QHDD and follow the prompts.

http://oascrasprod.co.health.qld.gov.au:7900/pls/crd_prd/crdapp

If you would like to obtain more information about the inventory of data elements please contact the Statistical Services Branch on email DQSTD@health.qld.gov.au.

2. Accessing the PNO system

The PNO system has been enhanced to meet National and State reporting requirements. The PNO system should only be accessed by using Internet Explorer 8 or above. Instructions for using Internet Explorer are shown below, however the same process can be followed using other browsers.

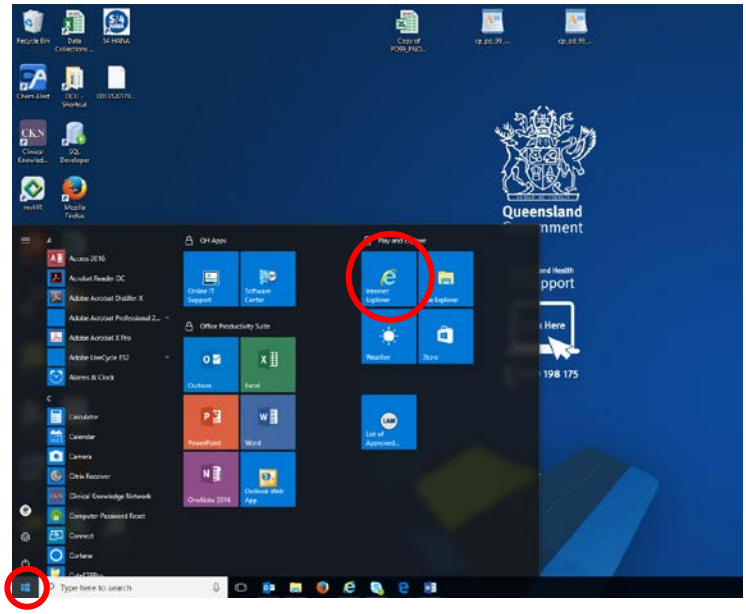
2.1 Initial Log on

The PNO system should only be accessed by using or Internet Explorer 8 or above. Instructions for using Internet Explorer are as follows.

Locating **Internet Explorer** on your computer.

Click the **Windows** button.

Click **Internet Explorer** icon.



Copy and paste the link within the email into the URL section at the top of the Internet Explorer screen.

On the **Log on** screen.

Click into the **Email address** field and enter your registered email address.

Click into **Password** and type your initial password.

Passwords are case sensitive and must be entered exactly the same as in the e-mail you receive**, ensuring there are no spaces before or after.**

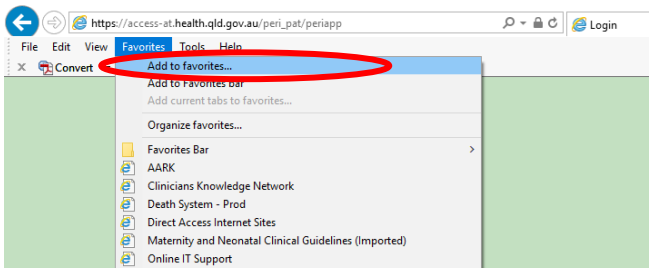
Click **Log on**.

2.1.1 Saving PNO as a Bookmark or Favourite

To save a webpage in Internet Explorer the term 'favorites' is used. Other browsers may refer to it as a 'bookmark'. The following instructions describe how to create a 'favorites' in Internet Explorer.

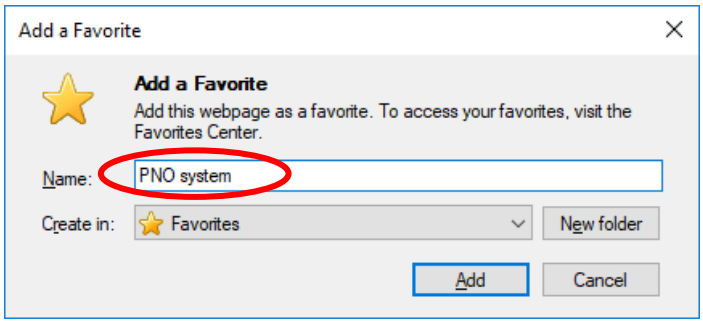
Click on **Favorites** in the menu/tool bar at the top of the screen.

Click on **Add to favorites**.

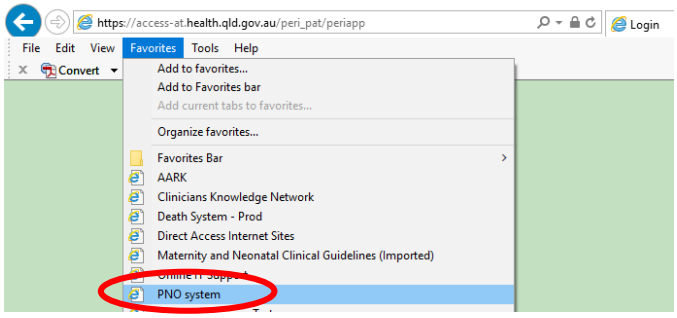


A pop up box labelled **Add a Favorite** will then appear.

In the **Add a Favorite** pop up box, type in the name for the bookmark (e.g.: PNO system) in the **Name** field and in the **Create in** field select **Favorites**. Then click the **Add** button. This will save PNO system as a favorite whenever you start Internet Explorer.



To access PNO simply select it from the **Favorites** dropdown menu in future sessions**.**



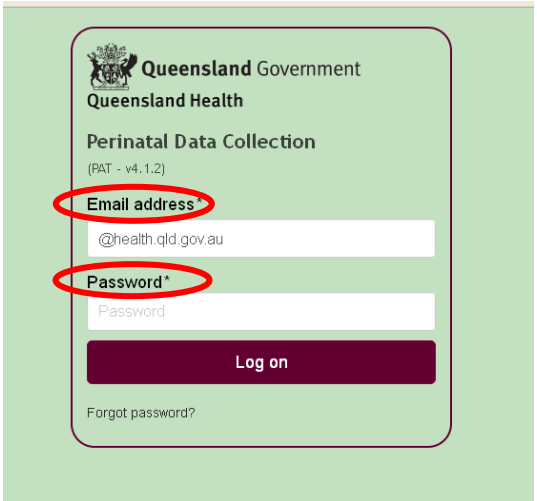
2.1.2 Logging on

Open the PNO system using a 'favourite' (Internet Explorer), or the link included in email sent to you when you are first given access (section 1.6 above).

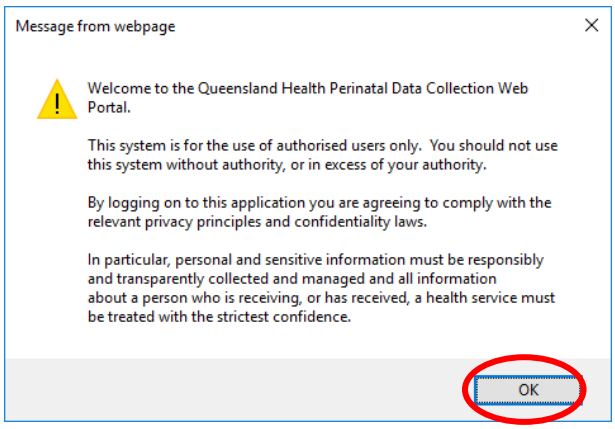
On the **Log on** screen, click into the **Email address** field and enter your Queensland Health email address, or if an external user, enter your hospital based email address.

Click into **Password** and type your password.

Click on the **Log on** button.



Read the security agreement and click on OK if you agree to use the system for its intended purpose.



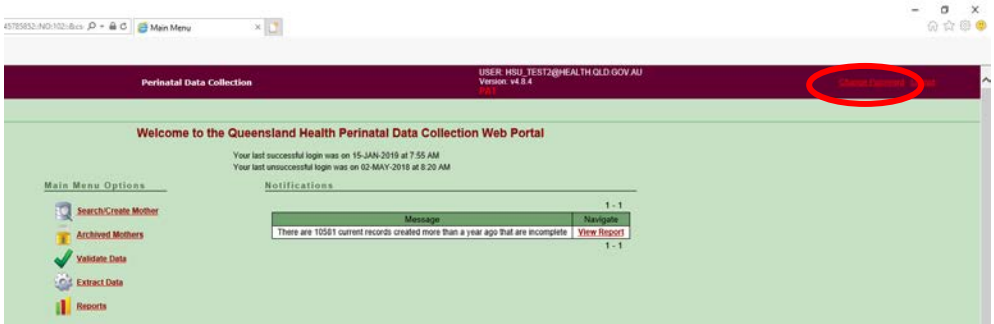
2.1.3 Changing your password

For security purposes, system users are required to change the temporary (system generated) password issued to their own password on their initial log on. After your initial password change, users are able to update their password at any time. To meet Departmental security requirements, every 3 months users must update their password. As such the PNO system will prompt users to change their password.

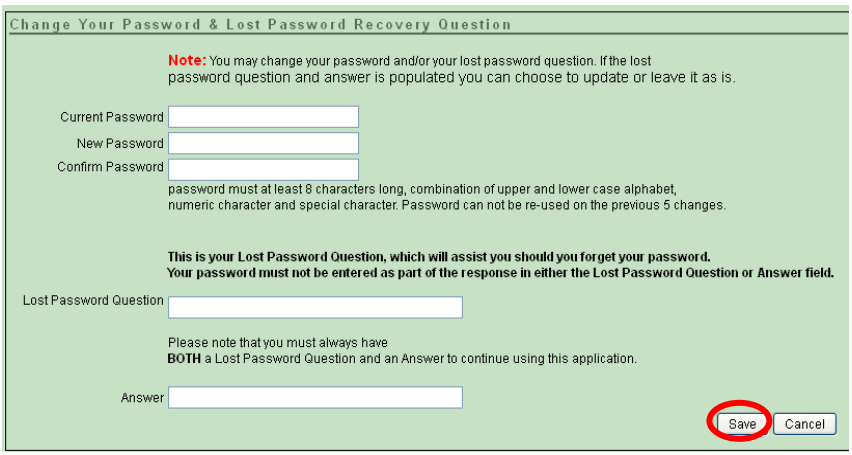
Passwords are case sensitive (i.e. upper case or lower case) so take notice of whether you have the *Caps Lock* key activated. Passwords must be at least 8 characters long and must be a combination of upper case and lower case letters, numbers and symbols. eg Pa$$word14.

Your password must not be entered as part of the response in either the Lost Password Question or Answer field.

To change your password at any other time, click on **Change Password**.



- In the **Current Password** field, type your current password.
- In the **New Password** field, type your new password.
- In the **Confirm Password** field, type your new password.
- In the **Lost Password Question** field, type your lost password question.
- In the **Answer** field, type your answer.
- Click **Save**.



You will get an error message if

- Your password has less than 8 characters/numbers.
- Your password is not a combination of characters, numbers and symbols.
- You do not confirm your new password.
- Your **New Password** and your **Confirm Password** are different.
- Your **New Password** has been used in the last 6 password changes.

If an error message occurs re-enter the passwords again and click **Save**.

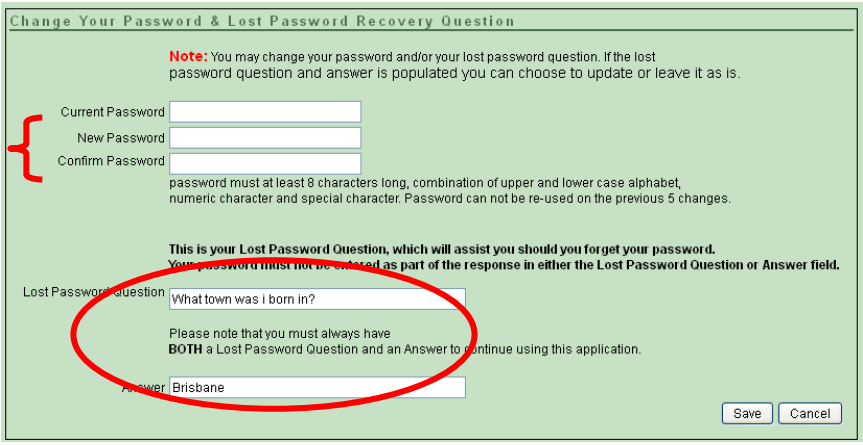
The main menu screen will now be open.

2.1.4 Lost password question

A lost password question and answer needs to be set up in case you have forgotten your password. It is important that this be something that you will remember as your personal question and answer.

From the **Main Menu** screen, click **Change Password**.

In the **Lost Password Question** enter your **Lost Password Question** and **Answer**.



The question should be as specific as possible, e.g. **What town was I was born in?** or **My mums maiden name?**

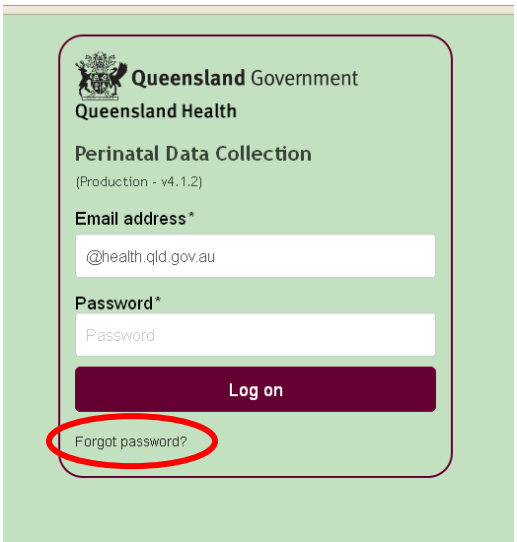
Please be aware that the lost password answer is **case sensitive** – if you need to answer this question in future you will need to type it exactly the same as how you set it, including using the same upper case and lower case.

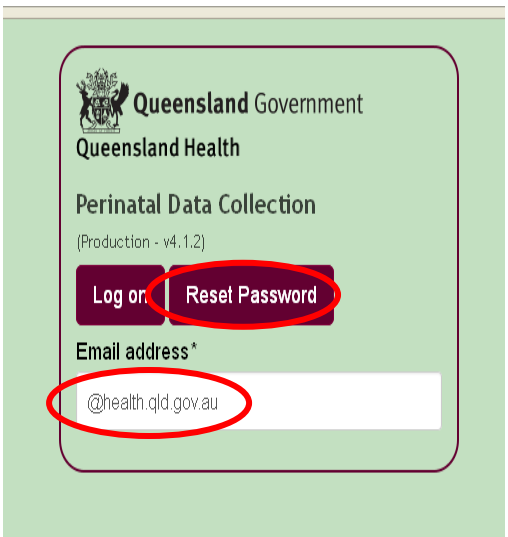
Once you **Save**, you will be returned to the **Main Menu** screen.

2.1.5 Forgotten passwords

If you have forgotten your password, from the log on screen click on the **Forgot password?** Type in your email address then click **Reset Password**.

Note: This functionality should be used if you have had two unsuccessful attempts at logging in to prevent your account being locked.

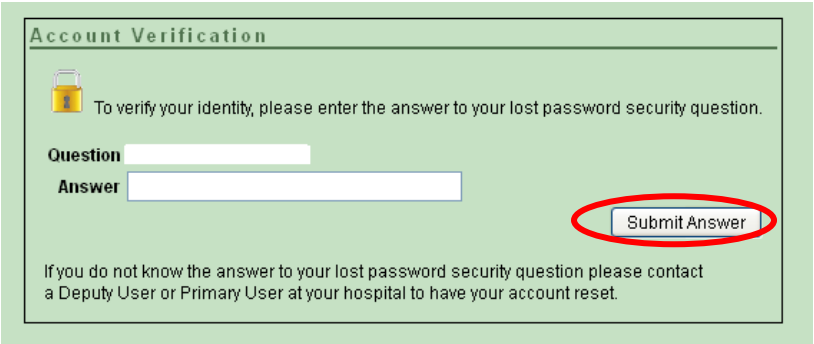




A pop up box will appear.

To reset your password Click **OK**.

An email will be sent to you advising you of your new password. Check your incoming emails for your new password.



To verify your identity, you will need to type in your lost password security question answer and click on the **Submit Answer**.

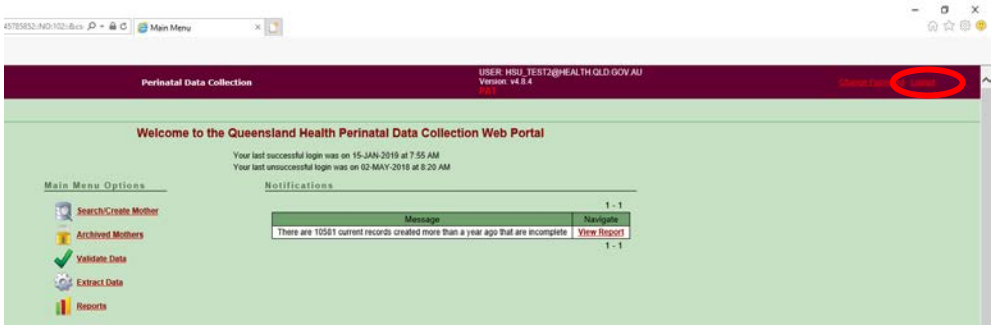
Contact your Primary User or Deputy User in your facility firstly, or the QPDC, if you have forgotten your **Lost Password** answer or the **Forgot Password** process is not working as expected, such as the lost password question is not retrieved or you don't receive the email.

2.1.6 Logging out of the PNO system

You can log out of the PNO system from any screen within the QPDC Online Form.

<u>PLEASE NOTE:</u> any changes made that have not been saved (by clicking Save) will not be saved on exit.

Click **Logout** (top right hand side of the screen).



You will be returned to the main log on screen.

3. User Management

3.1 User access levels

The PNO system allows 5 levels of access for various actions involving the QPDC Online Form, User Management, Data Validations etc. They are (from lowest to highest access level) as follows:

USER LEVELS	LOCATION/TYPEOF USER
Read Only User	Hospital Staff
User	Hospital Staff
Deputy User	Hospital Staff
Primary User	Hospital Staff
QPDC User	Perinatal Data Collection Staff

3.1.1 Read only user

There can be any number of Read Only Users for each hospital. Read Only Users

- Are responsible for maintaining their own user access (i.e. changing passwords etc.)
- Have Read Only User access to all records for the hospital/s they are registered for.
- Can be registered for Read Only User access for more than one hospital.

3.1.2 User

There can be any number of Users for each hospital. Users

- Are responsible for maintaining their own user access (i.e. changing passwords etc.)
- Have access to all records for the hospital/s they are registered for.
- Can validate individual record data.
- Can be registered for more than one hospital.

3.1.3 Deputy user

There can be any number of Deputy Users for each hospital. Deputy Users

- Are responsible for maintaining access for the staff in their area.
- Are responsible for maintaining their own user access (i.e. changing passwords etc.)
- Have access to all records for the hospital/s they are registered for.
- Override confirmed validations errors (e.g. unknown Apgar's with a BBA).
- Can validate all record data (and extract data if the Primary User is unavailable).
- Can be registered for more than one hospital.

3.1.4 Primary user

There can only be one Primary User for each hospital. Primary Users

- Are the highest level Hospital User.
- Are responsible for maintaining access for the staff in their area.
- Are responsible for maintaining their own user access (i.e. changing passwords etc.)
- Can register and maintain the Facility Level user accounts.
- Have access to all records for the hospital/s they are registered for.
- Override confirmed validations errors (e.g. unknown Apgar's with a BBA).
- Can validate all record data.
- Are responsible for extracting data to SCIU each month.
- Can be registered for more than one hospital.

3.1.5 QPDC user

QPDC Users: Management and staff within Perinatal Data Collection in Statistical Services Branch (SSB). QPDC users will have access to

- All records and associated functionality (i.e. validations and extracts).
- Override confirmed validations errors (e.g. unknown Apgar's with a BBA).
- Can register and maintain the Primary User accounts.

3.2 Your user details

Every user is responsible for maintaining their own user details such as passwords & lost password questions. To update your password or lost password question, follow Section 2.1.5 Forgotten Passwords

You can view (but not change) your

- Username
- Client Type
- Active Flag
- The facilities that you have access to
- The security level for those facilities
- Valid From and Valid To dates

If you require any change to the above items please contact your Primary User or Deputy User (at your hospital) or a QPDC contact.

4. User Administration (Primary/Deputy Users)

The following functions of the Perinatal Online form are only available to hospital users who have been allocated Primary User or Deputy User access.

4.1 Create a new user/update existing user

The Primary User or Deputy User can create and manage the Users at their facility i.e. all staff that will be entering details at your facility. Initially, check the User's email address in the Outlook Address book to ensure access is granted to the correct person.

From the **Main Menu** screen

- Click **User Accounts** and the Hospital User Management Options screen will appear.
- To create a new user who has never had access to the PNO system before, select **Create a New User Account.**
- If a user has been granted access before but requires updating select **Update Existing Users and/or their Access to Facilities under your Jurisdiction.**

4.1.1 Create a new user

The Primary User or Deputy User can create a new User account then grant the User access to a facility.

- Click **Create a New User Account**.
- Enter details in the Create User fields, check the username details (this is the user's unique Outlook email address), then click **Create**.
- Automatically generated emails containing the link and username will be sent in one email and the system generated password in a separate email.
- If the emails do not arrive, check the username that has been entered as this must be the user's unique Outlook email address.

The **Grant User Access to Facilities within your Jurisdiction** box will now be available.

- Select the Facility from the **Facility** drop down field.
- Select the security level from the **Security Level** drop down field.
- Select the valid from (or start date) from the **Valid From** drop down field.

  Date will default to current date but may be back dated or may be in the future.
- Select the valid to (or end date) from the **Valid To** drop down field (if required).

  Date will default to current date but may be back dated, future dated or left blank.
- Click on **Add Access**
- Click on **Save Access**

The User will now have access to the PNO system.

4.1.2 Update existing user

The Primary User or Deputy User can manage the User accounts of all staff using the Perinatal Online system at their facility.

Management of existing Users includes unlocking user accounts, adding user access to your facility and amending user accounts (active status, user levels and account valid dates).

To update an existing user

- From the **Main Menu** screen, click the **User Account** label.
- Select **Update Existing User and/or their Access to facilities under your Jurisdiction**.

This will display the User Accounts screen. The User Accounts screen allows the Primary User and Deputy User to search for a specific User and display User accounts with a specific status (e.g. inactive and locked).

The screen also contains Select Output buttons that allow the Primary User or Deputy User to select the types of user accounts they would like listed on the screen. Selection of one of these buttons will retrieve a list of selected users to appear. The buttons available to a Primary User or Deputy User include

- **Users at Facilities Under Your Jurisdiction** – lists users at facilities that the Primary User or Deputy User has administration responsibility for.
- **Users With No Access To Any Facilities** – lists users that have User accounts but do not have access to any facilities.
- **Users Assigned To Facilities Outside Your Jurisdiction** – lists users that have access to facilities that a Primary User or Deputy User has not administration responsibility for.
- **Inactive User Account** – lists users that have an inactive user account.
- **Locked User Accounts** – lists users that have a locked user account.
- **All** – displays all five lists of user.

The account of each listed User can be accessed by clicking on the edit button to the left of the Users family name. The update screen also has a link to allow a Primary User or Deputy User to edit their user account details. The edit button is located in the Update Personal Account box.

4.1.3 Search/manage existing user

The Primary User or Deputy User can search the User accounts of all staff that will be using the Perinatal Online system at your facility.

To search for an existing user

- From the **Main Menu** screen, click the **User Account** label.

- Select **Update Existing User and/or their Access to facilities under your Jurisdiction**.
- In the User Accounts screen, enter the username (email address) or First Name or Family name and click **Go**.

Any users matching the criteria will be displayed. The user's account can be accessed by clicking on an **Edit** button beside the user's name. Clicking the **Edit** button will allow the Primary User or Deputy User to manage the user account by

- Adding/modifying the users contact telephone number.
- Checking/changing the Active or Inactive field – a user can be made inactive if they are on a short period of leave but intend to return to their previous role.
- Add facility access.
- Amend the security level.
- Enter a Valid To date.

5. Search/view/edit record

5.1 Search record

From the main screen, click on either the **Go** button against your facility or click on the **Search/Create Mother** button.

From the **Search/Create Mother** screen, there are five methods to search for a mother's record.

5.1.1 Select Mother drop down box

Records are sorted and listed in alphabetical order by mother's family name and contains all current mothers (not yet extracted) for the facility you have selected. Locate the mother's record you require by using the up and down arrow keys, scrolling up and down using the scroll bar or scrolling up and down with the mouse.

5.1.2 Search using Mother's Family Name

Type the mother's full family name in the **Family Name** field and click **Find**. The results of your search will be listed.

5.1.3 Search using wildcard (%) with the first letter of the Mother's Family Name

Type the first letter/s of the family name followed by % (e.g. P%) and Click **Find**. This will list all records commencing with the 1st letter/s of the family name within the facility you are accessing. The results of your search will be listed.

5.1.4 Search using the Mother's UR Number

Type the mother's UR number in the UR number field and Click **Find**. The results of your search will be listed.

5.1.5 Search using wildcard (%) in conjunction with the first digit of UR Number

Type the first digit/s of the UR number followed by % (e.g. 5%) and Click **Find**. This will list all records commencing with the 1st digit/s of the UR number within the facility you are accessing. The results of your search will be listed.

5.2 View/edit record

When you have selected the mother record you want to view or edit, click **Edit** next to the mother's record. You will now be in the mother's record.

5.3 Record field types

The Perinatal Online form guides the user through completion of entry of pregnancy and birth information. Generally, if a field is visible it should have the relevant information entered. Accordingly, throughout the online form, there are specific selections that prompt a hidden field to appear. When this occurs, the online form will be expanded to display the additional field(s). These fields are mandatory fields and **must** be

completed. There are five different ways to enter data when completing the QPDC Online form.

5.3.1 Text fields

Click in the fields and enter the responses/text.

5.3.2 Single drop down fields

Click the drop down box then click on the correct response from the drop-down list.

5.3.3 Multiple selection fields

Throughout the online form, there are certain fields where more than one selection may be made e.g. antenatal care, assisted conception, non-pharmacological analgesia. To select more than one field, hold the **control key** while clicking on the appropriate fields. If free text needs to be added, click **Other** and the curser will appear in the free text box.

5.3.4 Multiple selection morbidity trees

When **Yes** is selected in certain fields, a tab appears with a counter beside it. The counter will show how many items were selected from the pop-up morbidity tree.

Upon entering this tab, a pop-up morbidity tree appears listing the most commonly reported conditions in this field. Click on the blue text of the morbidity/procedure on the left hand side and the selection/s will appear on the right hand side of the form. All relevant morbidities/procedures should be selected. If a morbidity/procedure is selected in error, click on the cross to delete the selection.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in the free text field and **Save** before clicking **Back to Mother/Baby**.

If the specific condition cannot be included in any of the conditions already identified, select **Other (specify)** from the very bottom of the pop-up morbidity tree and enter the condition in the free text field. If there is more than one condition that needs to be entered here, separate them with a comma. Ensure you Save the entry before clicking Back to Mother/Baby. If you wish to delete the **Other (specify)** entry, Click the **X** next to the **Delete** label.

5.3.5 Single selection morbidity trees

The following fields will only allow one selection to be made.

- Reason for Forceps/Vacuum Extraction.
- Reason for Admission to ICN/SCN.

If there is more than one reason for forceps/vacuum extraction, select the most severe and record the remaining conditions in Pregnancy Complications, Medical Conditions or Labour and Delivery Complications.

If there is more than one reason for admission to ICN/SCN, select the most severe and record the remaining conditions in Neonatal Morbidities or Congenital Anomalies.

5.3.6 Date fields

The same process is followed when completing all date fields throughout the form.

- The calendar will default to the current date.
- The Estimated Date of Confinement is the only date that can be a future date.
- Dates are entered by clicking on the calendar button beside the date field.
- The keyboard cannot be used to enter a date directly into the field.
- In the calendar box that appears, select the year by clicking on the drop down arrow in the year field then click on the year.
- Select the month by either clicking on the drop down arrow OR clicking on the arrows either side.
- Point the cursor over the required day until a hand (pointer) icon appears. Click on the required day.

The selected date will then appear in the field in which you are working.

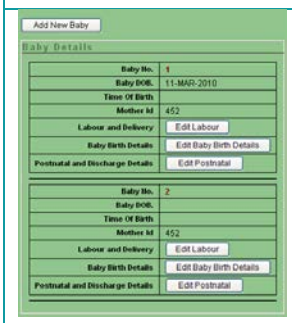
6. Mother record

6.1 Search/Create Mother

If your facility is not visible in the **Select Facility** box, click on the drop down box and select the required facility. There are multiple sections displayed to the user such as Mother, Mother's Details, Previous Pregnancy, Present Pregnancy and Mother Discharge.

6.2 Mother record functions

The following table outlines functionality available on the Mothers Details main screen.

BUTTONS	ACTIONS BY CLICKING BUTTONS
Cancel	Takes you back to **Search/Create Mother** Screen. All information not saved prior to clicking this button will be lost.
Create/Search Mothers	To create a new mother record or to search for a mother whose details have already been entered.
Delete	Deletes all information from screen and database for this record.
Report Print Preview	Preview Report prior to printing.
	Print Report.
Save	Saves data in current screen.
Proceed	Saves baby UR Number and/or date of birth and opens the Edit Labour screen (note: this button is only available when creating a new baby record).
Validate This Record	Validates record at any stage throughout pregnancy and birth.
	To add a baby or view / amend the Labour, Birth or Postnatal details (see below for more detailed information regarding specific buttons). The **Baby Details** section on the **Mother Details** screen allows birth details to be accessed after the baby UR and/or date of birth has been entered and saved (ie. there is a record available for the baby).

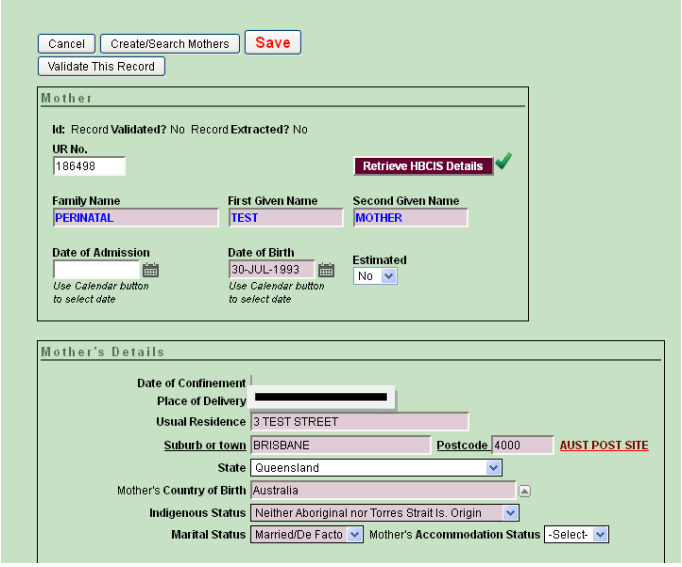
Add New Baby	Adds a new baby record. This field appears once Mother's demographic details have been entered and saved.
Edit Labour	To view or amend the mother's labour details (opens the Labour and Delivery Screen).
Edit Baby Birth Details	To view or amend the baby's details (opens the Baby Birth Details Screen).
Edit Postnatal	To view or amend Postnatal and Discharge Details (opens the Postnatal and Discharge Details screen).
Record **Validated?** No	Identifies whether validation has been completed.
Record **Extracted?** No	Identifies whether extraction has occurred.
Top	Takes you to the top of the screen.

6.3 Enter new mother using HBCIS ePADT (Public Hospitals using HBCIS only)

From 1 July 2015 (restricted to Public Hospitals using HBCIS) a new function will allow a web service call from PNO to ePADT (to access HBCIS data), to search for a UR No., and if found, retrieve basic mother demographic details into the PNO form. If UR No. is not found in ePADT then no data will be returned and will need to be entered manually.

- Enter the Mother UR No. to be queried.
- Click the **Retrieve HBCIS Details** button next to the UR No.
- If the UR No. exists in ePADT, the fields in grey below will be returned (if any grey items are not in ePADT the field will be blank and will need to be manually entered).
- If any data needs to be modified, click into the field and overtype the data. This will not alter any data in ePADT as it is a one way link.
- When retrieved, click **Save**

User must initially save the Mother's Record before continuing on to successfully complete the remaining sections of the QPDC Online form.



6.4 Enter new mother manually

If this is the first time a mother has been at the hospital and does not have a record in HBCIS already, or this is a Private Hospital, then the mother's demographic details will need to be entered in manually.

In the **Mother** section, enter the following details in the appropriate boxes

- UR Number.
- Family name.
- First Given Name.
- Second Given Name.
- Date of Admission (may be left blank if mother is to be admitted at a later date).
- Mother's Date of Birth.
- Estimated – Is the mother's date of birth estimated? - select either **Yes** or **No**.
- Click **Save**.

User must initially save the Mother's Record before continuing on to successfully complete the remaining sections of the QPDC Online form.

7. Mother's details

7.1.1 Postcode look up

If mother was born overseas click on the word **Postcode** to see a list overseas locations and codes. If postcode is unknown, click the **AUST POST SITE** and follow the prompts.

7.1.2 Antenatal transfer

If the mother has been transferred antenatally, the following fields will appear and require responses:

- Reasons Transferred - The **Reason for Transfer** pop-up morbidity tree will appear.
- Time of Transfer.
- Transferred From - If the place of transfer is a planned home birth, this can be found under **Planned Home Birth**.

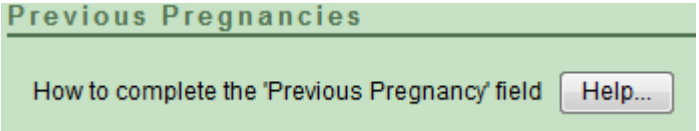
7.2 Previous pregnancies

Complete the **Previous Pregnancies** section using the drop down boxes.

If you select **Yes** in **Any Previous Pregnancies**, further fields will appear.

If the last birth was a multiple birth and more than one method was used e.g. twins - vaginal non-instrumental and forceps, click on the first method used, hold down the **Control** key and select the other method used. Both methods will then be highlighted.

Note: Click on the help button for additional information and hints.



7.3 Present pregnancy

Complete the **Present Pregnancy** section using the calendar, the drop down boxes and free text when applicable.

7.3.1 Height and weight

The mother's height and weight are to be reported in whole numbers i.e. 95kg instead of 95.3kg. As these fields are self-reported, they may be collected at any stage throughout the pregnancy, birth and postnatal period.

7.3.2 Medical conditions

If the mother had any medical conditions that affected the management of the pregnancy, click **Yes** and enter the details in the **Medical Conditions** pop-up morbidity tree. Click on the blue text condition for the appropriate medical conditions relevant to

this pregnancy. These conditions will appear on the right hand side of the pop-up screen.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in free text. If there is more than one condition that needs to be entered here, separate them with a comma. **Save** before clicking **Back to Mother**.

If the specific condition cannot be included in any of the conditions already identified, select **Other** from the bottom of the pop-up morbidity tree. Enter the condition in the free text field.

Ensure you **Save** the entry before clicking **Back to Mother**.

If a user changes a selection from **Yes** to **No**, for any Medical Conditions in the Present Pregnancy section, a check message will pop-up. Click **OK** to continue or **Cancel** to keep the preselected conditions. **Save** any changes made. This check functionality is standard across the PNO system for sections of the QPDC Online form.

7.4 Mother discharge

Complete the **Mother Discharge** section using the calendar, the drop down boxes and free text where applicable.

This section appears at the bottom of the Mother's screen below the **Present Pregnancy** section details. The **Mother Discharge** section can also be accessed from the **Postnatal and Discharge Details** screen by clicking on **Mother Specific Discharge Details** button.

8. Baby record

8.1 Search/Create new baby

To **create** a new baby record click **Add New Baby** according to the number of babies born e.g. singleton – click once; twins – click twice to create two baby records, etc.

For all babies, enter the baby's UR No (may be blank if baby is stillborn), baby's date of birth (if known at time of entry) and time of birth (if known at time of entry). Click **Proceed**.

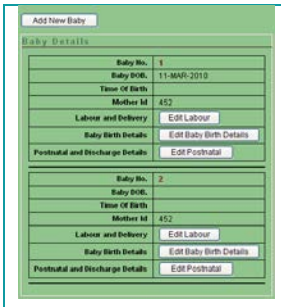
The labour, delivery and baby details screen will now open.

To **enter/amend** the baby birth details, click on the **Edit Labour** button on the Mother's Details screen. If an extra baby is added by mistake, click on the **Edit Labour** tab of this baby to enter the **Labour and Delivery** screen details. Click Delete.

8.2 Baby record functions

The following table outlines functionality available on the Labour and Delivery main screen.

BUTTONS	ACTIONS BY CLICKING BUTTONS
Cancel	Takes you to **Search/Create Mother** screen. Information not saved prior to clicking this button will be lost.
Delete	Deletes all information from screen regardless whether already saved for this record.
Report Print Preview	Preview Report prior to printing.
Back to Mother	Takes you back to the **Mother Details** screen.
Validate This Record	Validates record at any stage during pregnancy and birth.
	Print Report (report should be printed in landscape).
Save	Saves data in current screen.
Proceed	Saves baby UR Number and/or date of birth and opens the Edit Labour screen (note: this button is only available when entering a new baby).
Validate This Record	Validates record at any stage during pregnancy and birth.

	To add a baby or view / amend the Labour, Birth or Postnatal details (see below for more detailed information regarding specific buttons). The **Baby Details** section on the **Mother Details** screen allows birth details to be accessed after the baby UR and/or date of birth has been entered and saved (ie. there is a record available for the baby).
Add New Baby	Adds a new baby record. This field appears once Mother's demographic details have been entered and saved.
Edit Labour	To view or amend the mother's labour details (opens the Labour and Delivery Screen).
Edit Baby Birth Details	To view or amend the baby's details (opens the Baby Birth Details Screen).
Edit Postnatal	To view or amend Postnatal and Discharge Details (opens the Postnatal and Discharge Details screen).
Baby Specific Discharge Details	Takes you directly to **Postnatal and Discharge Details** screen for baby details and maternal puerperium complications and procedures.
	Multiple Births: Use drop down box in **Change Baby** field to switch between babies.
	Indicates entry of the **Labour and Delivery** screen. You can also click on the 2. Baby Birth Details or 3. Postnatal and Discharge Details links to open the relevant screen.
	Indicates entry of the **Baby Birth Details** screen. You can also click on the 1. Labour and Delivery or 3. Postnatal and Discharge Details links to open the relevant screen.
	Indicates entry of the **Postnatal and Discharge Details** screen. You can also click on the 1. Labour and Delivery or 2. Baby Birth Details links to open the relevant screen.
Top	Takes you to the top of the screen.

8.3 Labour and delivery

Complete the **Labour and Delivery** section using the drop down boxes and free text where applicable. Ensure values have been entered in **ALL** fields.

There are **two** options for entering Membranes Ruptured

Enter the date and time membranes ruptured and the system will calculate the number of Days, Hours and Minutes. Date and time of birth are required and must be after the membranes ruptured date for the system to calculate the correct length of time.

OR

Enter the number of Days, Hours and Minutes (Membrane ruptured date and time must be blank). If the date and time that the membranes ruptured is unknown, enter 999 in the days field, 99 in the hours and minutes fields.

8.3.1 Reasons for induction

Some responses will result in other fields being displayed e.g. if mother was induced, the **Main Reason for Induction** button will appear to prompt the entry of the main reason for the induction of labour. Click on **Reason** and the **Main Reason for Induction** pop-up morbidity tree will appear. Click on the appropriate condition from the **Choose a Reason for Induction** pop-up morbidity tree. If there is more than one reason for the induction, follow the prompts and select up to two additional reasons. You will automatically be taken back to the main **Labour and Delivery screen** with the selected condition displayed.

8.3.2 Placental abnormalities

If there are placental abnormalities, selecting **Yes** will result in the **Options** field appearing. Click on the correct response or click on **Other** and enter free text in the field provided.

8.3.3 Labour and delivery complications

If the mother had any **Labour and Delivery Complications**, Click **Yes** and select the complications from the **Choose a Delivery Complication** pop-up morbidity tree. Click on the blue text condition then select the appropriate labour and delivery complications. These conditions will appear on the right hand side of the screen.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in free text. If there is more than one condition that needs to be entered here, separate with a comma. **Save** before clicking **Back to Mother**.

If the specific condition cannot be included in any of the conditions already identified, select **Other** from the bottom of the pop-up morbidity tree. Enter the condition in the free text field. Ensure you **Save** the entry before clicking **Back to Mother**.

If you change a selection from **Yes** to **No**, a pop up box will appear. Click **OK** to continue or **Cancel** to keep the preselected conditions. **Save** any changes made.

When you have completed the mother's labour details, Click **Save**.

8.4 Baby birth details

To enter/amend the baby birth details, click on the **Edit Baby Birth Details** button on the Mother's Details screen or click the **Baby Birth Details** link from the Labour and Delivery or Postnatal and Discharge Details screens. Complete the **Baby Details** section using the calendar, the drop down boxes or free text when applicable.

When **Born Alive** is selected, the APGAR scores, regular respirations and calculate the APGAR score fields will appear.

If this is a multiple birth, **SAVE** details then change to baby number 2 by clicking on the drop down box on the Labour and Delivery screen and selecting the required baby. Follow the same process as with baby number 1, **SAVE** all entries/changes.

When you have completed the Baby Birth Details screen, click on the **SAVE** button.

You may edit the record by clicking on

Edit button which will take you to the specific field to be amended.

Mother Record button which will take you to the mother's details.

Labour Record will take you to the labour and delivery screen.

Baby's Birth Details will take you to the baby birth details screen.

Baby's Postnatal Record will take you to the postnatal and discharge details screen.

8.4.1 Hepatitis B vaccination

If Hepatitis B Vaccination is not administered in the Birth Suite, leave this field at **Select**. This will ensure a validation is generated prior to discharge to remind the Midwives in the postnatal ward to amend this field.

8.5 Postnatal and discharge

Complete the **Postnatal Details** using the drop down boxes and free text when applicable. To change between babies in a multiple birth, click on the drop down arrow in the **Change Baby** field.

8.5.1 Neonatal morbidities

A **Yes** response will prompt **Neo. Morbidities** button to appear. Click the **Neo. Morbidities** button. The **Choose a Neonatal Morbidity** pop-up morbidity tree will appear. Click on the blue text condition/s from the **Choose a Neonatal Morbidity** pop-up morbidity tree. Select all applicable morbidities. These conditions will appear on the right hand side.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in the free text field and **Save** before exiting.

If the specific condition cannot be included in any of the conditions already identified, select **Other** from the bottom of the pop-up morbidity tree and enter the condition in the free text field. If there is more than one condition that needs to be entered here, separate them with a comma.

If you wish to delete any of the **Other (specify)** entries, Click the **X** next to **Delete**.

After completing your selection/s, click **SAVE** then click the **Back to Baby** button.

8.5.2 Neonatal treatment

If **Neonatal Treatment** is **Yes**, the neonatal treatment box appears. Select the appropriate responses. Hold the **control key** to make multiple selections. If selecting **Other** the field **must** be completed with free text. All neonatal treatment selections will be highlighted.

8.5.3 ICN/SCN

A **Yes** response will result in the ICN days and SCN days fields appearing where a response must be entered in **both** fields. If the baby was admitted to either nursery for less than 24 hours, round up and enter as 1 day. A **Yes** response will also prompt the **Reason** button to appear. Click the **Reason** button. The **Choose a Reason for Admission to ICN/SCN** pop-up morbidity tree will appear. Click on the blue text condition from the **Choose a Reason for Admission to ICN/SCN** pop-up morbidity tree. Only 1 selection can be made. The selected condition will appear on the right of **Reason for Admission to ICN/SCN** button.

If **Other (specify)** is selected, a text box will appear. This is a mandatory field and must be completed.

If there is more than one reason for admission to ICN/SCN, enter the **most severe** reason in this field and enter the other reasons in the neonatal morbidity or congenital anomaly field.

8.5.4 Congenital Anomaly

A **Yes** response will prompt the **Cong. Anomalies** button to appear. Click the **Cong. Anomalies** button. The **Choose a Congenital Anomaly** pop-up morbidity tree will appear.

- **Position:** First select the position of the congenital anomaly from the drop down box.

1.1. The **Position** may not be applicable for all congenital anomalies that are reported e.g. Syndromes, Gastroschisis, neural tube defects.

1.2. If the **Position** is left at **Not stated** a validation will be generated.

- **Status:** Click the drop down box and select the status of the congenital anomaly.

1.3. If the **Status** is left at **Not stated/Unknown** a validation will be generated.

- **Diagnosed antenatally:** Click the drop down box and select the appropriate response for the congenital anomaly.

After selecting Position, Status and Diagnosed Antenatally then, select the blue text congenital anomaly/ies from the **Choose a Congenital Anomaly** pop-up morbidity tree. Your selection/s will appear on the right hand side of the pop-up morbidity tree.

If **Other (specify)** is selected, a text box will appear. The **Position** and **Status** selections from the top left hand side of the form will transfer across automatically to the

Other (specify) field. These selections can also be changed using the drop down arrows. When entering details in the **Other (specify)** field, ensure you **SAVE** the entry before clicking **Back To Baby**.

If you wish to delete the **Other (specify)** entry, Click the **X** next to **Delete**.

After completing your selection/s, click **Back to Baby**.

8.6 Mother discharge report

The **Mother Discharge Report** section is located in Postnatal and Discharge Details of the Baby Details screen.

Two sections must be completed before discharging a mother.

Questions relating to Puerperium Complications and Puerperium Procedures, and Mother Specific Discharge Details such as discharge status, date of discharge, early discharge program.

Complete the **Mother Discharge Report** using the drop down boxes and free text where applicable for the **Puerperium Complications** and **Puerperium Procedures**. Then Click on the **Mother Specific Discharge Details** button.

8.6.1 Puerperium Complications

A **Yes** response will prompt the **Puerperium Comp** button to appear. Click the **Puerperium Comp** button. The **Choose a Puerperium Complication** pop-up morbidity tree will appear. Click on the blue text condition/s from the **Choose a Puerperium Complication** pop-up morbidity tree. Your selection/s will appear on the right hand side of the pop-up morbidity tree.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in free text. If there is more than one condition that needs to be entered here, separate with a comma. **Save** before clicking **Back to Mother**.

If the specific condition cannot be included in any of the conditions already identified, select **Other** from the bottom of the pop-up morbidity tree. Enter the condition in the free text field. Ensure you **Save** the entry before clicking **Back to Mother**.

If you wish to delete the **Other (specify)** entry, tick then Click **X** next to **Delete**.

After completing your selection/s, click **Back to Baby**.

8.6.2 Puerperium Procedures

A **Yes** response will prompt **Procs. And Opers.** button to appear. Click the **Procs. And Opers.** button. The **Choose a Puerperium Procedure** pop-up morbidity tree will appear. Click on the blue text condition. Your selection/s will appear on the right hand side of the pop-up morbidity tree.

If the specific condition is not listed but can be included with a condition already identified, select **Other (specify)** from that specific field. Enter the condition in free text. If there is more than one condition that needs to be entered here, separate with a comma. **Save** before clicking **Back to Baby**.

If the specific condition cannot be included in any of the conditions already identified, select **Other** from the bottom of the pop-up morbidity tree. Enter the condition in the free text field.

If you wish to delete the **Other (specify)** entry, Click **X** next to **Delete**.

Ensure you **Save** the entry before clicking **Back to Baby**.

8.7 Baby discharge

The **Baby Discharge** section is located in **Postnatal and Discharge Details**. Complete the **Baby Discharge** section using text and the drop down and date boxes available.

- When completing the …..**fluid at any time from birth to discharge** question, a **Yes** response will prompt the drop down box. Select the appropriate fluid/s.
- When completing the …..**fluid 24hr prior to discharge** question, A **Yes** response will prompt the drop down box. Select the appropriate fluid/s.

Click **Save**.

9. Saving and validating

9.1 Saving mother/baby records

When a user completes a section (e.g.: Baby Birth Details, Mother's Details) or partially completes a section they should always save what has been entered into the QPDC Online form by clicking either of the **Save** buttons located at the top or bottom of the screen.

9.2 Validating mother/baby records

When a user completes a section (e.g. Baby Birth Details, Mother's Details) they should validate the data entered onto the QPDC Online form for the mother and associated baby/s records (that are created). Updating of any errors/warnings at the record level (as they occur) should greatly reduce the number of validations on validation reports when extracting data at the end of a reference period. PNO system functionality allows users to validate mother and associated baby records (that are created) at any stage whether complete or not.

To validate a mother and associated baby record/s, click on the **Validate This Record** button at the bottom or top of the screen. Click **OK** and you will be taken directly to the validation screen.
The validations for each field/question are grouped by section i.e. Mother's Details, Previous Pregnancy, and/or Present Pregnancy.

Identify the relevant validations that require attention. Return to the mother's record to amend the validations by clicking on the **Edit** button or the **Mother Record** button. You will be returned to the **Mother** screen where the amendments can then be made and saved. The **Edit** button will take you directly to the specific field that has flagged a validation exception in the Validation Log.

If there is a multiple birth flagged in the Validation Log, the baby number (twin 1 or twin 2) is displayed in the Baby No column. Amend validations for all babies of a multiple birth.

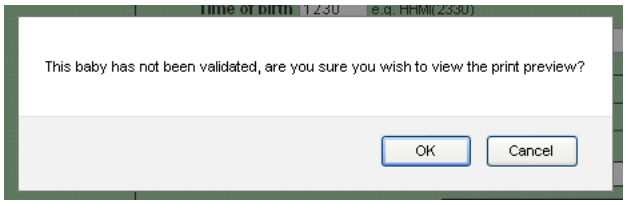
The validation report may be printed by clicking on **Printer Friendly** located under the Validation Log title.

All changes/updates (as a result of data validation) must be saved. Following changes/updates records should be re-validated to ensure the data is clean (no validation exceptions generated). Once the mother and associated baby record/s are completed and validated (with no validation exceptions) the perinatal record is now completed.

10. Print preview

The record (mother and associated baby records created) may be printed at any stage throughout the confinement. Any fields not completed will appear as **Not Stated**.

If the **Report Print Preview** button is clicked (whilst in a baby record) and that record has not been validated, the following message appears.

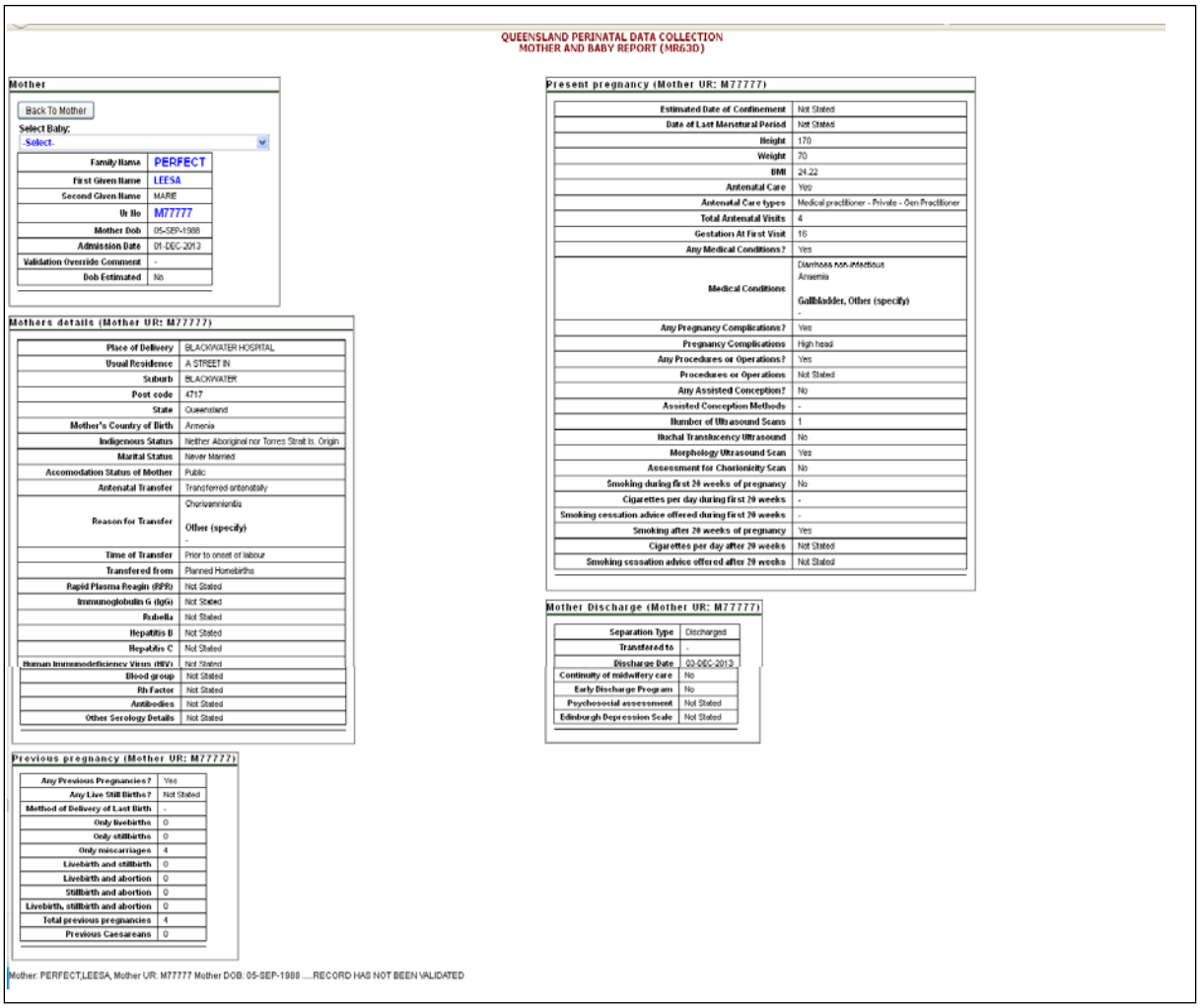


It is preferable to print after the validation process is complete.

Any printed QPDC Online form reports may then be distributed according to hospital policy eg filed in mother and baby charts.

The **Report Print Preview** tab is situated on the tool-bar of the **Mother's Details** and **Baby Birth Details** screens. It is available at any time when in the **Labour and Delivery** and the **Postnatal and Discharge** screens.

The report (for the Mother) will appear in the format below.



QUEENSLAND PERINATAL DATA COLLECTION
MOTHER AND BABY REPORT (MR63D)

Mother

Back To Mother

Select Baby:
-Select-

Family Name	PERFECT
First Given Name	LEESA
Second Given Name	MARIE
Ur No	M77777
Mother Dob	05-SEP-1988
Admission Date	01-DEC-2013
Validation Override Comment	-
Dob Estimated	No

Mothers details (Mother UR: M77777)

Place of Delivery	BLACKWATER HOSPITAL
Usual Residence	A STREET IN
Suburb	BLACKWATER
Post code	4717
State	Queensland
Mother's Country of Birth	Armenia
Indigenous Status	Neither Aboriginal nor Torres Strait Is. Origin
Marital Status	Never Married
Accomodation Status of Mother	Public
Antenatal Transfer	Transferred antenatally
Reason for Transfer	Chorioamnionitis Other (specify) -
Time of Transfer	Prior to onset of labour
Transfered from	Planned Homebirths
Rapid Plasma Reagin (RPR)	Not Stated
Immunoglobulin G (IgG)	Not Stated
Rubella	Not Stated
Hepatitis B	Not Stated
Hepatitis C	Not Stated
Human Immunodeficiency Virus (HIV)	Not Stated
Blood group	Not Stated
Rh Factor	Not Stated
Antibodies	Not Stated
Other Serology Details	Not Stated

Previous pregnancy (Mother UR: M77777)

Any Previous Pregnancies?	Yes
Any Live Still Births?	Not Stated
Method of Delivery of Last Birth	-
Only livebirths	0
Only stillbirths	0
Only miscarriages	4
Livebirth and stillbirth	0
Livebirth and abortion	0
Stillbirth and abortion	0
Livebirth, stillbirth and abortion	0
Total previous pregnancies	4
Previous Caesareans	0

Present pregnancy (Mother UR: M77777)

Estimated Date of Confinement	Not Stated
Date of Last Menstural Period	Not Stated
Height	170
Weight	70
BMI	24.22
Antenatal Care	Yes
Antenatal Care types	Medical practitioner - Private - Gen Practitioner
Total Antenatal Visits	4
Gestation At First Visit	16
Any Medical Conditions?	Yes
Medical Conditions	Diarrhoea non-infectious Anaemia Gallbladder, Other (specify) -
Any Pregnancy Complications?	Yes
Pregnancy Complications	High head
Any Procedures or Operations?	Yes
Procedures or Operations	Not Stated
Any Assisted Conception?	No
Assisted Conception Methods	-
Number of Ultrasound Scans	1
Nuchal Translucency Ultrasound	No
Morphology Ultrasound Scan	Yes
Assessment for Chorionicity Scan	No
Smoking during first 20 weeks of pregnancy	No
Cigarettes per day during first 20 weeks	-
Smoking cessation advice offered during first 20 weeks	-
Smoking after 20 weeks of pregnancy	Yes
Cigarettes per day after 20 weeks	Not Stated
Smoking cessation advice offered after 20 weeks	Not Stated

Mother Discharge (Mother UR: M77777)

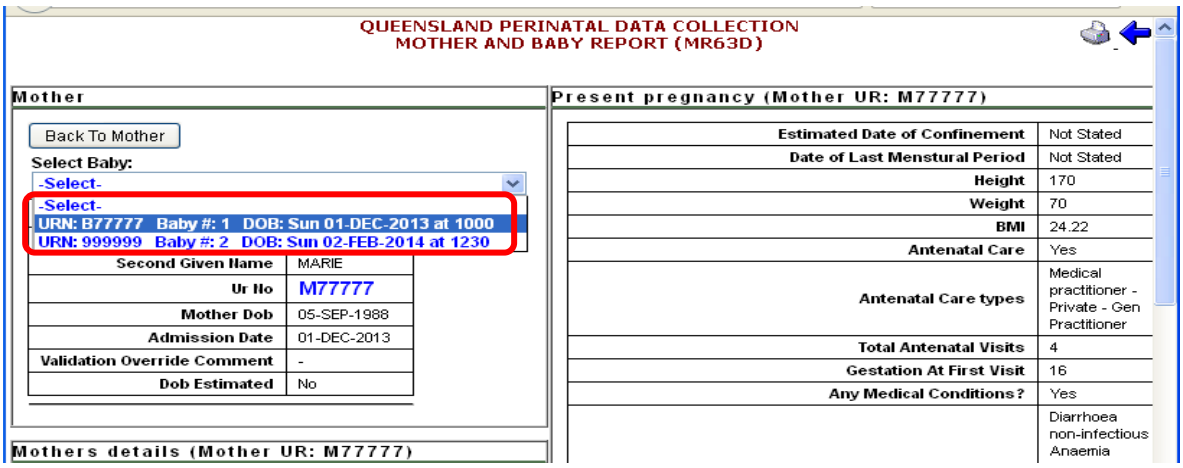
Separation Type	Discharged
Transfered to	-
Discharge Date	03-DEC-2013
Continuity of midwifery care	No
Early Discharge Program	No
Psychosocial assessment	Not Stated
Edinburgh Depression Scale	Not Stated

Mother: PERFECT,LEESA, Mother UR: M77777 Mother DOB: 05-SEP-1988 ....RECORD HAS NOT BEEN VALIDATED

To change the Print Preview to display a Baby/s report, Click on the **Select Baby** drop down arrow as displayed below.

A user can toggle between baby records when there are multiple births.

Click on the baby record required from the **Select Baby** drop down arrow in Print Preview as displayed below.



A user can return to sections of the QPDC Online form at any time by Clicking on the **Back to Mother** button (whilst previewing the Mother record).

A user can return to Mother's Print Preview Report at any time by Clicking on the **Mother's Report** button.

A user can return to sections of the QPDC Online form at any time by Clicking on the **Labour Record**, **Baby's Birth Detail Record** and **Baby's Postnatal Record** buttons at the top of the screen (whilst previewing the Baby record).

To print, click on the printer icon in the top right corner of the screen.

All Sections of the Report now contain the unit record number of the mother and baby.

11. Validate data

From the **Main Menu** screen click **Validate Data.** This can also be accessed from all other screens using the **Validate Data** selection from the top tool-bar.

In the **Facility** field, if your hospital is not displayed, click on the drop down box, then select the facility/hospital you wish to validate.

In the **Period** field, click the drop down box, then select the month you wish to validate.

There are two types of validations that can be run over the data for a selected reference period (month).

- Validations for Admitted Patients.
- Validations for records to be extracted.

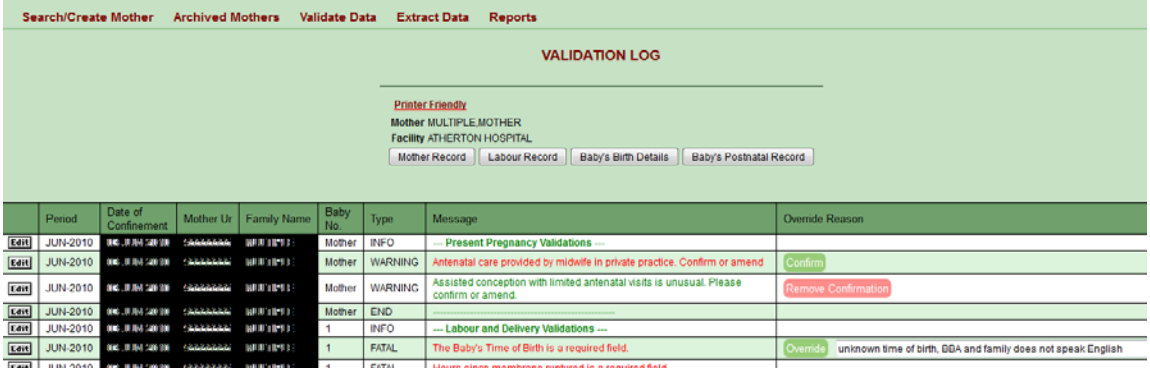
11.1 Running validations

The validation report will validate records for the specified month, as well as any previous months, where the baby is still admitted, **Validations for Admitted Patients,** or where the baby has been discharged, **Validations for records to be extracted**. Both validation reports run in the same manner as outlined below.

The records selected from the discharged patient validation will form part of the monthly QPDC extraction process.

- Click either **Validations for Admitted Patients** or **Validations for records to be extracted**.
- A confirmation message will appear.
- To Proceed: Click **OK**.
- If you do not wish to proceed: Click **Cancel**.
- If there are no records to validate, the following message will appear at the top of the screen.

  There are no records to validate for the chosen period and facility
- If there are records to validate the following screen will appear.



NB: Mother UR & Family Name have been blocked out for user guide display purposes only. These fields will contain data in the operational setting.

- If there are data validations requiring confirmation that the data is correct, please Click on the Confirm button. To remove the confirmation click on Remove Confirmation button.
- If the information is unable to be obtained, click in the free text box alongside the Override button and enter the reason. Once the reason for the error is entered click on the Override button. This must be performed for each of these types of error. This option is only available for Deputy and Primary users.

To select validations for Individual Records, Click the **Mother** drop down box and click on the Mother you wish to validate as displayed above. Once a mother is selected, the Validation Log will update accordingly only displaying validations for that record.

The Validation Log allows you to

- Identify all Mother/Baby Records requiring validation for the facility you have selected.
- Select the individual Mother Record for the facility you have selected.
- Access the Mother Record, Baby's Labour Record and Baby's Postnatal Record to correct validations.
- Re-Run the Validation Report.
- Print the Validation Report.

After identifying the relevant validations that require editing, return to the mother's record to amend the validations by clicking on the **Edit** button.

11.2 Printing the Validation Log

When amending multiple validations, it is recommended you print the Validation Log as this will save you time from having to re-run the validation report each time you amend a field.

Click **Printer Friendly**.

The report will now be in a format that can be printed.

If there are validations flagged for multiple births, the baby number (twin 1 or twin 2) is displayed in the **Baby No** column.

All changes/updates (as a result of data validation) must be saved.

Following changes/updates records should be re-validated to ensure the data is clean (no validation exceptions generated).

Once all the mother and associated baby record/s are completed and validated (with no validation exceptions) for the reference period the perinatal data is ready to extract.

12. Extract data

Extraction of data is only available to Primary User and Deputy User levels.

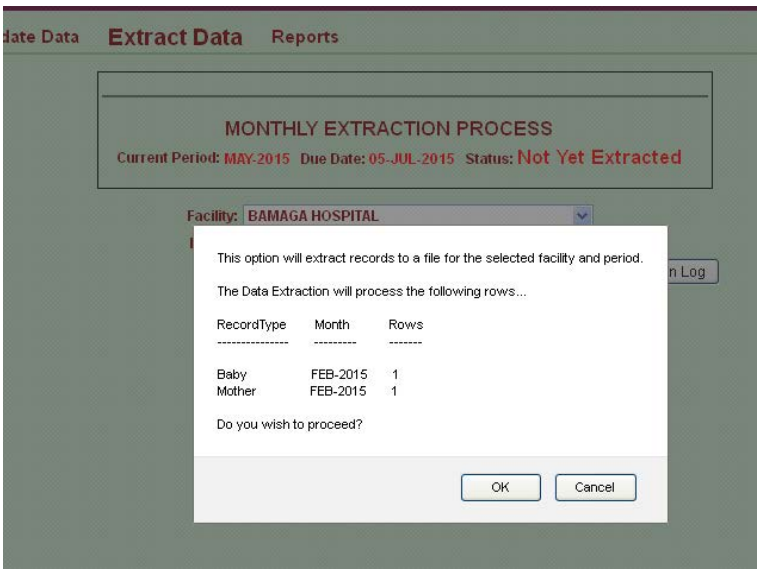
Prior to extracting, run the validation report to ensure all outstanding validations have been amended. See section 11. Validate data

Once there are no outstanding validations, the month can then be extracted.

Enter the **Main Menu** screen. Click **Extract Data.** The **Extract Data** screen displays the Current Period due, Due Date (date extract is due) and Status (extracted or not yet extracted). From the **Extract Data** screen, ensure the correct facility is viewed. Click on the drop down arrow to select the period (month) you wish to extract.

A pop up box appears showing the number of Baby records and Mother records that will be included in the extract. If the number is what is expected for the month click on **OK**. The extraction process is now complete.

If the number is not what you are expecting, click **Cancel** to go back and check the records



13. Archived mothers

When a mother/baby record has been extracted for a month the record is no longer available via the **Search/Create** record function. The record will now be available as a read only printable record via the Archived Mothers function.

From the **Main Menu** screen Click **Archived Mothers**. Archived Mothers screen can also be accessed from all other menus using the **Archived Mothers** selection from the top tool-bar.

The search functions to locate an archived mother record are the same as those to find a search/create mother record.

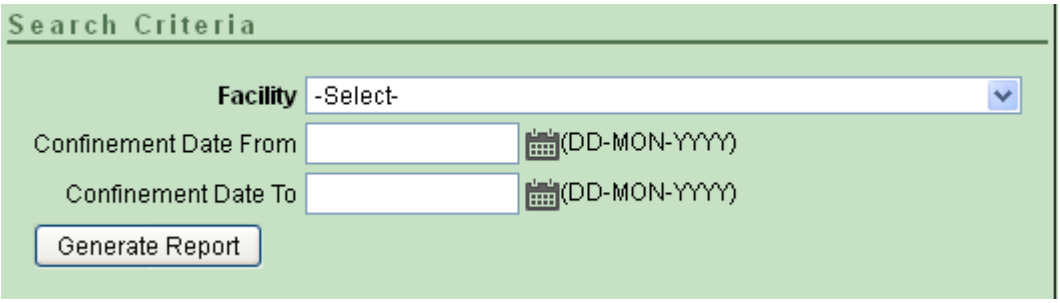
The Mother's record in printable format will appear.

14. Reports

Reports can be run by all Primary User and Deputy Users for all current and extracted records.

If you have access to more than one facility, you will need to select the correct facility.

Regardless of the type of report to be run, the date ranges need to be selected.



14.1 Monthly Births Report

The monthly birth report identifies the number of mothers/babies by month.

Monthly Birth Details

1 - 3

Period	Mothers Giving Birth	Babies Born	Admitted Mothers	Discharged Mothers	Discharged Babies	Mothers Validated That Still Have Errors	Mothers Validated With No Errors	Extracted Mothers	Extracted On
March 2015	23	23	23	21	21	4	17	21	08-MAY-2015
February 2015	11	11	11	11	11	0	0	0	30-MAR-2015
January 2015	20	20	19	19	19	0	0	0	06-MAR-2015

14.2 Birth Report

The birth report identifies the number of livebirths and stillbirths in the selected date range.

Birth Report

LIVEBIRTHS	STILLBIRTHS
1	0

Download

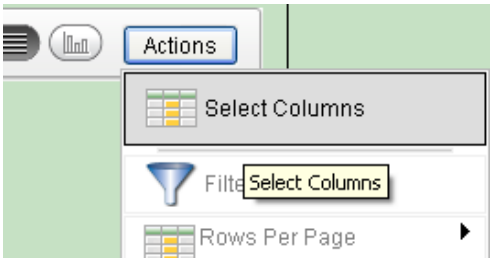
This can be downloaded as Excel and saved for future reference by clicking **Download** and **Open**.

The report will open in Excel and the user can save it the file to their directory.

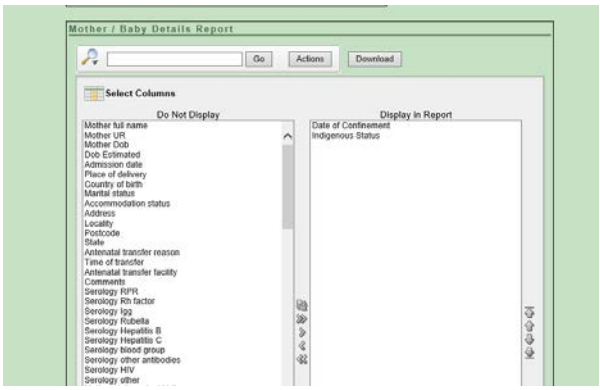
14.3 Mother and Baby Details Report

The mother and baby details report can report all mother and baby data items by selecting the required data items.

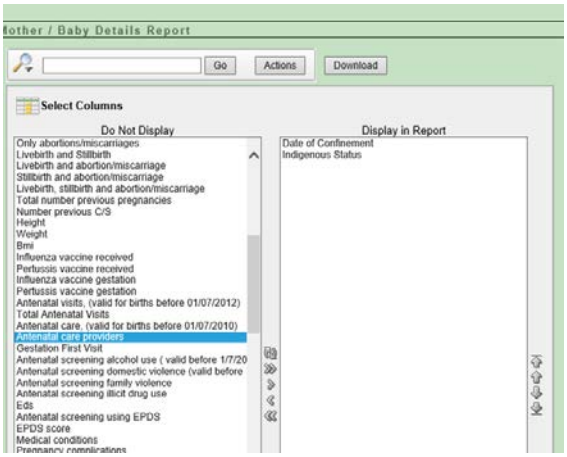
After generating a report, click **Actions**, then **Select Columns**

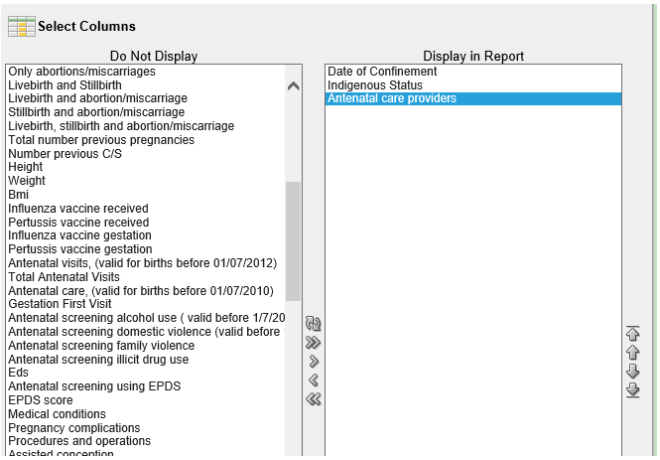


The Do Not Display column on the left lists all of the data items available for selection. The Display in Report column on the right lists those data items selected by the User to be displayed in the report.



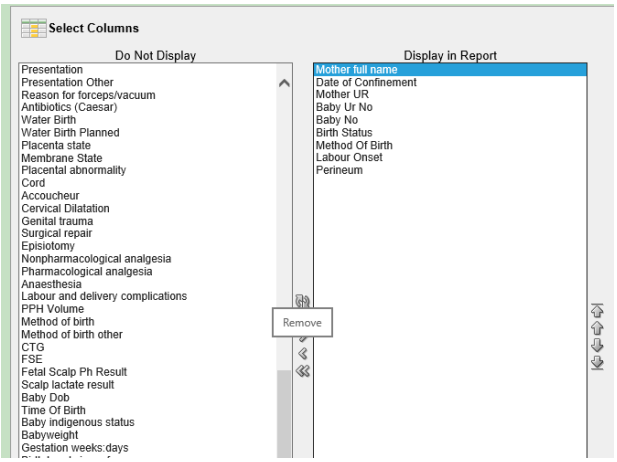
Click on required data item and then the **>** symbol. This will move the data item to the Display in Report column on the right.





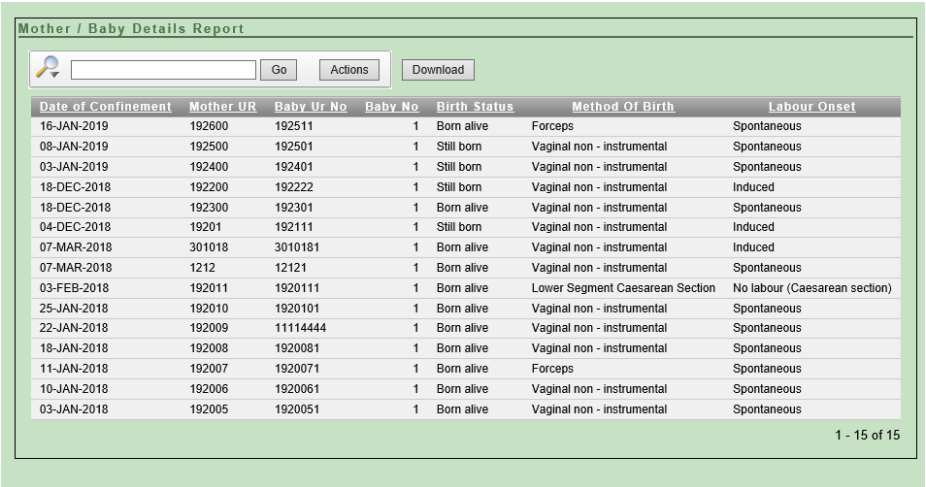
Continue this process until all data items that you require have been selected.

If a data item has been incorrectly selected, highlight it and click the **<** arrow to de-select it back to the column on the left.



Clicking **>>** or **<<** will de-select all of the data items across to the opposite side.

When all required data items have been selected, click **Apply**.



Date of Confinement	Mother UR	Baby Ur No	Baby No	Birth Status	Method Of Birth	Labour Onset
16-JAN-2019	192600	192511	1	Born alive	Forceps	Spontaneous
08-JAN-2019	192500	192501	1	Still born	Vaginal non - instrumental	Spontaneous
03-JAN-2019	192400	192401	1	Still born	Vaginal non - instrumental	Spontaneous
18-DEC-2018	192200	192222	1	Still born	Vaginal non - instrumental	Induced
18-DEC-2018	192300	192301	1	Born alive	Vaginal non - instrumental	Spontaneous
04-DEC-2018	19201	192111	1	Still born	Vaginal non - instrumental	Induced
07-MAR-2018	301018	3010181	1	Born alive	Vaginal non - instrumental	Induced
07-MAR-2018	1212	12121	1	Born alive	Vaginal non - instrumental	Spontaneous
03-FEB-2018	192011	1920111	1	Born alive	Lower Segment Caesarean Section	No labour (Caesarean section)
25-JAN-2018	192010	1920101	1	Born alive	Vaginal non - instrumental	Spontaneous
22-JAN-2018	192009	11114444	1	Born alive	Vaginal non - instrumental	Spontaneous
18-JAN-2018	192008	1920081	1	Born alive	Vaginal non - instrumental	Spontaneous
11-JAN-2018	192007	1920071	1	Born alive	Forceps	Spontaneous
10-JAN-2018	192006	1920061	1	Born alive	Vaginal non - instrumental	Spontaneous
03-JAN-2018	192005	1920051	1	Born alive	Vaginal non - instrumental	Spontaneous

Download the report by clicking **Download**.

Click **Open**.

The report will open in Excel and the user can save it the file to their directory.

15. Important points to remember

The information collected in the QPDC Online Form (through the PNO system) is the same as the paper MR63D form.

15.1 Screens

Perinatal Online consists of four screens

1. Antenatal screen (mothers discharge details at the bottom of this screen).
2. Labour and Delivery.
3. Baby Birth Details.
4. Postnatal Details.

15.2 Save

When the initial mother's details have been entered, **Save** the record to ensure the data is saved in the PNO system. The following buttons will appear:

The pop-up Morbidity trees (for conditions etc.) will not function properly if the record is not saved.

When entering the Labour and Delivery screen, enter the baby UR or date of birth and then **Save**. The following buttons will appear:

-

15.3 Date fields

All date fields must be entered using the calendar format.

If the baby's date of birth hasn't been entered, ignore not valid at baby's date of birth validations.

15.4 Save and validate

Save and validate at the end of each screen.

Save record/s before leaving your workstation.

16. Abbreviations

ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICN	Intensive Care Nursery
MR63D	Queensland Perinatal Data Collection Form
QPDC	Perinatal Data Collection
PNO	Perinatal Online Form
QHDD	Queensland Health Data Dictionary
SCIU	Statistical Collections and Integration Unit
SCN	Special Care Nursery
SSB	Statistical Services Branch
UR	Unit Record Number
US	Ultrasound