Victorian Perinatal Data Collection (VPDC) manual 2022-23

Section 3 Data definitions

Version 10.0

OFFICIAL

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Contents

Introduction

This section provides the specifications for each Victorian Perinatal Data Collection (VPDC) data element collected and reported to the department.

The format for the transmission of VPDC data is specified in Section 5: Compilation and submission.

Software vendors should read Section 3: Data definitions and Section 5: Compilation and submission together, along with Section 4: Business rules, to understand the VPDC and transmission requirements.

Additional items are derived from the items reported in the VPDC. These are referenced in Section 2: Concept and derived item definitions, for information only.

Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother

Specification

Definition	Whether the mother is admitted into a high dependency unit (HDU) / intensive care unit (ICU) in this health service during the birth episode.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	94
Permissible values	**Code** **Descriptor** 1 Admitted to high dependency unit / intensive care unit 2 Not admitted to high dependency unit / intensive care unit 9 Not stated / inadequately described		
Reporting guide	Depending on the facilities, and policies of the hospital, this high dependency care may take place in the labour ward, high dependency unit, intensive care unit, coronary care unit, or any other specialist unit. The mother may spend time in this unit for days either before and/or after the birth.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	High dependency unit (HDU), intensive care unit (ICU)		
Related data items (this section):	Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Hospital code (agency identifier); Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for operative delivery – free text; Indications for operative delivery – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications – ICD-10-AM code		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2020
Codeset source	DH	Collection start date	1999

Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby

Specification

Definition	Whether the neonate is admitted into a special care nursery (SCN) or neonatal intensive care unit (NICU) in this health service during the birth episode.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	113
Permissible values	Code Descriptor 1 Admitted to SCN 2 Admitted to NICU 3 Not admitted to SCN or NICU 9 Not stated / inadequately described		
Reporting guide	The criteria for admissions to SCN may vary depending on the facilities available and level of care provided within a particular hospital. This data element is a flag for neonatal morbidity and/or congenital anomalies: if code 1 Admitted to SCN OR code 2 Admitted to NICU is reported, then a code/condition must be reported in Neonatal morbidity and/or Congenital anomalies. If the neonate is admitted to both SCN and NICU, report code 2 Admitted to NICU. Do not report a value for stillbirth episodes, leave blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All live birth episodes		
Related concepts (Section 2):	Intensive care unit (ICU)		
Related data items (this Section):	Congenital anomalies – ICD-10-AM code; Congenital anomalies – indicator; Hospital code (agency identifier); Neonatal morbidity – free text; Neonatal morbidity – ICD-10-AM code		
Related business rules (Section 4):	Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items; Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby, Setting of birth – actual and Hospital code (agency identifier) valid combinations; Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2007 3. January 2020
Codeset source	DH	Collection start date	1999

Admitted patient election status – mother

Specification

Definition	Whether the mother is admitted as a public or private patient		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	17

Permissible values

Code	Descriptor
1	Public
2	Private
9	Not stated / inadequately described

Reporting guide	Homebirths under the care of an independent midwife or medical practitioner should be reported as code 2 Private. Homebirths under the public homebirth program must be reported as code 1 Public. Transport Accident Commission (TAC), Department of Veterans' Affairs (DVA) and WorkCover patients must be reported as code 1 Public.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (section 4):	Mandatory to report data items; Setting of birth – actual and Admitted patient election status – mother valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1998
Codeset source	DH	Collection start date	1998

Anaesthesia for operative delivery – indicator

Specification

Definition	Whether anaesthesia is administered to the mother for, or associated with, the operative delivery of the baby (forceps, vacuum/ventouse or caesarean section)		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	79
Permissible values	**Code** **Descriptor** 1 Anaesthesia administered 2 Anaesthesia not administered 9 Not stated / inadequately described		
Reporting guide	Operative delivery includes caesarean section, hysterotomy, forceps and vacuum/ventouse extraction. Do not report a value for birth episodes with no operative delivery, leave blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes with an operative delivery		
Related concepts (Section 2):	Anaesthesia; Operative delivery		
Related data items (this section):	Anaesthesia for operative delivery – type; Method of birth		
Related business rules (Section 4):	Anaesthesia for operative delivery – indicator and Method of birth valid combinations; Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data items; Anaesthesia for operative delivery – indicator and Anaesthesia for operative delivery – type valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2009
Codeset source	DH	Collection start date	1999

Anaesthesia for operative delivery – type

Specification

Definition	The type of anaesthesia administered to a woman during a birth event		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x4)
Location	Episode record	Position	80

Permissible values

Code	Descriptor
2	Local anaesthetic to perineum
3	Pudendal block
4	Epidural or caudal block
5	Spinal block
6	General anaesthetic
7	Combined spinal-epidural block
8	Other anaesthesia
9	Not stated / inadequately described

Reporting guide

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

Code 7 Combined spinal-epidural block:
The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter, inserted during the technique, enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

Code 8 Other anaesthesia:
May include parenteral opioids, nitrous oxide.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Birth episodes with an operative delivery
Related concepts (Section 2):	Anaesthesia; Operative delivery
Related data items (this section):	Anaesthesia for operative delivery – indicator
Related business rules (Section 4):	Anaesthesia for operative delivery – indicator and Anaesthesia for operative delivery – type valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source	NHDD	Version	1. January 1999 2. July 2015
Codeset source	NHDD (DH modified)	Collection start date	1999

Analgesia for labour – indicator

Specification

Definition	Whether analgesia is administered to the woman to relieve pain during labour		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	77

Permissible values

Code	Descriptor
1	Analgesia administered
2	Analgesia not administered
9	Not stated / inadequately described

Reporting guide

Analgesia will usually be administered by injection or inhalation.

This item is to be recorded for first and second stage labour, but not third stage labour (for example, removal of placenta), and not when it is used primarily to enable operative birth.

Inhalation analgesia such as nitrous oxide (N_2O and O_2) can be used for manual removal of placenta on occasion.

Do not report a value for birth episodes where the woman does not have labour, leave blank.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Birth episodes where there is a labour
Related concepts (Section 2):	Analgesia
Related data items (this section):	Analgesia for labour – type; Labour type
Related business rules (section 4):	Analgesia for labour – indicator and Labour type valid combinations; Labour type and Analgesia for labour – indicator conditionally mandatory date item; Analgesia for labour – indicator and Analgesia for labour – type valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999

Codeset source	DH	Collection start date	1999

Analgesia for labour – type

Specification

Definition	The type of analgesia administered to the woman during a birth event.		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x4)
Location	Episode record	Position	78

Permissible values

Code	Descriptor
2	Nitrous oxide
3	Systemic opioids
4	Epidural or caudal block
5	Spinal block
7	Combined spinal-epidural block
8	Other analgesia
9	Not stated / inadequately described

Reporting guide

This item is to be recorded for first and second stage labour, but not for third stage labour, e.g. removal of placenta.

Code 3 Systemic opioids:
Includes intramuscular and intravenous opioids.

Code 7 Combined spinal-epidural block:
The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter, inserted during the technique, enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

Code 8 Other analgesia:
Includes all non-narcotic oral analgesia. Includes non-pharmacological methods such as hypnosis, acupuncture, massage, relaxation techniques, temperature regulation, aroma therapy and other.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Birth episodes where there is a labour
Related concepts (Section 2):	Analgesia
Related data items (this section):	Analgesia for labour – indicator
Related business rules (Section 4):	Analgesia for labour – indicator and Analgesia for labour – type valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1999 2. July 2015
Codeset source	NHDD (DH modified)	Collection start date	1999

Antenatal corticosteroid exposure

Specification

Definition	Administration of any antenatal dose of steroids for the purpose of fetal lung maturation		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	139

Permissible values

Code	Descriptor
1	None
2	One dose
3	Two doses (one course)
4	More than two doses
9	Not stated / inadequately described

Reporting guide	Report the number of steroid doses given during the pregnancy
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019 2. January 2020
Codeset source	DH	Collection start date	2019

Antenatal mental health risk screening status

Specification

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

Permissible values

Code	Descriptor
1	Yes
2	Not offered
3	Declined
9	Not stated stated/inadequately described

Reporting guide

Antenatal screening for mental health risk is conducted using a validated screening tool, which is an instrument that has been psychometrically tested for reliability, validity and sensitivity, for example the Edinburgh Postnatal Depression Scale (EPDS).

Code 1 Yes
The woman was screened using a validated screening tool

Report whether the screening was conducted at the same health service where the birth occurs, or at another service or health care provider

Code 2 Not offered
The woman was not offered screening using a validated screening tool

Report also when screening was not offered at the time of birth, or in other circumstances where a care plan was interrupted due to an atypical course during the pregnancy, for example a precipitate labour or premature birth

Code 3 Declined
The woman declined screening for mental health risk

Report also when screening was offered to and accepted by the woman, but could not be completed, for example due to safety risk

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Edinburgh Postnatal Depression Scale score; Presence or history of mental health condition – indicator
Related business rules (Section 4):	Mandatory to report data items

Administration

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

Apgar score at one minute

Specification

Definition	Numerical score used to indicate the baby's condition at one minute after birth		
Representation class	Total	Data type	Number
Format	N[N]	Field size	2
Location	Episode record	Position	102
Permissible values	Range: zero to 10 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	The score is used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, reflexes and colour. The maximum or best score is 10. If the Apgar score is unknown, for example, for babies born before arrival, report as 99. For stillbirth episodes, report the Apgar score as 00.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Apgar score at five minutes		
Related business rules (Section 4):	Birth status ‘Stillborn’ and associated data items valid combinations; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1998
Codeset source	NHDD	Collection start date	1998

Apgar score at five minutes

Specification

Definition	Numerical score used to indicate the baby's condition at five minutes after birth		
Representation class	Total	Data type	Number
Format	N[N]	Field size	2
Location	Episode record	Position	103
Permissible values	Range: zero to 10 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	The score is used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, reflexes and colour. The maximum or best score is 10. If the Apgar score is unknown, for example, for babies born before arrival, report as 99. For stillbirth episodes, report the Apgar score as 00.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Apgar score at one minute		
Related business rules (Section 4):	Birth status ‘Stillborn’ and associated data items valid combinations; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	NHDD	Collection start date	1982

Artificial reproductive technology – indicator

Specification

Definition	Whether artificial reproductive technology (ART) was used to assist the current pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	60
Permissible values	**Code Descriptor** 1 Artificial reproductive technology was used to assist this pregnancy 2 Artificial reproductive technology was not used to assist this pregnancy 9 Not stated / inadequately described		
Reporting guide	If reporting code 1 Artificial reproductive technology was used to assist this pregnancy, also report the type of ART in Procedure – free text and/or Procedure – ACHI code, for example, IVF, Clomid, GIFT or ICSI.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Artificial reproductive technology – indicator conditionally mandatory data items, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Birth order

Specification

Definition	The sequential birth order of the baby, including that in a multiple birth for the current pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	99

Permissible values

Code	Descriptor
1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other
9	Not stated / inadequately described

Reporting guide	Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be reported as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Birth plurality and Birth order valid combinations, Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	NHDD	Collection start date	1982

Birth plurality

Specification

Definition	The total number of babies resulting from a single pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	98

Permissible values

Code	Descriptor
1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated / inadequately described

Reporting guide	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 is 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 when pregnancy ended at 20 or more weeks gestation.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Birth order
Related business rules (Section 4):	Birth plurality and Birth order valid combinations; Birth plurality and Chorionicity of multiples valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source	NHDD	Version	1. January 1982 2. July 2015
Codeset source	NHDD	Collection start date	1982

Birth presentation

Specification

Definition	Presenting part of the fetus (at the cervix) at birth		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	73

Permissible values

Code	Descriptor
1	Vertex
2	Breech
3	Face
4	Brow
5	Compound
6	Cord
7	Shoulder
8	Other
9	Not stated / inadequately described

Reporting guide

For a multiple pregnancy with differing presentations, report the presentation of the fetus for each birth.

Code 1 Vertex:
Includes incomplete rotation of fetal head

Code 2 Breech:
Includes breech with extended legs, breech with flexed legs, footling and knee presentations.

Code 5 Compound:
Refers to more than one presenting part. It is the situation where there is an associated prolapse of hand and/or foot in a cephalic presentation or hand(s) in a breech presentation.

Code 8 Other – specify:
When Other – specify is reported, further details must be reported in Events of labour and birth – free text or Events of labour and birth – ICD-10-AM code.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified

Related data items (this section):	None specified
Related business rules (Section 4):	Birth presentation conditionally mandatory data items; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1999 3. January 2009 4. July 2022
Codeset source	NHDD (DH modified)	Collection start date	1982

Birth status

Specification

Definition	Status of the baby at birth		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	100

Permissible values

Code	Descriptor
1	Live born
2	Stillborn (occurring before labour)
3	Stillborn (occurring during labour)
4	Stillborn (timing of occurrence unknown)
9	Not stated / inadequately described

Reporting guide

Code 1 Liveborn:
CCOPMM defines liveborn as the birth of an infant, regardless of maturity or birth weight, who breathes or shows any other signs of life after being born.

Code 2 Stillborn (occurring before labour)
Code 3 Stillborn (occurring during labour) and
Code 4 Stillborn (timing of occurrence unknown):
CCOPMM defines a stillbirth as the birth of an infant of at least 20 weeks' gestation or if gestation is unknown, weighing at least 400 grams, which shows no signs of life after birth.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Live birth, Stillbirth (fetal death)
Related data items (this section):	Apgar score at one minute, Apgar score at five minutes
Related business rules (Section 4):	Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations; Birth status 'Live born' and associated conditionally mandatory data items; Birth status 'Stillborn' and associated data items valid combinations; Estimated gestational age conditionally mandatory data items for Birth status code 1 Liveborn; Mandatory to report data items, Scope 'Stillborn'

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. July 2015 3. January 2017
Codeset source	NHDD	Collection start date	1982

Birth weight

Specification

Definition	The first weight, in grams, 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.		
Representation class	Total	Data type	Number
Format	NN[NN]	Field size	4
Location	Episode record	Position	101
Permissible values	Range: 10 to 9998 (inclusive) **Code** **Descriptor** 9999 Not stated / inadequately described		
Reporting guide	Unit of measure is in grams. For live births, birth weight should preferably be measured within the first few hours after birth before significant postnatal weight loss has occurred. While statistical tabulations include 500g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured. In the case of babies born before arrival at the hospital, the birth weight should be taken shortly after the baby has been admitted to hospital.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Birth weight		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items; Scope ‘Stillborn’		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD (DH modified)	Version	1. January 1982
Codeset source	NHDD	Collection start date	1982

Blood loss assessment – indicator

Specification

Definition	Indicator of the method of assessing the quantity of blood loss reported in data element Blood loss (ml)		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	147

Permissible values

Code	Descriptor
1	All blood loss measured (ml)
2	All blood loss estimated (ml)
3	Combination of measured and estimated blood loss (ml)
9	Not stated/inadequately described

Reporting guide	Report the method used to determine the amount of blood loss (ml) reported in the data element Blood loss (ml)
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where a value greater than 0 is reported in Blood loss (ml)
Related concepts (Section 2):	Primary postpartum haemorrhage
Related data items (this section):	Blood loss (ml)
Related business rules (Section 4):	Blood loss (ml) and Blood loss assessment – indicator valid combinations; Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type, Perineal laceration – indicator conditional reporting

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2020
Codeset source	DH	Collection start date	2020

Blood loss (ml)

Specification

Definition	The amount of blood lost after the baby's birth and in the following 24 hours, reported in millilitres (whether the loss is from the vagina, from an abdominal incision, or retained for example, broad ligament haematoma)		
Representation class	Total	Data type	Number
Format	N[NNNN]	Field size	5
Location	Episode record	Position	89
Permissible values	Range: zero to 40000 (inclusive) **Code Descriptor** 99999 Not stated / inadequately described		
Reporting guide	Report the amount of blood lost in millilitres (ml). Report only blood loss after the baby's birth. Include stage 3, eg postpartum haemorrhage. Exclude blood loss during labour, eg abruption, concealed haemorrhage, placenta praevia blood loss.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Primary postpartum haemorrhage		
Related data items (this section):	Blood loss assessment – indicator		
Related business rules (Section 4):	Blood loss (ml) and Blood loss assessment – indicator valid combinations; Blood loss (ml) and Main reason for excessive blood loss following childbirth valid combinations; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Blood product transfusion – mother

Specification

Definition	Whether the mother was given a transfusion of whole blood, or any blood product (excluding anti-D), during her postpartum stay		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	90

Permissible values

Code	Descriptor
1	Transfusion of blood products received
2	Transfusion of blood products not received
9	Not stated / inadequately described

Reporting guide

Blood products may include:

- whole blood
- packed cells
- platelets
- fresh frozen plasma (FFP)

Intramuscular administration of Hepatitis B immunoglobulins is not to be reported as a transfusion of blood products.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Blood loss (ml); Blood loss assessment – indicator; Main reason for excessive blood loss following childbirth
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009
Codeset source	NHDD	Collection start date	2009

Breastfeeding attempted

Specification

Definition	Whether the mother attempted to breastfeed the baby or express breast milk at least once		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	115

Permissible values

Code	Descriptor
1	Attempted to breastfeed / express breast milk
2	Did not attempt to breastfeed / express breast milk
9	Not stated / inadequately described

Reporting guide

For this data item, expressed breast milk is considered breastfeeding initiation.

Code 1 Attempted to breastfeed/express breast milk:
includes if the baby was put to the breast at all, regardless of the success of the attempt, or if there was any attempt to express milk for the baby.

Code 2 Did not attempt to breastfeed/express breast milk:
includes if the baby was never put to the breast and there was no attempt to express milk for the baby. Also includes if the mother was transferred or died before she could attempt to breastfeed/express breast milk.

If the baby was transferred or died, still indicate if the mother attempted to express milk at least once.

Do not report a value for stillbirth episodes, leave blank.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All live birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items, Birth status ‘Stillborn’ and associated data items valid combinations, Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Category of unplanned caesarean section urgency

Specification

Definition	Category of unplanned caesarean section urgency		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	148

Permissible values

Code	Descriptor	
1	Category 1	Urgent threat to the life or the health of a woman or fetus
2	Category 2	Maternal or fetal compromise but not immediately life-threatening
3	Category 3	Needing earlier than planned delivery but without currently evident maternal or fetal compromise
4	Category 4	At a time acceptable to both the woman and the caesarean section team, understanding that this can be affected by a number of factors
9	Urgency not stated/inadequately described	

Reporting guide

Report the category of urgency of any unplanned caesarean section, whether this occurs before or during labour, **at the time the decision for caesarean section is made by the medical practitioner**. While the category may be subsequently downgraded or upgraded, it is to be reported as at the time the decision is made.

The category of urgency code must be reported for all births with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour.

Where a decision is made for an urgent caesarean section, but vaginal birth occurs before the caesarean section can be performed, report the actual Method of birth.

The Royal Australasian College of Obstetricians and Gynaecologists recommends and endorses the use of a 4-grade classification system for emergency caesarean section.[1]

Some services use a Code Green classification system. A Code Green caesarean section should be reported as code 1 Category 1. These services should use the descriptors for codes 2-4 to report caesareans other than Code Green.

[1]Statement on categorisation of urgency for caesarean section, RANZCOG, reviewed July 2019 <Microsoft Word - Categorisation of urgency for caesarean section (C-Obs 14) (ranzcog.edu.au)>

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for	Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes.
Related concepts (Section 2):	Labour type
Related data items (this section):	Date of decision for unplanned caesarean section; Method of birth; Time of decision for unplanned caesarean section
Related business rules (Section 4):	Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; Date and time data item relationships; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. 1 July 2021
Codeset source	RANZCOG	Collection start date	July 2021

Chorionicity of multiples

Specification

Definition	The number of chorionic membranes that surround the index fetus in a multiple pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	140
Permissible values	**Code** **Descriptor** 1 Monochorionic 2 Dichorionic 3 Trichorionic 9 Not stated / inadequately described		
Reporting guide	Report the number of chorionic membranes surrounding index fetus in multiple pregnancy – ie monochorionic, dichorionic and trichorionic		
Reported by	All Victorian hospitals where a multiple birth has occurred and homebirth practitioners		
Reported for	All birth episodes with a Birth plurality of two or three		
Related concepts (Section 2):	None specified		
Related data items (this section):	Birth plurality		
Related business rules (Section 4):	Birth plurality and Chorionicity of multiples – conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019
Codeset source	DH	Collection start date	2019

Collection identifier

Specification

Definition	A unique identifier for VPDC data collection		
Representation class	Identifier	Data type	String
Format	AAAA	Field size	4
Location	Episode record Header record File name	Position	1
Permissible values	**Code** **Descriptor** VPDC Victorian Perinatal Data Collection		
Reporting guide	Software-system generated		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Congenital anomalies – ICD-10-AM code

Specification

Definition	Structural, functional, genetic, chromosomal and biochemical abnormalities that can be detected before birth, at birth or days later, in either a live born or stillborn baby. They may be multiple or isolated.		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5(x9)
Location	Episode record	Position	134
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at <hdss.helpdesk@health.vic.gov.au>		
Reporting guide	Any congenital abnormality detected before birth, at birth or days later. This includes structural, functional, genetic, chromosomal and biochemical anomalies in either a liveborn or stillborn baby. These anomalies may be multiple or isolated. Other anomalies that include neoplasms, metabolic and haematological conditions should also be reported. The most common congenital anomalies are listed in Section 2. Congenital anomalies not required to be reported are also listed in Section 2.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where a congenital anomaly is present		
Related concepts (Section 2):	Congenital anomalies		
Related data items (this section):	Congenital anomalies – indicator		
Related business rules (Section 4):	Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items; Congenital anomalies – indicator and Congenital anomalies – ICD-10-AM code conditionally mandatory data items; Sex – baby		

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2018 2. January 2020 3. July 2022
Codeset source	ICD-10-AM 12th edition plus CCOPMM additions	Collection start date	2018

Congenital anomalies – indicator

Specification

Definition	Whether there were any reportable congenital anomalies identified, and if so, whether these were identified antenatally or postnatally or both		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	107

Permissible values

Code	Descriptor
2	Reportable congenital anomalies not identified
3	Reportable congenital anomalies identified antenatally
4	Reportable congenital anomalies identified postnatally
5	Reportable congenital anomalies identified both antenatally and postnatally
9	Not stated / inadequately described

Reporting guide	Where reportable congenital abnormalities are identified, report the most appropriate codes in the Congenital anomalies – ICD-10-AM code field.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Congenital anomalies – includes a list of the most common congenital anomalies for reporting in the Congenital anomalies – ICD-10-AM code field, and a list of congenital anomalies that do not need to be reported as a congenital anomaly
Related data items (this section):	Congenital anomalies – ICD-10-AM code
Related business rules (Section 4):	Congenital anomalies – indicator and Congenital anomalies – ICD-10-AM code conditionally mandatory data item; Mandatory to report data items; Sex – baby and Congenital anomalies – indicator conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2009 3. January 2020
Codeset source	DH	Collection start date	1999

Cord complications

Specification

Definition	Umbilical cord status, including abnormalities and complications		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5(x3)
Location	Episode record	Position	141

Permissible values

Code	Descriptor
1	No abnormalities or complications relating to umbilical cord
O691	Nuchal cord (cord tightly around baby's neck)
O692	True knot
O690	Umbilical cord prolapse
O693	Short umbilical cord
O694	Vasa previa
Q2701	Two vessels in cord
O698	Other
9	Not stated / inadequately described

Reporting guide

Report the umbilical cord status, including abnormalities and complications detected during the birth episodes.

Cord loosely around the baby's neck should be reported as code 1.

Report up to 3 codes.

No code should be reported more than once.

Reported by: All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for: All birth episodes

Related concepts (Section 2): Not specified

Related data items (this section): Birth status; Apgar score at one minute; Apgar score at five minutes; Birth presentation; Congenital anomalies – ICD-10-AM code; Congenital anomalies – indicator; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Fetal monitoring in labour; Fetal monitoring prior to birth – not in labour; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for operative delivery – free text; Indications for operative delivery – ICD-10-AM code; Neonatal morbidity – free text; Neonatal morbidity – ICD-10-AM code; Procedure – ACHI code; Procedure – free text

Related business rules (Section 4): Cord complications valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2020
Codeset source	DH	Collection start date	2020

Country of birth

Specification

Definition	The country in which the mother was born		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	18
Permissible values	Please refer to the 'Country of birth and country of residence SACC codeset' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files>		
Reporting guide	Report the country in which the person was born, not the country of residence. Select the code which best describes the mother's country of birth (COB) as precisely as possible from the information provided. Codes representing a country do not end in 'zero' or 'nine' For example, patient response 'Australia' is coded 1101 *Australia.* Codes ending in 'zero' are used for supplementary (not further defined, nfd) categories For example, patient response 'Great Britain' does not contain enough information to be coded to a country so is coded 2100 *United Kingdom, Channel Islands and Isle of Man, nfd* Codes ending in 'nine' are used for residual (not elsewhere classified, nec) categories For example, patient response 'Christmas Island' is coded 1199 *Australian External Territories, nec*		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Migrant status		
Related data items (this section):	Spoken English proficiency; Year of arrival in Australia		
Related business rules (Section 4):	Country of birth and Year of arrival in Australia conditionally mandatory data items; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1994 3. January 2009
Codeset source	NHDD	Collection start date	1982

COVID19 vaccination during this pregnancy

Specification

Definition	Whether the mother received one or more doses of a vaccination against novel coronavirus (SARS-CoV-2 or COVID19) during this pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	152

Permissible values

Code	Descriptor
1	Yes
2	No
7	Declined to answer
9	Not stated / inadequately described

Reporting guide

Report the statement that best describes the woman's understanding of her COVID19 vaccine status during this pregnancy.

Report this status as at the time of this birth.

Report code 1 Yes if the woman received one or more doses of any COVID19 vaccine in the period from conception of this pregnancy to the birth of this baby.

Where code 1 Yes is reported, also report the gestation during this pregnancy when COVID19 vaccination dose/s were received (Gestation at first COVID19 vaccination during this pregnancy and if relevant also Gestation at second COVID19 vaccination during this pregnancy and if relevant also Gestation at third COVID19 vaccination during this pregnancy).

Report code 2 No in the following cirumstances:

- where the woman had received one or more doses of a COVID19 vaccine before the conception of this pregnancy, but did not receive any doses between conception and the birth of this baby OR

- where the woman received one or more doses of a COVID19 vaccine after the birth of this baby and before discharge from this birth episode, but did not receive any doses between conception and the birth of this baby.

Report code 7 only where the woman declines to answer this question, or is unable to accurately respond to the question (eg is unconscious and does not regain consciousness before being transferred).

Leave blank where COVID19 vaccination status code 2 No or 7 Declined to answer are reported.

Report code 9 where COVID19 vaccination status code 9 is reported.

Details should be captured during the antenatal course, and updated if the status changes, and must be current as at the Discharge date – mother.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Mandatory for all birth episodes where COVID19 vaccination status code 1 Yes or 9 Not stated / inadequately describe is reported.
Related concepts (Section 2):	None specified
Related data items (this section):	COVID19 vaccination status; Gestation at first COVID19 vaccination during this pregancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy
Related business rules (Section 4):	COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy, Gestation at third COVID19 vaccination during this pregnancy valid combinations

Administration

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

COVID19 vaccination status

Specification

Definition	Whether the mother has received a vaccination against the novel coronavirus (SARS-CoV-2 or COVID19)		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	151

Permissible values

Code	Descriptor
1	Yes
2	No
7	Declined to answer
9	Not stated / inadequately described

Reporting guide

Report the statement that best describes the woman's understanding of her COVID19 vaccine status as at the end of this birth episode.

Report code 1 Yes in the following circumstances:

- if the woman received one or more doses of any COVID19 vaccine prior to the conception of this pregnancy OR

- if the woman received one or more doses of any COVID19 vaccine in the period from the conception of this pregnancy until the birth of this baby OR

- if the woman received one or more doses of any COVID19 vaccine during the current birth episode but after the birth of the baby.

This includes if one dose of a multi-dose course has been received at any time until the end of the current birth episode.

Where code 1 Yes is reported, also report:

- whether the mother received any dose/s of COVID19 vaccination during the current pregnancy (COVID19 vaccination during this pregnancy) and if so,

- the gestation during this pregnancy when COVID19 vaccination dose/s were received (Gestation at first COVID19 vaccination during this pregnancy and if relevant also Gestation at second COVID19 vaccination during this pregnancy and if relevant also Gestation at third COVID19 vaccination during this pregnancy).

Report code 2 No if the woman has not had any dose of any COVID19 vaccine prior to this pregnancy or during this pregnancy or after the birth of this baby but before discharge at the end of this birth episode.

Report code 7 only where the woman declines to answer this question, or is unable to accurately respond to the question (eg is unconscious and does not regain consciousness before being transferred).

	Details should be captured during the antenatal course, and updated if the status changes, and must be current as at the Discharge date – mother.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy
Related business rules (Section 4):	COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy, Gestation at third COVID19 vaccination during this pregnancy valid combinations; Mandatory to report data items

Administration

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

Data submission identifier

Specification

Definition	File name component that identifies this file using a date and time format		
Representation class	Identifier	Data type	Date/time
Format	YYYYMMDDhhmm	Field size	12
Location	File name, Header record	Position	Not applicable
Permissible values	A valid calendar date and time value using a 24-hour clock (not 0000 or 2400)		
Reporting guide	Software-system generated. Time must be in 24-hour clock format. May be the date and time the VPDC electronic submission file is generated in 24-hour clock format, or may represent the end date used in selecting records for inclusion in the submission file. Cannot be later than the date and time on which the file is submitted for processing. Refer also to Section 5 Compilation and submission of the VPDC manual.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	None specified		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Date of admission – mother

Specification

Definition	The date on which the mother is admitted		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	7
Permissible values	A valid calendar date **Code** **Descriptor** 99999999 Not stated / inadequately described		
Reporting guide	Report the appropriate date based on the circumstances of the birth (attending hospital or using a home practitioner).		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Date and time data item relationships; Date of admission – mother and Date of birth – baby conditionally mandatory data items; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1998
Codeset source	NHDD	Collection start date	1982

Date of birth – baby

Specification

Definition	The date of birth of the baby		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	95
Permissible values	A valid calendar date **Code** **Descriptor** 99999999 Not stated / inadequately described		
Reporting guide	Century (CC) can only be reported as 20.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Date of admission – mother		
Related business rules (Section 4):	Date and time data item relationships, Date of admission – mother and Date of birth – baby conditionally mandatory data items, Date of birth – baby and Separation date – baby conditionally mandatory data items, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1998
Codeset source	NHDD	Collection start date	1982

Date of birth – mother

Specification

Definition	The date of birth of the mother		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	22
Permissible values	A valid calendar date **Code** **Descriptor** 99999999 Not stated / inadequately described		
Reporting guide	Century (CC) can only be 19 or 20.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Date and time data item relationships, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1998
Codeset source	NHDD	Collection start date	1982

Date of completion of last pregnancy

Specification

Definition	Date on which the pregnancy preceding the current pregnancy was completed		
Representation class	Date	Data type	Date/time
Format	{DD}MMCCYY	Field size	6 (8)
Location	Episode record	Position	42

Permissible values

Dates provided must be either a valid complete calendar date or recognised part of a calendar date.

Code	Descriptor
DDMMCCYY	Date, year and month known (where DD = day, MM = month, CCYY = year)
MMCCYY	Date unknown, year and month known (where MM = month, CCYY = year)
99CCYY	Year known, month unknown (where CCYY = year)
999999	Not stated / inadequately described

Reporting guide

Record the date of completion of the pregnancy preceding the current pregnancy.

Century (CC) can only be 19, 20 or 99.

If the day, month and year is known, report all components of the date.

99CCYY should not be reported if the value of CCYY is the same as, or the year preceding, the value of CCYY reported in Date of birth – baby.

Regardless of the format reported, the value of the year component (CCYY) cannot be greater than the value of CCYY reported in Date of birth – baby.

If this is the first pregnancy, that is, there is no preceding pregnancy, do not report a value, leave blank.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for

Birth episodes where Gravidity is greater than 01 Primigravida

Related concepts (Section 2):

None specified

Related data items (this section):	Gravidity; Parity
Related business rules (Section 4):	Date and time data item relationships; Date of completion of last pregnancy, Date of birth – baby and Estimated gestational age valid combinations [Warning validation]; Gravidity ‘Multigravida’ conditionally mandatory data items; Gravidity ‘Primigravida’ and associated data items valid combinations; Parity and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1999 3. July 2022
Codeset source	NHDD	Collection start date	1982

Date of decision for unplanned caesarean section

Specification

Definition	The date of decision for unplanned caesarean section		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	149
Permissible values	A valid calendar date		

Code	Descriptor
99999999	Not stated / inadequately described

Reporting guide	The date on which the medical practitioner decides to deliver by urgent caesarean section where that was not the previously planned method of birth, for example where the plan was for a vaginal birth or planned caesarean section, but circumstances change and the decision is made to proceed to an urgent caesarean section. In cases of transfer to theatre for trial of forceps, report the date on which the plan changed to delivery by caesarean section. Century (CC) can only be reported as 20.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes
Related concepts (Section 2):	Labour type
Related data items (this section):	Category of unplanned caesarean section urgency; Method of birth; Time of decision for unplanned caesarean section
Related business rules (Section 4):	Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; Date and time data item relationships; Labour type ‘Woman in labour’ and associated data items valid combinations; Labour type ‘Woman not in labour’ and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. July 2021
Codeset source	DH	Collection start date	July 2021

Date of onset of labour

Specification

Definition	The date of onset of labour		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	61
Permissible values	A valid calendar date		

Code	Descriptor
88888888	No labour
99999999	Not stated / inadequately described

Reporting guide

Century (CC) can only be reported as 20.

Code 88888888 No labour:
report only when the mother has a caesarean section (planned or unplanned) with no labour.

There is little consensus regarding definitions of labour onset. Most definitions include the presence of regular, painful contractions accompanied by effacement and/or dilatation of the cervix. Many women find it difficult to state the time labour started.

Where the woman cannot provide a specific time, asking her when she noticed the change that prompted her to seek advice or care (eg backache, a show, SROM, etc), will aid in deciding on the commencement date and time. It will often be necessary to make an ‘educated guess or best estimate’ when given the history (Hanley, G et al. 2016, BMC Pregnancy and Childbirth).

Not all midwives would make the same judgement call about the ‘exact’ time and date labour commenced. Therefore, it is generally accepted as an ‘educated guess’.

The above points are intended to assist in determining the date and time of onset of labour.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Labour type

Related data items (this section):	Date of onset of second stage of labour; Date of rupture of membranes; Method of birth; Time of onset of labour; Time of onset of second stage of labour; Time of rupture of membranes
Related business rules (Section 4):	Date and time data item relationships; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Date of onset of second stage of labour

Specification

Definition	The date of the start of the second stage of labour		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	63

Permissible values: A valid calendar date

Code	Descriptor
88888888	No labour
99999999	Not stated / inadequately described

Reporting guide:

Code 88888888 No second stage of labour:
report only when the mother has a caesarean section (planned or unplanned) and did not reach second stage of labour.

Century (CC) can only be reported as 20.

In the instance of the woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:

1. Did she have a show or rupture of membranes (ROM)?
2. Did she vomit at all within the hour prior to giving birth or thought she was going to vomit?
3. Was there any noticeable urge to push?
4. Did she notice if she had bowel pressure prior to having the baby and how long before?
5. Did any family member notice any change in her behaviour (restless, agitated) prior to having baby?

If none of these questions can be answered then a reasonable assumption would be that the birth occurred within one to two contractions prior to the birth and second stage may be judged to be two and five minutes prior to the birth.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Date of onset of labour; Date of rupture of membranes; Method of birth; Time of onset of labour; Time of onset of second stage of labour; Time of rupture of membranes

Related business rules (Section 4):	Date and time data item relationships; Labour type ‘Woman in labour’ and associated data items valid combinations; Labour type ‘Woman not in labour’ and associated data items valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Date of rupture of membranes

Specification

Definition	The date on which the mother's membranes ruptured (spontaneously or artificially)		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	65
Permissible values	A valid calendar date		

Code	Descriptor
77777777	No record of date of rupture of membranes
88888888	Membranes ruptured at caesarean
99999999	Not stated / inadequately described

Reporting guide

Report the date on which it is believed the membranes ruptured, whether spontaneously or artificially. If there is a verified hindwater leak that is followed by a forewater rupture, record the earlier date.

If there is some vaginal loss that is suspected to be ruptured membranes, but in hindsight seems unlikely, record the time at which the membranes convincingly ruptured.

For a caul birth, report the date and time of ROM as the date and time of birth.

If date of ROM is known, but time of ROM is not, report the known date and report time as unknown. Only report unknown date and time of ROM for episodes where there is absolutely no evidence in the medical record to indicate the timing of the rupture of membranes. An estimate of at least the date of ROM is far preferable to no record. Use of the no record codes will be monitored and sites reporting a high frequency of no record codes will be followed up.

Century (CC) can only be reported as 20.

Code 88888888 Membranes ruptured at caesarean:
this code is only reported when the mother has a planned or unplanned caesarean section and membranes were ruptured during caesarean.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified

Related data items (this section):	Date of onset of labour; Date of onset of second stage of labour; Method of birth; Time of onset of labour; Time of onset of second stage of labour; Time of rupture of membranes
Related business rules (Section 4):	Date and time data item relationships; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations; Mandatory to report data items

Administration

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

Diabetes mellitus during pregnancy – type

Specification

Definition	Report whether the mother has diabetes mellitus during this pregnancy, and if so, the type of diabetes mellitus		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	142

Permissible values

Code	Descriptor
1	No diabetes mellitus during this pregnancy
2	Pre-existing Type 1 diabetes mellitus
3	Pre-existing Type 2 diabetes mellitus
4	Gestational diabetes mellitus (GDM)
8	Other type of pre-existing diabetes mellitus
9	Not stated / inadequately described

Reporting guide

Report the statement that best describes whether the mother has diabetes mellitus during this pregnancy, and if so, what type of diabetes mellitus

Code 1 No diabetes mellitus during this pregnancy
Includes intermediate hyperglycaemia

Code 2 Pre-existing Type 1 diabetes mellitus
(equivalent to ICD-10-AM code O24.0)

Code 3 Pre-existing Type 2 diabetes mellitus
Includes mothers with pre-existing Type 2 diabetes mellitus during the current pregnancy
(equivalent to ICD-10-AM codes O24.12, O24.13, O24.14, O24.19)

Code 4 Gestational diabetes mellitus (GDM)
(equivalent to ICD-10-AM codes O24.42, O24.43, O24.44, O24.49)

Code 8 Other type of diabetes mellitus
Includes pre-existing other specified type of diabetes mellitus
(equivalent to ICD-10-AM codes O24.22, O24.23, O24.24, O24.29);
Where no other information is available, report code 8 for patients with pre-existing diabetes mellitus of unspecified type
(equivalent to ICD-10-AM codes O24.32, O24.33, O24.34, O24.39).
Excludes impaired glucose regulation.

Code 9 Not stated / inadequately described
Includes diabetes mellitus of unknown onset or reported as ICD-10-AM codes O24.92, O24.93, O24.94 or O24.99.

Reported by

All Victorian hospitals where a birth has occurred and homebirth practitioners

Reported for	All birth episodes
Related concepts (Section 2):	Diabetes mellitus; Gestational diabetes mellitus
Related data items (this section):	Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus – pre-existing – diagnosis timing; Diabetes mellitus therapy during pregnancy; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications- ICD-10-AM code
Related business rules (Section 4):	Diabetes mellitus during pregnancy – type, Diabetes mellitus – gestational – diagnosis timing, Diabetes mellitus – pre-existing – diagnosis timing and Diabetes mellitus therapy during pregnancy valid combinations; Diabetes mellitus during pregnancy – type, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code and Postpartum complications – ICD-10-AM code valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	AIHW	Version	1. January 2020
Codeset source	AIHW	Collection start date	2020

Diabetes mellitus – gestational – diagnosis timing

Specification

Definition	The gestation at which gestational diabetes mellitus was diagnosed during this pregnancy		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	143
Permissible values	Range: 01 to 43 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	For mothers diagnosed with gestational diabetes mellitus during the current pregnancy, report the gestation in completed weeks during this pregnancy when the diagnosis of gestational diabetes mellitus was made. Leave blank for mothers who were: - not diagnosed with diabetes mellitus, - diagnosed with type 1 or type 2 diabetes mellitus before the current pregnancy, - diagnosed with gestational diabetes mellitus only during a previous pregnancy but not the current pregnancy.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where Diabetes mellitus during pregnancy – type code 4 Gestational diabetes mellitus (GDM) is reported		
Related concepts (Section 2):	Diabetes mellitus; Gestational diabetes mellitus		
Related data items (this section):	Diabetes mellitus during pregnancy – type; Diabetes mellitus – pre-existing – diagnosis timing; Diabetes mellitus therapy during pregnancy; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications –ICD-10-AM code		
Related business rules (Section 4):	Diabetes mellitus during pregnancy – type, Diabetes mellitus – gestational – diagnosis timing, Diabetes mellitus – pre-existing –		

	diagnosis timing and Diabetes mellitus therapy during pregnancy valid combinations

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2020
Codeset source	DH	Collection start date	2020

Diabetes mellitus – pre-existing – diagnosis timing

Specification

Definition	The year in which pre-existing diabetes mellitus was diagnosed		
Representation class	Date	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	144
Permissible values	Range: 1960 to current year **Code** **Descriptor** 9999 Not stated / inadequately described		
Reporting guide	For mothers diagnosed with diabetes mellitus before the current pregnancy only, report the year in which the mother was diagnosed with diabetes mellitus. Leave blank for mothers who were: - not diagnosed with diabetes mellitus, - diagnosed with gestational diabetes mellitus only during the current pregnancy		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where Diabetes mellitus during pregnancy – type is reported as code 2 Pre-existing Type 1 diabetes mellitus or code 3 Pre-existing Type 2 diabetes mellitus or code 8 Other type of diabetes mellitus or code 9 Not stated / inadequately described		
Related concepts (Section 2):	Diabetes mellitus; Gestational diabetes mellitus		
Related data items (this section):	Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus therapy during pregnancy; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications – ICD-10-AM code		
Related business rules (Section 4):	Diabetes mellitus during pregnancy – type, Diabetes mellitus – gestational – diagnosis timing, Diabetes mellitus – pre-existing –		

	diagnosis timing and Diabetes mellitus therapy during pregnancy valid combinations

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2020
Codeset source	DH	Collection start date	2020

Diabetes mellitus therapy during pregnancy

Specification

Definition	The type/s of therapy prescribed during the pregnancy for diabetes mellitus		
Representation class	Code	Data type	String
Format	N	Field size	1(x3)
Location	Episode record	Position	145

Permissible values

Code	Descriptor
2	Insulin
3	Oral hypoglycaemics
4	Diet and exercise
9	Not stated / inadequately described

Reporting guide

Report all therapies prescribed during the pregnancy, up to 3 codes.

Code 2 Insulin:
Equivalent to 5th digit 2 (insulin treated) on ICD-10-AM codes in the range O24.1- to O24.9-.

Code 3 Oral hypoglycaemics:
Includes sulphonylurea, biguanide (eg metformin), alpha-glucosidase inhibitor, thiazolidinedione, meglitinide, combination (eg biguanide and sulphonylurea) or other.

Equivalent to 5th digit 3 (oral hypoglycaemic therapy) on ICD-10-AM codes O24.1- to O24.9-.

Code 4 Diet and exercise:
Includes generalised prescribed diet; avoidance of added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

Equivalent to 5th digit 4 (other; diet; exercise; lifestyle management) on ICD-10-AM codes O24.1- to O24.9-.

Leave blank for mothers with Type 1 diabetes mellitus diagnosed before the current pregnancy (reported as code 2 in Diabetes mellitus during pregnancy – type) as insulin therapy is assumed.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes reporting Diabetes mellitus during pregnancy – type codes 3, 4, 8 or 9.
Related concepts (Section 2):	Diabetes mellitus; Gestational diabetes mellitus

Related data items (this section):	Diabetes mellitus during pregnancy – type; Diabetes mellitus – gestational – diagnosis timing; Diabetes mellitus – pre-existing – diagnosis timing; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indication for operative delivery (main reason) – ICD-10-AM code; Indications for operative delivery (other) – free text; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free text; Postpartum complications- ICD-10-AM code
Related business rules (Section 4):	Diabetes mellitus during pregnancy – type, Diabetes mellitus – gestational – diagnosis timing, Diabetes mellitus – pre-existing – diagnosis timing and Diabetes mellitus therapy during pregnancy valid combinations; Diabetes mellitus therapy during pregnancy valid combinations

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	AIHW	Version	1. January 2020
Codeset source	AIHW	Collection start date	2020

Discipline of antenatal care provider

Specification

Definition	The discipline of the clinician who provided most occasions of antenatal care		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	54

Permissible values

Code	Descriptor
1	Obstetrician
2	Midwife
3	General practitioner
4	No antenatal care provider
8	Other
9	Not stated / inadequately described

Reporting guide

Code 1 Obstetrician:
includes public and private obstetric care including care provided by medical staff in hospitals under the supervision of an obstetrician

Code 2 Midwife:
includes public and private midwifery care including care provided by midwife-led units in hospitals with limited medical input

Code 3 General practitioner:
includes public and private care by general practitioners (including those with a diploma of obstetrics) and care provided by medical staff in hospitals under the supervision of a general practitioner

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Registered nurse
Related data items (this section):	Discipline of lead intrapartum care provider
Related business rules (Section 4):	Discipline of antenatal care provider and Number of antenatal care visits valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Discipline of lead intrapartum care provider

Specification

Definition	The discipline of the clinician who, at the time of admission for the birth, is expected to be primarily responsible for making decisions regarding intrapartum care		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	93

Permissible values

Code	Descriptor
1	Obstetrician
2	Midwife
3	General practitioner
4	No intrapartum care provider
8	Other
9	Not stated / inadequately described

Reporting guide

The discipline of the clinician who, at the time of admission for the birth, is expected to be primarily responsible for making decisions regarding intrapartum care. In some cases birth will take place without any direct input from this person, for example, rapid, uncomplicated labour. Please note that this responsibility may transfer during labour with transfer from midwifery to GP/obstetric care, or from GP to obstetric care.

Code 1 Obstetrician:
includes public and private obstetric care, including care provided by midwives and medical staff in hospital when the mother is admitted under the supervision of an obstetrician.

Code 2 Midwife:
includes public and private midwifery care and including care provided by midwife-led units in hospital with limited medical input.

Code 3 General practitioner: :
includes public and private care by general practitioners (including those with a diploma of obstetrics) including care provided in hospitals when the mother is admitted under the supervision of a general practitioner.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Registered nurse

Related data items (this section):	Discipline of antenatal care provider
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Edinburgh Postnatal Depression Scale score

Specification

Definition	The degree of the woman's possible symptoms of depression at an antenatal care visit, as represented by an Edinburgh Postnatal Depression Scale (EPDS) score		
Representation class	Code	Data type	Number
Format	N[N]	Field size	2
Location	Episode record	Position	157
Permissible values	Valid score range: 0 to 30 inclusive		

Code	Description
77	Edinburgh Postnatal Depression Scale not evaluated at any antenatal care visit during this pregnancy
98	Unknown EPDS score
99	Not stated stated/inadequately described

Reporting guide

Report the total score on the Edinburgh Postnatal Depression Scale (EPDS) derived at an antenatal care visit

This data may be self-reported or derived from medical information.

If an EPDS score was derived during the antenatal period by a service other than the antenatal care provider (eg at a mental health service), and there was no EPDS score derived during any antenatal care visits, report the EPDS score derived by the other care provider.

Where there is more than one EPDS score taken during this pregnancy, report the highest score.

77 Edinburgh Postnatal Depression Scale not evaluated at any antenatal care visit during this pregnancy

Report this code also where:
- the woman was offered, and declined, the EPDS evaluation
- the woman had no antenatal care
- an assessment was attempted but not completed

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None stated
Related data items (this section):	Antenatal mental health risk screening status; Presence or history of mental health condition – indicator
Related business rules (Section 4):	Mandatory to report data items

Administration

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

Episiotomy – indicator

Specification

Definition	Whether an incision of the perineum and vagina was made		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	88

Permissible values

Code	Descriptor
1	Incision of the perineum and vagina made
2	Incision of the perineum and vagina not made
9	Not stated / inadequately described

Reporting guide	For episiotomies extended by laceration or laceration extended by episiotomy record Perineal laceration – indicator as code 1 Laceration of the perineum following birth, Episiotomy indicator as code 1 Incision of perineum and vagina made and Perineal laceration – repair as code 1 Repair of perineum undertaken. Specify the degree of the tear in Perineal/genital laceration – degree/type.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Method of birth
Related business rules (Section 4):	Episiotomy – indicator and Method of birth valid combinations; Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2009
Codeset source	DH	Collection start date	1999

Episode Identifier

Specification

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

Administration

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

Estimated date of confinement

Specification

Definition	The estimated date of confinement (agreed due date)		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	47
Permissible values	A valid calendar date.		
	Code 99999999	**Descriptor** Not stated / inadequately described	
Reporting guide	The Estimated date of confinement (agreed due date) may be based on the date of the last normal menstrual period (LNMP) or on clinical or ultrasound assessments. If there is uncertainty in each of these, report the agreed due date based on the best available information in the particular case. Century (CC) can only be reported as 20.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Date and time data item relationships, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Estimated gestational age

Specification

Definition	The number of completed weeks of the period of gestation as measured from the first day of the last normal menstrual period to the date of birth		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	48
Permissible values	Range: 16 to 45 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed weeks (for example, if a baby is 37 weeks and six days, this should be recorded as 37 weeks).		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Estimated date of confinement		
Related business rules (Section 4):	Estimated gestational age and Gestational age at first antenatal visit valid combinations; Estimated gestational age conditionally mandatory data items; Mandatory to report data items; Scope ‘Stillborn’		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	NHDD	Collection start date	1982

Events of labour and birth – free text

Specification

Definition	Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta		
Representation class	Text	Data type	String
Format	A(300)	• Field size	300
Location	Episode record	• Position	81
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Report complications arising after the onset of labour and before the completed birth of the baby and placenta. Only report conditions in this field when there is no ICD-10-AM code available for selection in your software.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Births where events occurred during the labour and/or birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother; Birth presentation; Events of labour and birth – ICD-10-AM code		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Birth presentation conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Events of labour and birth – ICD-10-AM code

Specification

Definition	Medical and obstetric complications arising after the onset of labour and before the completed delivery of the baby and placenta		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (x9)
Location	Episode record	Position	82
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk at <hdss.helpdesk@health.vic.gov.au> A small number of additional codes have been created solely for VPDC reporting in this data element: **Code Descriptor** O839 Water birth Z2929 Antibiotic therapy in labour		
Reporting guide	Complications arising after the onset of labour and before the completed birth of the baby and placenta. Report conditions related to the neonate, and classifiable to code range P00–P96 Certain conditions originating in the perinatal period, in data element Neonatal morbidity – ICD-10-AM code.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Births where events occurred during the labour and/or birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother; Birth presentation; Events of labour and birth – free text		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Birth presentation conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009 2. January 2015 3. January 2020 4. July 2022
Codeset source	ICD-10-AM 12th edition plus CCOPMM additions	Collection start date	2009

Family violence screening status

Specification

Definition	Whether the woman has received screening for family violence		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	159

Permissible values

Code	Description
1	Yes
2	Not offered
3	Declined
9	Not stated stated/inadequately described

Reporting guide

Screening for family violence is conducted using a validated screening tool, which is an instrument that has been psychometrically tested for reliability, validity and sensitivity eg, the Humiliation, Afraid, Rape, Kick (HARK) tool.

Code 1 Yes
The woman was screened using a validated screening tool

Code 2 Not offered
The woman was not offered screening using a validated screening tool

Code 3 Declined
The woman declined screening using a validated screening tool

Report also when screening was offered to and accepted by the woman, but could not be completed, for example due to safety risk, or the woman declined to respond to further questions.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None stated
Related data items (this section):	None stated
Related business rules (Section 4):	Mandatory to report data items

Administration

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

Fetal monitoring in labour

Specification

Definition	Methods used to monitor the wellbeing of the fetus during labour		
Representation class	Code	Data type	String
Format	NN	Field size	2 (x7)
Location	Episode record	Position	72

Permissible values

Code	Descriptor
01	None
02	Intermittent auscultation
03	Admission cardiotocography
04	Intermittent cardiotocography
05	Continuous external cardiotocography
06	Internal cardiotocography (scalp electrode)
07	Fetal blood sampling
88	Other
99	Not stated / inadequately described

Reporting guide

Up to seven methods of monitoring can be reported.

Code 02 Intermittent auscultation:
performed by Pinnards or sonicaid

Code 03 Admission cardiotocography:
a routine cardiotocography (CTG) of limited duration (e.g. 30 minutes) on admission

Code 04 Intermittent cardiotocography:
fetal heart monitoring by CTG on a number of occasions in labour, but not continuously

Code 05 Continuous cardiotocography:
fetal heart monitoring by CTG more or less continuously from some point in labour until about the time of birth

Code 07 Fetal blood sampling:
includes scalp lactate

If there was no labour, leave blank

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where there is a labour
Related concepts (Section 2):	None specified
Related data items (this section):	Fetal monitoring prior to birth – not in labour; Labour type

Related business rules (Section 4):	Fetal monitoring in labour and Labour type valid combinations; Labour type ‘Woman not in labour’ and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Fetal monitoring prior to birth – not in labour

Specification

Definition	Methods used to monitor the wellbeing of the fetus prior to birth, but not in labour (for example, prior to a caesarean section).		
Representation class	Code	Data type	String
Format	NN	Field size	2 (x5)
Location	Episode record	Position	131

Permissible values

Code	Descriptor
01	None
02	Intermittent auscultation
03	Admission cardiotocography
04	Intermittent cardiotocography
05	Continuous external cardiotocography
88	Other
99	Not stated / inadequately described

Reporting guide

Report this field if Labour Type is 5 – No labour

Up to five methods of monitoring can be reported.

Code 02 Intermittent auscultation: performed by Pinnards or sonicaid

Code 03 Admission cardiotocography: a routine cardiotocography (CTG) of limited duration (eg 30 minutes) on admission

Code 04 Intermittent cardiotocography: fetal heart monitoring by CTG (not in labour) on a number of occasions, but not continuously

Code 05 Continuous cardiotocography: fetal heart monitoring by CTG more or less continuously from some point until about the time of birth

If there was labour, leave blank.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where there was no labour
Related concepts (Section 2):	None specified
Related data items (this section):	Fetal monitoring in labour; Labour Type
Related business rules (Section 4):	Fetal monitoring prior to birth – not in labour and Labour type valid combinations; Labour type ‘Woman in labour’ and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2017 2. January 2020
Codeset source	DH	Collection start date	2017

First given name – mother

Specification

Definition	The first given name of the mother		
Representation class	Text	Data type	String
Format	A(40)	Field size	40
Location	Episode record	Position	9
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	The given name(s) of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	Not applicable	Collection start date	1982

Formula given in hospital

Specification

Definition	Whether any infant formula was given to this baby in hospital, whether by bottle, cup, gavage or other means		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	116

Permissible values

Code	Descriptor
1	Infant formula given in hospital
2	Infant formula not given in hospital
9	Not stated / inadequately described

Reporting guide	Do not report a value for stillbirth episodes, leave blank.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All live birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Gestation at first COVID19 vaccination during this pregnancy

Specification

Definition	The earliest gestation during the current pregnancy at which a dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman		
Representation class	Total	Data type	Number
Format	[N]N	Field size	2
Location	Episode record	Position	153
Permissible values	Range: 01 to 45 (inclusive)		

Code	Descriptor
88	Unknown Gestation
99	Not stated / inadequately described

Reporting guide

The earliest gestation during the current pregnancy at which a dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.

If the woman receives one or more doses of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the first of those doses was received.

Report only COVID19 vaccines received during this pregnancy, that is, from the conception of this pregnancy to the birth of this baby.

If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has one or more further dose/s during this pregnancy, report in this field only the first dose received during this pregnancy.

Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.

Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated.

Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where:

- the woman received one or more doses of any COVID19 vaccine before conception of this pregnancy but none between the conception and the birth of this baby OR

	- the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby. Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or code 9 Not stated / inadequately described is reported.
Related concepts (Section 2):	None specified
Related data items (this section):	COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy
Related business rules (Section 4):	COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations; Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations

Administration

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

Gestation at second COVID19 vaccination during this pregnancy

Specification

Definition	The gestation during the current pregnancy when a second dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman		
Representation class	Total	Data type	Number
Format	[N]N	Field size	2
Location	Episode record	Position	154
Permissible values	Range: 01 to 45 (inclusive)		

Code	Descriptor
77	No second dose received during this pregnancy
88	Uknown gestation
99	Not stated / inadequately described

Reporting guide

The gestation during the current pregnancy when a second dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.

If the woman receives more than one dose of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the second of those doses was received.

Report only COVID19 vaccines received during this pregnancy.

If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has more than one dose during this pregnancy, report in this field only the second dose received during this pregnancy.

Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.

Report 77 in the following circumstances:
- if the woman received only one dose of a COVID19 vaccine during this pregnancy OR
- if a single-dose vaccine was received during this pregnancy OR
- if one dose of a COVID19 vaccine was received during the pregnancy, and the next dose was received after the birth of this baby but before the woman was discharged from this birth episode (report code 77 because the second dose was not received during the pregnancy; do not report the gestation at delivery in this instance).

	Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where: - the woman received one or more doses of any COVID19 vaccine before conception of this pregnancy but none between the conception and the birth of this baby OR - the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby. Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated. Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or 9 Not stated / inadequately described is reported.
Related concepts (Section 2):	None specified
Related data items (this section):	COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at third COVID19 vaccination during this pregnancy
Related business rules (Section 4):	COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations; Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations

Administration

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

Gestation at third COVID19 vaccination during this pregnancy

Specification

Definition	The gestation during the current pregnancy when a third dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman		
Representation class	Total	Data type	Number
Format	[N]N	Field size	2
Location	Episode record	Position	155
Permissible values	Range: 01 to 45 (inclusive)		

Code	Descriptor
77	No third dose received during this pregnancy
88	Unknown gestation
99	Not stated / inadequately described

Reporting guide

The gestation during the current pregnancy when a third dose of a vaccine against novel coronavirus (SARS-CoV-2 or COVID19) was received by the woman.

If the woman receives more than one dose of a COVID19 vaccine between conception of this pregnancy and the birth of this baby, report in this field the gestation at which the third of those doses was received.

Report only COVID19 vaccines received during this pregnancy.

If the woman had received one or more doses of a COVID19 vaccine prior to this pregnancy, and then has more than one dose during this pregnancy, report in this field only the third dose received during this pregnancy.

Report the gestation in completed weeks. If a precise gestation is not known, report the estimated gestation in completed weeks.

Report 77 in the following circumstances:
- if the woman received one or two dose(s) of a COVID19 vaccine during this pregnancy, but not a third dose OR
- if a single-dose vaccine was received during this pregnancy OR
- if the woman received one or two dose(s) of a COVID19 vaccine during the pregnancy, and the next dose was received after the birth of this baby but before the woman was discharged from this birth episode (report code 77 because the third dose was not received during the pregnancy; do not report the gestation at delivery in this instance).

Leave blank where code 2 No or 7 Declined to answer is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy: this includes where:
- the woman received one or more doses of any COVID19 vaccine before

	conception of this pregnancy but none between the conception and the birth of this baby OR - the woman received one or more doses of any COVID19 vaccine after the birth of this baby and before discharge from the birth episode, but had not received any other COVID19 vaccine dose between conception of this pregnancy and the birth of this baby. Report code 88 Unknown gestation only when the woman does not know the gestation, and the gestation cannot be estimated. Report 99 where code 9 is reported for COVID19 vaccination status or COVID19 vaccination during this pregnancy.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Mandatory for all birth episodes where COVID19 vaccination during this pregnancy code 1 Yes or 9 Not stated / inadequately described is reported.
Related concepts (Section 2):	None specified
Related data items (this section):	COVID19 vaccination status; COVID19 vaccination during this pregnancy; Gestation at first COVID19 vaccination during this pregnancy; Gestation at second COVID19 vaccination during this pregnancy
Related business rules (Section 4):	COVID19 vaccination status, COVID19 vaccination during this pregnancy, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations; Estimated gestational age, Gestation at first COVID19 vaccination during this pregnancy, Gestation at second COVID19 vaccination during this pregnancy and Gestation at third COVID19 vaccination during this pregnancy valid combinations

Administration

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

Gestational age at first antenatal visit

Specification

Definition	The number of completed weeks' gestation at the time of the first visit as measured from the first day of the last normal menstrual period. The visit is an intentional encounter between a pregnant woman and a midwife or doctor to assess and improve maternal and fetal well-being throughout pregnancy and prior to labour.		
Representation class	Total	Data type	Number
Format	N[N]	Field size	2
Location	Episode record	Position	53
Permissible values	Range: two to 45 (inclusive)		

Code	Descriptor
88	No antenatal care
99	Not stated / inadequately described

Reporting guide	The gestational age at first visit should be recorded in completed weeks, for example, if gestation is eight weeks and six days, this should be recorded as eight weeks. The visit may occur in the following clinical settings: Antenatal outpatients clinic Specialist outpatient clinic General practitioner surgery Obstetrician private rooms Community health centre Rural and remote health clinic Independent midwife practice setting including home of the pregnant mother.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Estimated gestational age and Gestational age at first antenatal visit valid combinations; Gestational age at first antenatal visit and Number of antenatal care visits valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Definition source	DH	Version	1. January 2009 2. January 2018
Codeset source	DH	Collection start date	2009

Gravidity

Specification

Definition	The total number of pregnancies including the current one		
Representation class	Total	Data type	Number
Format	N[N]	Field size	2
Location	Episode record	Position	33
Permissible values	Range: one to 30 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Report the numbers of known pregnancies regardless of the gestation, that is, count all pregnancies that result in live births, stillbirths and spontaneous or induced abortions. Include the current pregnancy. If this is the first pregnancy, report code 01 Primigravida. Pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy, even though it has two outcomes.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Date of completion of last pregnancy		
Related business rules (Section 4):	Gravidity 'Multigravida' conditionally mandatory data items, Gravidity 'Primigravida' and associated data items valid combinations, Gravidity and Parity valid combinations, Gravidity and related data items, Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Head circumference - baby

Specification

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

Administration

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

Height – self-reported – mother

Specification

Definition	The mother's self-reported height, measured in centimetres, at about the time of conception		
Representation class	Total	Data type	Number
Format	NNN	Field size	3
Location	Episode record	Position	23
Permissible values	Range: 100 to 250 (inclusive) **Code** **Descriptor** 999 Not stated / inadequately described		
Reporting guide	Height is measured in centimetres. It is acceptable to report the measured height of the mother.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD (DH modified)	Version	1. January 2009
Codeset source	NHDD	Collection start date	2009

Hepatitis B antenatal screening – mother

Specification

Definition	Whether the woman had a hepatitis B serology (HBsAg) screening test during this pregnancy, and if so, whether the result was positive or negative		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	160

Permissible values

Code	Descriptor
1	Hepatitis serology (HBsAg) was negative
2	Hepatitis serology (HBsAg) was positive
3	Hepatitis serology (HBsAg) was not performed at any time during this pregnancy
9	Not stated/inadequately described

Reporting guide	Report the results of hepatitis B screening in all pregnant woman. Where a hepatitis serology screening test was conducted, but the result cannot be located or is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None stated
Related data items (this section):	None stated
Related business rules (Section 4):	Mandatory to report data items

Administration

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

Hepatitis B vaccine received

Specification

Definition	Whether the baby received an immunisation vaccine for hepatitis B during the birth admission		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	114

Permissible values

Code	Descriptor
2	Hepatitis B vaccine received after seven days of age
3	Hepatitis B vaccine not received
4	Hepatitis B vaccine received less than 24 hours of age
5	Hepatitis B vaccine received between 24 hours and 7 days of age
9	Not stated / inadequately described

Reporting guide	Report the administration of a dose of paediatric hepatitis B vaccine. Do not report immunoglobulin. Do not report a value for stillbirth episodes, leave blank.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All live birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Birth status
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2017
Codeset source	DH	Collection start date	2009

Hospital code (agency identifier)

Specification

Definition	Numeric code for the hospital campus reporting to the VPDC		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record, Header record, File name	Position	4
Permissible values	Please refer to the 'Campus Code Table' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files>		
Reporting guide	Software-system generated. Report the campus code for your maternity hospital (includes birth centres).		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	Hospital; Transfer		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

HIV antenatal screening – mother

Specification

Definition	Whether the mother had an HIV antenatal screening serology test during this pregnancy, and if so, the result		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	161

Permissible values

Code	Descriptor
1	HIV serology was performed: result was negative
2	HIV serology was performed: result was positive
3	No HIV serology performed at any time during this pregnancy
9	Not stated/inadequately described

Reporting guide

Report whether HIV serology screening was performed during this pregnancy, and if so, report the laboratory result.

Where a HIV serology screening test was conducted, but the result cannot be located or is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None stated
Related data items (this section):	None stated
Related business rules (Section 4):	Mandatory to report data items

Administration

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

Hypertensive disorder during pregnancy

Specification

Definition	Whether the woman has a hypertensive disorder during this pregnancy, based on a current or previous diagnosis, and if so, the type of hypertensive disorder		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x3)
Location	Episode record	Position	163

Permissible values

Code	Descriptor
1	Eclampsia
2	Pre-eclampsia
3	Gestational hypertension
4	Chronic hypertension
7	Hypertension, not further specified
8	No hypertensive disorder during this pregnancy
9	Not stated stated/inadequately described

Reporting guide

Report any hypertensive disorder the woman has had during this pregnancy. Include hypertensive disorders controlled through treatment during this pregnancy.

Code 1 Eclampsia
Eclampsia is characterised by grand mal seizures, hypertension, proteinuria, oedema and may progress to coma. Before a seizure, a patient may experience a body temperature of over 40°C, anxiety, epigastric pain, severe headache and blurred vision. Complications of eclampsia may include cerebral haemorrhage, pulmonary oedema, renal failure, abruptio placentae and temporary blindness (NCCH 2000).

Code 2 Pre-eclampsia
Pre-eclampsia is a multi-system disorder characterised by hypertension and involvement of one or more other organ systems and/or the fetus. Proteinuria is the most commonly recognised additional feature after hypertension but should not be considered mandatory to make the clinical diagnosis.

A diagnosis of pre-eclampsia can be made when hypertension arises after 20 weeks gestation and is accompanied by one or more of the following: renal involvement, haematological involvement, liver involvement, neurological involvement, pulmonary oedema, fetal growth restriction, placental abruption.

Includes HELLP syndrome (Haemolysis, Elevated Liver Enzymes, Low Platelet count), which is a variant of pre-eclampsia.

Code 3 Gestational hypertension
Gestational hypertension is characterised by the new onset of hypertension

after 20 weeks gestation without any maternal or fetal features of pre-eclampsia, followed by return of blood pressure to normal within 3 months post-partum.

Code 4 Chronic hypertension
This may include essential or secondary hypertension. Essential hypertension is defined by a blood pressure greater than or equal to 140 mmHg systolic and/or greater than or equal to 90 mmHg diastolic confirmed before pregnancy or before 20 completed weeks gestation without a known cause. It may also be diagnosed in females presenting early in pregnancy taking antihypertensive medications where no secondary cause for hypertension has been determined.

Important secondary causes of chronic hypertension in pregnancy include:

- chronic kidney disease, e.g. glomerulonephritis, reflux nephropathy, and adult polycystic kidney disease
- renal artery stenosis
- systemic disease with renal involvement, e.g. diabetes mellitus or systemic lupus erythematosus
- endocrine disorders, e.g. phaeochromocytoma, Cushing's syndrome and primary hyperaldosteronism
- coarctation of the aorta.

In the absence of any of the above conditions it is likely that a female with high blood pressure in the first half of pregnancy has essential hypertension.

For all other values, diagnosis is to be based on Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) Guideline for the Management of Hypertensive Disorders of Pregnancy (Lowe et al. 2014). If the clinician does not have information as to whether the above guidelines have been used, available information about diagnosis of hypertensive disorder is still to be reported.

The diagnosis is preferably derived from and substantiated by clinical documentation, which should be reviewed at the time of delivery. However, this information may not be available in which case the patient may self-report to the clinician that they have been diagnosed with a hypertensive disorder

Code 7 Hypertension, not further specified
Report only when the woman reports hypertension, but no further details are available about the type of hypertensive disorder or whether it arose during this pregnancy.

Up to three (3) codes from the valid code set can be reported:

- for a woman who has preeclampsia superimposed on chronic hypertension, report both Code 2 and Code 4;
- for a woman who develops gestational hypertension which progresses to eclampsia, record both Code 1 and Code 3.

Code 8 No hypertensive disorder during this pregnancy
Report if the woman does not have a hypertensive disorder during this pregnancy

Codes 3 and 4 are not to be reported together.

Code 7 is not to be reported with code 3 or code 4.

Neither Code 8 nor Code 9 can be reported with any other code.

Report consistently with ICD-10-AM codes in clinical data fields:

Reporting hypertensive disorders in this 'Hypertensive disorder during pregnancy' data item does not preclude also reporting the same condition in one or more of the clinical data fields as an ICD-10-AM code.

For example, a woman has an unplanned caesarean due to developing severe pre-eclampsia: report both:
code 2 Pre-eclampsia in this Hypertensive disorder during pregnancy field,
and
ICD-10-AM code O141 in the Indication for operative delivery (main reason) – ICD-10-AM code field.

When reporting hypertensive disorders in any of the clinical data fields using ICD-10-AM codes, use the following codes to report hypertensive disorders consistently with the disorder(s) reported in this 'Hypertensive disorder during pregnancy' field:

Code	Hypertensive disorder	ICD-10-AM code
1	Eclampsia in pregnancy	O150
1	Eclampsia in labour	O151
1	Eclampsia in the puerpium	O152
1	Eclampsia, unspecified as to time period	O159
2	Mild to moderate pre-eclampsia	O140
2	Severe pre-eclampsia	O141
2	HELLP syndrome	O142
2	Pre-eclampsia, unspecified	O149
3	Gestational/pregnancy-induced hypertension	O13
4	Chronic hypertension (without pre-eclampsia)	O10
4	Pre-existing hypertension in pregnancy, childbirth and the puerperium	O10
7	Hypertension, not further specified	O16
2 & 4	Pre-eclampsia superimposed on chronic hypertension	O11
1 & 3	Eclampsia in labour following gestational hypertension	O13 & O151

When reporting any of the above ICD-10-AM codes in any of the clinical data fields, the type of hypertensive disorder(s) must be reported consistently with the disorder(s) reported in this 'Hypertensive disorder during pregnancy' field, and in any other of the clinical data fields.

	For example, do not report code O13 (Gestational hypertension) in Obstetric complications and O10 (Chronic hypertension) in Maternal medical conditions. Only combinations consistent with the combinations acceptable in this 'Hypertensive disorders during pregnancy' field are acceptable. When code 8 No hypertensive disorder during this pregnancy is reported in this Hypertensive disorder during pregnancy field, none of the ICD-10-AM codes listed above may be reported in any of the clinical data fields reported as ICD-10-AM codes. Valid combinations of codes in this field, and ICD-10-AM codes in clinical data fields, are set out in the business rule 'Hypertensive disorder during pregnancy, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complications – ICD-10-AM code, Postpartum complications – ICD-10-AM code valid combinations'.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Hypertensive disorder during pregnancy
Related data items (this section):	Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indication for operative delivery (main reason) – ICD-10-AM code; Maternal medical conditions – ICD-10-AM code; Obstetric complication – ICD-10-AM code; Postpartum complications – ICD-10-AM code
Related business rules (Section 4):	Hypertensive disorder during pregnancy, Events of labour and birth – ICD-10-AM code, Indication for induction (main reason) – ICD-10-AM code, Indication for operative delivery (main reason) – ICD-10-AM code, Maternal medical conditions – ICD-10-AM code, Obstetric complication – ICD-10-AM code, Postpartum complications – ICD-10-AM code valid combinations; Mandatory to report data items

Administration

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

Indication for induction (main reason) – ICD-10-AM code

Specification

Definition	The main reason given for an induction of labour		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (X1)
Location	Episode record	Position	71
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>. A small number of additional codes have been created solely for VPDC reporting in this data element: **Code Descriptor** O480 Social induction (when documented as such) Z8751 Past history of shoulder dystocia Z8752 Past history of third or fourth degree perineal tear		
Reporting guide	Report where a medical or surgical induction is performed for the purpose of stimulating and establishing labour in a mother who has not started labour spontaneously.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where an induction was performed		
Related concepts (Section 2):	Induction		
Related data items (this section):	Indications for induction (other) – free text		
Related business rules (Section 4):	Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; Labour type, Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations		

Administration

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

Indications for induction (other) – free text

Specification

Definition	Any other reasons given for an induction of labour		
Representation class	Text	Data type	String
Format	A(50)	Field size	50
Location	Episode record	Position	70
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters A small number of additional codes have been created solely for VPDC reporting in this data element: **Code Descriptor** O480 Social induction (when documented as such) Z8751 Past history of shoulder dystocia Z8752 Past history of third or fourth degree perineal tear		
Reporting guide	Report any other indications for induction in this field.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where an induction was performed and there is more than one indication for the induction.		
Related concepts (Section 2):	Induction		
Related data items (this section):	Indication for induction (main reason) – ICD-10-AM code		
Related business rules (Section 4):	Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; Labour type, Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2020
Codeset source	Not applicable	Collection start date	1999

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

Specification

Definition	The main reason given for an operative birth		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5
Location	Episode record	Position	76
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>. A small number of additional codes have been created solely for VPDC reporting in this data element: **Code Descriptor** Z8751 Past history of shoulder dystocia Z8752 Past history of third or fourth degree perineal tear		
Reporting guide	Report the main reason for operative delivery as an ICD-10-AM code. Report the 'main reason' for the operative birth by reporting in this field a single ICD-10-AM code for each birth in which Method of birth code is reported as one of: 1 Forceps 4 Planned caesarean – no labour 5 Unplanned caesarean – labour 6 Planned caesarean – labour 7 Unplanned caesarean – no labour 8 Vacuum extraction 10 Other operative birth		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth		
Related concepts (Section 2):	Operative delivery; Procedure		
Related data items (this section):	Indications for operative delivery (other) – free text; Method of birth		
Related business rules (Section 4):	Labour type 'Failed induction' conditionally mandatory data items; Method of birth, Indications for operative delivery (other) – free text and Indication for operative delivery (main reason) – ICD-10-AM code valid combinations		

Administration

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

Indications for operative delivery (other) – free text

Specification

Definition	Any other reason(s) given for an operative birth		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	75
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number or ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters A small number of additional codes have been created solely for VPDC reporting in this data element: **Code Descriptor** Z8751 Past history of shoulder dystocia Z8752 Past history of third or fourth degree perineal tear		
Reporting guide	Must report in the data item 'Indication for operative delivery (main reason) a single ICD-10-AM code to indicate the 'main reason' for operative birth when Method of birth code is reported as one of: 1 Forceps 4 Planned caesarean – no labour 5 Unplanned caesarean – labour 6 Planned caesarean – labour 7 Unplanned caesarean – no labour 8 Vacuum extraction 10 Other operative birth Report any other indications for operative delivery in this field, in order from the most to least influential in making the decision.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where method of delivery is caesarean section, forceps or vacuum extraction (ventouse) or other operative birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Indication for operative delivery (main reason) – ICD-10-AM code; Method of birth		

Related business rules (Section 4):	Labour type ‘Failed induction’ conditionally mandatory data items; Method of birth, Indication for operative delivery (main reason) – ICD-10-AM code and Indications for operative delivery (other) – free text valid combinations

Administration

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

Indigenous status – baby

Specification

Definition	Whether a person identifies their baby as being of Aboriginal or Torres Strait Islander origin.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	20

Permissible values

Code	Descriptor
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
8	Question unable to be asked
9	Not stated / inadequately described

Reporting guide

This information must be collected for every birth, regardless of the data collector's perceptions based on appearance or other factors. Software must not be set up to input a default code.

To collect Indigenous status – baby, it is suggested the parents are asked the following questions:

Question 1: Is this baby's mother of Aboriginal or Torres Strait Islander origin, or both?

If the response is 'no', ask Question 2:

Question 2: Is this baby's father of Aboriginal or Torres Strait Islander origin, or both?

If the response to Questions 1 and 2 are both 'no', record code 4 for this baby; no further questions.

If the response to either Question 1 or Question 2 is 'yes', record the appropriate code (1, 2 or 3 respectively) to reflect those responses for the baby, and confirm this response with the parents.

Code 8 Question unable to be asked should only be used under the following circumstances:
- when the patient's medical condition prevents the question of Indigenous status being asked
- in the case of an unaccompanied child who is too young to be asked their Indigenous status.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified

Related data items (this section):	Indigenous status – mother
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009 2. July 2021
Codeset source	NHDD (DH modified)	Collection start date	2009

Indigenous status – mother

Specification

Definition	Whether a person (mother) identifies as being of Aboriginal or Torres Strait Islander origin.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	19

Permissible values

Code	Descriptor
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
8	Question unable to be asked
9	Not stated / inadequately described

Reporting guide

This information must be collected for every birth, regardless of the data collector's perceptions based on appearance or other factors. Software must not be set up to input a default code.

To collect Indigenous status – mother, it is suggested the questions are asked as follows:

Question 1: Are you of Aboriginal or Torres Strait Islander origin?

If the response is 'no', record code 4; no further questions.

If the response is 'yes', ask Question 2:

Question 2: Are you of Aboriginal origin, Torres Strait Islander origin, or both?

Record the appropriate code (1, 2 or 3 respectively) to reflect the response.

Code 8 Question unable to be asked should only be used under the following circumstances:
- when the patient's medical condition prevents the question of Indigenous status being asked.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Indigenous status – baby

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1999 3. January 2009 4. July 2021
Codeset source	NHDD (DH modified)	Collection start date	1982

Influenza vaccination status

Specification

Definition	Whether or not the mother has received an influenza vaccine(s) during this pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	125
Permissible values	**Code** **Descriptor** 1 Influenza vaccine(s) received at any time during this pregnancy 2 Influenza vaccine not received at any time during this pregnancy 9 Not stated / inadequately described		
Reporting guide	Report the statement that best describes the woman's understanding of her influenza vaccine status for this pregnancy. Report code 2 Influenza vaccine not received at any time during this pregnancy, if the vaccination was received prior to this pregnancy		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. July 2015 2. July 2022
Codeset source	DH	Collection start date	1 July 2015

Labour induction/augmentation agent

Specification

Definition	Agents used to induce or assist in the progress of labour		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x4)
Location	Episode record	Position	68

Permissible values

Code	Descriptor
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Cervical Ripening – balloon catheter
8	Other – specify
9	Not stated/inadequately described

Reporting guide

Report up to four codes.

Code 2 Prostaglandins: includes misoprostil

Code 4 Cervical Ripening – balloon catheter:
includes all catheter types

Code 8 Other – specify:
if code 8 is reported, specify the agent of induction or augmentation in Labour induction/augmentation agent – other specified description

If labour is not induced or augmented do not report a value, leave blank.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where labour was induced or augmented
Related concepts (Section 2):	Augmentation, Labour type
Related data items (this section):	Indication for Induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Labour induction / augmentation agent – other specified description
Related business rules (Section 4):	Labour induction / augmentation agent and Labour induction / augmentation agent – other specified description – conditionally mandatory data item; Labour type and Labour induction / augmentation agent valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2017
Codeset source	METeOR 270037	Collection start date	1999

Labour induction/augmentation agent – other specified description

Specification

Definition	The agent used to induce or augment labour		
Representation class	Text	Data type	String
Format	A(20)	Field size	20
Location	Episode record	Position	69
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Specify the type of Labour induction/augmentation agent as free text.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	When Labour induction/augmentation agent code 8 other – specify is reported		
Related concepts (Section 2):	None specified		
Related data items (this section):	Labour induction/augmentation agent		
Related business rules (Section 4):	Labour induction/augmentation agent and Labour induction/augmentation agent – other specified description conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Labour type

Specification

Definition	The manner in which labour starts in a birth event		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x3)
Location	Episode record	Position	67

Permissible values

Code	Descriptor
1	Spontaneous
2	Induced - medical
3	Induced – surgical
4	Augmented
5	No labour
9	Not stated / inadequately described

Reporting guide

Labour commences at the onset of regular uterine contractions which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostoglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

A combination of up to three valid codes can be reported.

- Spontaneous: labour occurs naturally without any intervention.
- Induction of labour: a procedure performed for the purpose of initiating and establishing labour, either medically and/or surgically and/or mechanically.
  - Medical includes prostaglandins, oxytocins, cervical ripening – balloon catheter or other hormonal derivatives (eg cervidal, misoprostyl).
  - Surgical is the artificial rupture of membranes (ARM) either by hindwater or forewater rupture.
- Augmentation of labour: spontaneous onset of labour complemented with the use of drugs such as oxytocins, prostaglandins or their derivatives, and/or artificial rupture of membranes (ARM) either by hindwater or forewater rupture. If labour was augmented, select and record both spontaneous and augmented in Labour type.
  Code 4 Augmented cannot be reported on its own.
- No labour: indicates the total absence of labour, as in an elective caesarean or a failed induction. If a failed induction occurred, that is, the mother failed to establish labour, select both the induction type (medical, surgical or both) and no labour.

An induction, medical and/or surgical, cannot be recorded with augmentation. If an induction has occurred, record the reason in Indication for induction (main reason) – ICD-10-AM code.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Labour type
Related data items (this section):	Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Labour induction / augmentation agent; Labour induction / augmentation agent – other specified description; Method of birth
Related business rules (Section 4):	Labour type 'Failed induction' conditionally mandatory data items; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations; Labour type and Labour induction/augmentation agent valid combinations; Labour type, Indication for induction (main reason) – ICD-10-AM code and Indications for induction (other) – free text valid combinations; Mandatory to report data items; Method of birth and Labour type valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. July 2015
Codeset source	NHDD (DH Modified)	Collection start date	1982

Last birth – caesarean section indicator

Specification

Definition	An indicator of whether a caesarean section was performed for the most recent previous pregnancy that resulted in a birth.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	44
Permissible values	Code Descriptor 1 Last birth was caesarean section 2 Last birth was not caesarean section 9 Not stated / inadequately described		
Reporting guide	Previous birth includes live birth, stillbirth or neonatal death. Only relates to the last birth, not the last pregnancy when the outcome of last pregnancy was an abortion or ectopic pregnancy. Do not report a value for episodes where the mother has not had a previous birth.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Episodes where the mother has had a previous birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Total number of previous caesareans		
Related business rules (Section 4):	Gravidity ‘Multigravida’ conditionally mandatory data items; Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1999 2. January 2009 3. July 2015
Codeset source	NHDD (DH Modified)	Collection start date	1999

Last feed before discharge taken exclusively from the breast

Specification

Definition	Whether the last feed prior to discharge was taken exclusively from the breast, with no complementary feeding of any kind		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	117
Permissible values	**Code** **Descriptor** 1 Last feed before discharge taken exclusively from breast 2 Last feed before discharge not taken exclusively from breast 9 Not stated / inadequately described		
Reporting guide	Discharge in the context of this data element means the end of the birth episode. This encompasses discharge to home, died and transfer to another hospital. Do not report a value for stillbirth episodes, leave blank. Code 1 Last feed before discharge taken exclusively from breast: includes when the baby took the entire last feed prior to discharge directly from the breast. Can include the use of a nipple shield. Code 2 Last feed before discharge not taken exclusively from breast: includes any expressed breast milk or formula given at the last feed before discharge from hospital, whether by cup, spoon, gavage or by any other means.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All live birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Breastfeeding attempted		
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations; Birth status, Breastfeeding attempted and Last feed before discharge taken exclusively from the breast valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009
Codeset source	NHDD	Collection start date	2009

Main reason for excessive blood loss following childbirth

Specification

Definition	Report the main reason for excessive blood loss in the first 24 hours following childbirth.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	146

Permissible values

Code	Descriptor
1	Uterine atony
2	Trauma
3	Placental insertion abnormality
4	Coagulopathy or haematological disorder
5	Other
9	Not stated / inadequately described

Reporting guide

Report the statement that best describes the main reason for excessive blood loss in the first 24 hours following childbirth.

Code 2 Trauma
includes tear/s to labia, perineum, cervix, uterus; episiotomy; accidental injury during caesarean section eg extension of abdominal incision

Code 3 Placental insertion abnormality
includes retained placenta; placenta accreta/increta/percreta; other placental abnormality

Code 4 Coagulopathy or haematological disorder
includes disseminated intravascular coagulation (DIC), haematological disorder; retroperitoneal haemorrhage

Conditions indicated by reporting code 1, 2, 3, 4 or 5 should also be reported using appropriate ICD-10-AM code/s or free text entry in one or more of the following data elements, as relevant:

- Events of labour and birth – ICD-10-AM code;
- Events of labour and birth – free text;
- Postpartum complications – ICD-10-AM code and/or
- Postpartum complications – free text

and, where appropriate, using the relevant codes in other data elements:

- Blood loss assessment – indicator
- Episiotomy – indicator
- Perineal/genital laceration – degree/type
- Perineal laceration – indicator
- Perineal laceration – repair

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where Blood loss (ml) is reported as 500 or more
Related concepts (Section 2):	Primary postpartum haemorrhage
Related data items (this section):	Blood loss (ml); Blood loss assessment – indicator; Episiotomy – indicator; Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Perineal/genital laceration – degree/type; Perineal laceration – indicator; Perineal laceration – repair; Postpartum complications – free text; Postpartum complications – ICD-10-AM code
Related business rules (Section 4):	Blood loss (ml) and Main reason for excessive blood loss following childbirth – valid combinations

Administration

Principal data users	Consultative Council on Obstetric Paediatric Mortality and Morbidity		
Definition source	DH	Version	1 January 2020
Codeset source	DH	Collection start date	2020

Manual removal of placenta

Specification

Definition	Whether the placenta was manually removed		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	84

Permissible values

Code	Descriptor
1	Placenta manually removed
2	Placenta not manually removed
9	Not stated / inadequately described

Reporting guide	This includes the placenta that is trapped behind the cervix by an oxytocic contraction and requires the placenta to be removed by inserting the hand through the cervix. If method of birth is via caesarean section, do not report a value, leave blank.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes, except for those who delivered via caesarean section
Related concepts (Section 2):	None specified
Related data items (this section):	Method of birth
Related business rules (Section 4):	Method of birth and Manual removal of placenta conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Marital status

Specification

Definition	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		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	21

Permissible values

Code	Descriptor
1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married
6	De facto
9	Not stated / inadequately described

Reporting guide	Report the current marital status of the mother
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Date of birth – mother
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	NHDD (DH Modified)	Collection start date	1982

Maternal alcohol use at less than 20 weeks

Specification

Definition	A self-reported indicator of alcohol frequency intake at any time during the first 20 weeks of her pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	135

Permissible values

Code	Descriptor
1	Never
2	Monthly or less
3	2-4 times a month
4	2-3 times a week
5	4 or more times a week
9	Not stated / inadequately described

Reporting guide	Report the statement that best describes maternal alcohol use behaviour during pregnancy before 20 weeks gestation
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Maternal alcohol volume intake at less than 20 weeks
Related business rules (Section 4):	Mandatory to report data items; Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 or more weeks valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019
Codeset source	DH	Collection start date	2019

Maternal alcohol use at 20 or more weeks

Specification

Definition	A self-reported indicator of alcohol frequency at 20 or more weeks of her pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	137

Permissible values

Code	Descriptor
1	Never
2	Monthly or less
3	2-4 times a month
4	2-3 times a week
5	4 or more times a week
9	Not stated / inadequately described

Reporting guide	Report the statement that best describes maternal alcohol use behaviour at 20 or more weeks gestation
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Maternal alcohol volume intake at 20 or more weeks
Related business rules (Section 4):	Mandatory to report data items; Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 or more weeks valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019
Codeset source	DH	Collection start date	2019

Maternal alcohol volume intake at less than 20 weeks

Specification

Definition	A self-reported indicator of alcohol volume intake at any time during the first 20 weeks of her pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	136
Permissible values	**Code** **Descriptor** 1 1 or 2 standard drinks 2 3 or 4 standard drinks 3 5 or 6 standard drinks 4 7 to 9 standard drinks 5 10 or more standard drinks 9 Not stated / inadequately described		
Reporting guide	Report the average amount of standard drinks consumed per occasion when drinking		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes who report any alcohol intake in the first 20 weeks of pregnancy		
Related concepts (Section 2):	None specified		
Related data items (this section):	Maternal alcohol use at less than 20 weeks		
Related business rules (Section 4):	Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 or more weeks valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019
Codeset source	DH	Collection start date	2019

Maternal alcohol volume intake at 20 or more weeks

Specification

Definition	A self-reported indicator of alcohol volume intake at 20 or more weeks of her pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	138
Permissible values	**Code** **Descriptor** 1 1 or 2 standard drinks 2 3 or 4 standard drinks 3 5 or 6 standard drinks 4 7 to 9 standard drinks 5 10 or more standard drinks 9 Not stated / inadequately described		
Reporting guide	Report the average amount of standard drinks consumed per occasion when drinking		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes who report any alcohol intake at 20 or more weeks' gestation		
Related concepts (Section 2):	None specified		
Related data items (this section):	Maternal alcohol use at 20 or more weeks		
Related business rules (Section 4):	Maternal alcohol use at less than 20 weeks, Maternal alcohol use at 20 or more weeks, Maternal alcohol volume intake at less than 20 weeks, Maternal alcohol volume intake at 20 or more weeks valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2019
Codeset source	DH	Collection start date	2019

Maternal medical conditions – free text

Specification

Definition	Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	49
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Report conditions in this field when there is no ICD-10-AM code available for selection in the software. Only record conditions that affected the care or surveillance of this pregnancy. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded. Do not report past operations such as appendicectomy, knee reconstruction that do not affect or have not occurred during this pregnancy.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where a maternal medical condition is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	Not applicable	Collection start date	1982

Maternal medical conditions – ICD-10-AM code

Specification

Definition	Pre-existing maternal diseases and conditions that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (x12)
Location	Episode record	Position	50
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>. An additional code has been created solely for VPDC reporting in this data element: **Code Descriptor** Z9884 Bariatric surgery status		
Reporting guide	Only record conditions that affected the care or surveillance of this pregnancy. Examples of maternal medical conditions include past history of a hydatidiform mole, rheumatoid arthritis, asthma, deafness, polycystic ovaries and multiple sclerosis. Transient conditions such as depression or UTI that are completely resolved prior to this pregnancy should not be recorded. Do not report past operations such as appendectomy, knee reconstruction, which do not affect or have not occurred during this pregnancy. When pregnancy-related renal disease, psychosocial problem or disease of the circulatory system (cardiac condition) is reported, also report the specified condition in this field or in the Maternal medical conditions – free text field.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where a maternal medical condition is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	Maternal medical conditions – free text		

Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Date of admission – mother and Date of birth – baby conditionally mandatory data items

Administration

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

Maternal smoking at less than 20 weeks

Specification

Definition	A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	31
Permissible values	**Code** **Descriptor** 1 No smoking at all before 20 weeks of pregnancy 2 Quit smoking during pregnancy (before 20 weeks) 3 Continued smoking before 20 weeks of pregnancy 9 Not stated / inadequately described		
Reporting guide	Report the statement that best describes maternal smoking behaviour before 20 weeks' gestation. Code 2 Quit smoking during pregnancy (before 20 weeks): Describes the mother who ceased smoking on learning she was pregnant or gave up prior to the 20 week gestation. This does not include mothers who give up smoking prior to falling pregnant.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Maternal smoking at more than or equal to 20 weeks		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD (DH modified)	Version	1. January 2009 2. July 2015
Codeset source	DH	Collection start date	2009

Maternal smoking at more than or equal to 20 weeks

Specification

Definition	The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth.		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	32
Permissible values	Range: zero to 97 (inclusive) **Code** **Descriptor** 98 Occasional smoking (less than one) 99 Not stated / inadequately described		
Reporting guide	Data should be collected after the birth. After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (>=20 weeks + 0 days). 'Usually' is defined as 'according to established or frequent usage, commonly, ordinarily, as a rule'. If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting. If the woman smokes tobacco, but not cigarettes, estimate the number of cigarettes that would approximate the amount of tobacco used, for example, in a pipe.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD (DH modified)	Version	1. January 2009 2. July 2015
Codeset source	DH	Collection start date	2009

Maternity model of care – antenatal

Specification

Definition	The Maternity model of care a woman received for the majority of pregnancy care		
Representation class	Code	Data type	Number
Format	NNNNNN	Field size	6
Location	Episode record	Position	164

Permissible values

Code	Description
NNNNNN	Maternity model of care for the majority of this pregnancy
999994	Planned homebirth with care from a registered private homebirth midwife
999997	No antenatal care received by the woman for this pregnancy
988888	Majority of antenatal care at a hospital interstate
988899	Majority of antenatal care at a health service outside Australia
999999	Not stated stated/inadequately described

Reporting guide

NNNNNN
Report the six-digit unique Model of care code from the Maternity Care Classification System (MaCCS) that represents the model of care the woman received for the majority of her pregnancy care, as determined by the number of antenatal visits within that Model of care.

Where the number of antenatal visits is equal for more than one Model of care, the referring Model of care should be reported. For example, if the woman was in a low-risk GP shared care model for 6 antenatal visits and then developed hypertension and pre-eclampsia and was referred to a high-risk model for 6 antenatal visits, the GP shared care should be reported.

Report this data item after the birth, to ensure all antenatal care is represented.

Where the majority of the woman's antenatal care was provided at a health service other than the one where the birth occurred, report the relevant code of the model of care for the health service that provided the antenatal care. Maternity models of care for all health services in Australia are listed on the MaCCS DCT website. Where that other hospital was interstate, and no further details are available, report the supplementary code 988888.

Report only a code that has been valid for the duration of the care it represents, and is listed for that period for the health service campus where that antenatal care was provided, as found at the MaCCS DCT website.

Maternity model of care codes can be found at the AIHW's MaCCS DCT website <https://maccs.aihw.gov.au>

999994
Planned homebirth with care from a registered private homebirth midwife. If

	this care is provided by a registered homebirth midwife through a public hospital, report the code for the relevant Maternity model of care for that public hospital. Refer to the MaCCS DCT website. 999997 Report if no antenatal care was received by the woman for this pregnancy, or where an informal plan was in place with a carer who is not a registered private homebirth midwife 988888 Report where the majority of antenatal care was provided by a health service interstate, and no further details of the Maternity model of care at that hospital are available 988899 Report where the majority of antenatal care was provided by a health service outside Australia 999999 Not stated stated/inadequately described. Should be used only in exceptional circumstances, such as where the woman is unconscious and cannot provide any details of her antenatal care or plan
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Maternity model of care – at onset of labour or non-labour caesarean section
Related business rules (Section 4):	Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations; Mandatory to report data items; Model of care code is invalid

Administration

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

Maternity model of care – at onset of labour or non-labour caesarean section

Specification

Definition	The Maternity model of care a woman is under at the onset of labour or at the time of non-labour caesarean section		
Representation class	Code	Data type	Number
Format	NNNNNN	Field size	6
Location	Episode record	Position	165

Permissible values

Code	Description
NNNNNN	Maternity model of care at the time of onset of labour or non-labour caesarean section
999994	Planned homebirth with care from a registered private homebirth midwife
999997	No antenatal care received by the woman for this pregnancy
988888	Majority of antenatal care at a hospital interstate
988899	Majority of antenatal care at a health service outside Australia
999999	Not stated stated/inadequately described

Reporting guide

NNNNNN

Report the six-digit unique Model of care code from the Maternity Care Classification System (MaCCS) that represents the model of care the woman is under at the onset of labour or at the time of non-labour caesarean section.

This may or may not be the same Model of care as reported in the Maternity model of care – antenatal. For example, if the woman was in a low-risk GP shared care model for most of this pregnancy, but towards the end of this pregnancy developed hypertension and pre-eclampsia and was referred to a high-risk model, the high-risk model should be reported as it is current at the time of onset of labour or non-labour caesarean section.

Report this data item after the birth.

Where antenatal care was provided at a health service other than the one where the birth occurred, report the relevant code of the model of care for the health service that provided the antenatal care. Maternity models of care for all health services in Australia are listed on the MaCCS DCT website.

If the birth occurred at a location that was not planned, whether at a health service, in transit or born elsewhere before arrival at a health service, and the woman had a Maternity model of care at the time of the onset of labour or non-labour caesarean section, report the code for that model of care, including if it is for another health service.

Report only a code that is valid at the time of the birth, as found at the MaCCS DCT website.

	Maternity models of care can be found at the AIHW's MaCCS DCT website <https://maccs.aihw.gov.au>. 999994 Planned homebirth with care from a registered private homebirth midwife. If this care is provided by a registered homebirth midwife through a public hospital, report the code for the relevant Maternity model of care for that public hospital. Refer to the MaCCS DCT website. 999997 Report if no antenatal care was received by the woman at the onset of labour or non-labour caesarean section, or where an informal plan was in place with a carer who is not a registered private homebirth midwife 988888 Report where the majority of antenatal care was provided by a health service interstate, and no further details of the Maternity model of care at that hospital are available 988899 Report where the plan at onset of labour or non-labour caesarean section had been provided by a health service outside Australia 999999 Not stated stated/inadequately described. Should be used only in exceptional circumstances, such as where the woman is unconscious and cannot provide any details of Maternity model of care at onset of labour or non-labour caesarean section.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Maternity model of care – antenatal
Related business rules (Section 4):	Maternity model of care – antenatal, Maternity model of care – at onset of labour or non-labour caesarean section and Number of antenatal care visits valid combinations; Mandatory to report data items; Model of care code is invalid

Administration

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

Method of birth

Specification

Definition	The method of complete expulsion or extraction from the woman of a product of conception in a birth event		
Representation class	Code	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	74

Permissible values

Code	Descriptor
1	Forceps
3	Vaginal birth – non-instrumental
4	Planned caesarean – no labour
5	Unplanned caesarean – labour
6	Planned caesarean – labour
7	Unplanned caesarean – no labour
8	Vacuum extraction
9	Not stated / inadequately described
10	Other operative birth

Reporting guide

In the case of multiple births, the method of birth is reported in each baby's episode record.

Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.

Code 1 Forceps:
Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the head during breech presentations. Includes vaginal breech with forceps to the aftercoming head

Code 3 Vaginal birth – non-instrumental:
Includes manual assistance for example, a vaginal breech that has been manually rotated

Code 4 Planned caesarean – no labour:
Caesarean takes place as a planned procedure before the onset of labour

Code 5 Unplanned caesarean – labour*:
Caesarean is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced.

Code 6 Planned caesarean – labour:
Caesarean was a planned procedure, but occurs after spontaneous onset of labour

Code 7 Unplanned caesarean – no labour*:
Procedure is undertaken for an urgent indication before the onset of labour.

	Code 10 Other operative birth Includes D&C, D&E, hysterotomy and laparotomy; Excludes operative methods of birth for which a specific code exists. *Note: for Unplanned caesarean (codes 5 or 7): if a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate. In this situation also report: - Category of unplanned caesarean section urgency AND - Date of decision for unplanned caesarean section AND - Time of decision for unplanned caesarean section.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Anaesthesia for operative delivery – indicator, Anaesthesia for operative delivery – type, Analgesia for labour – indicator, Analgesia for labour – type; Category of unplanned caesarean section urgency; Date of decision for unplanned caesarean section; Time of decision for unplanned caesarean section
Related business rules (Section 4):	Anaesthesia for operative delivery – indicator and Method of birth valid combinations; Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type and Perineal laceration – indicator conditional reporting; Episiotomy – indicator and Method of birth valid combinations; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations; Mandatory to report data items; Manual removal of placenta and Method of birth conditionally mandatory data items; Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data item; Method of birth and Labour type valid combinations; Method of birth and Manual removal of placenta conditionally mandatory data item; Method of birth and Setting of birth – actual valid combinations; Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations; Perineal laceration – indicator and Method of birth valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1999 3. January 2009

			4. June 2015 5. July 2021
Codeset source	NHDD (DH Modified)	Collection start date	1982

Middle name – mother

Specification

Definition	The middle name of the mother		
Representation class	Text	Data type	String
Format	A(40)	Field size	40
Location	Episode record	Position	10
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	The middle name of the patient. Permitted characters: A to Z, space, apostrophe and hyphen. The first character must be an alpha character.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes when applicable		
Related concepts (Section 2):	None specified		
Related data items (this section):	First given name – mother; Surname/family name – mother		
Related business rules (Section 4):	None specified		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Name of software

Specification

Definition	Name of the software used by the hospital		
Representation class	Identifier	Data type	String
Format	A(10)	Field size	10
Location	Header record	Position	Not applicable
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Software-system generated.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	None specified		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Neonatal morbidity – free text

Specification

Definition	Illness and/or birth trauma experienced by the baby up to the time of discharge		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	111
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number or ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Report conditions in this field when there is no ICD-10-AM code available for selection in the software. Excludes congenital anomalies. Morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU. Examples include jaundice requiring phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections. It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates, record all associated morbidity.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where neonatal morbidity is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	Neonatal morbidity – ICD-10-AM code		
Related business rules (Section 4):	Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items; Date of birth – baby and Separation date – baby conditionally mandatory data items; Estimated gestational age conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	Not applicable	Collection start date	1982

Neonatal morbidity – ICD-10-AM code

Specification

Definition	Illness and/or birth trauma experienced by the baby up until the time of discharge		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (x10)
Location	Episode record	Position	112
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.		
Reporting guide	Excludes congenital anomalies. Morbidity or conditions (excluding congenital anomalies) that necessitate special care or medications in the ward, SCN or NICU. Examples include jaundice requiring phototherapy, respiratory distress, excessive weight loss, hypoglycaemia, birth asphyxia, hypoxic ischaemic encephalopathy, intraventricular haemorrhage and eye infections. It is expected that babies who have been admitted to a SCN and/or NICU will report at least one neonatal morbidity or congenital anomaly. For extreme premature and premature neonates record all associated morbidity.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where neonatal morbidity is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	Neonatal morbidity – free text		
Related business rules (Section 4):	Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby conditionally mandatory data items; Date of birth – baby and Separation date – baby conditionally mandatory data items; Estimated gestational age conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. January 1999 3. January 2009 4. July 2015 5. January 2020 6. July 2022

Codeset source	ICD-10-AM/ACHI 12th edition plus CCOPMM additions	Collection start date	1982

Number of antenatal care visits

Specification

Definition	The total number of antenatal care visits attended by a pregnant female		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	124
Permissible values	Range: zero to 30 (inclusive)		
	Code **Descriptor**		
	99 Not stated / inadequately described		
Reporting guide	Antenatal care visits are attributed to the pregnant woman. In rural and remote locations where a midwife or doctor is not employed, registered Aboriginal health workers and registered nurses may perform this role within the scope of their training and skill licence. Include all pregnancy-related appointments with medical doctors where the medical officer has entered documentation related to that visit on the antenatal record. An antenatal care visit does not include a visit where the sole purpose of contact is to confirm the pregnancy only, or those contacts that occurred during the pregnancy that related to other non-pregnancy related issues. An antenatal care visit does not include a visit where the sole purpose of contact is to perform image screening, diagnostic testing or the collection of bloods or tissue for pathology testing. Exception to this rule is made when the health professional performing the procedure or test is a doctor or midwife and the appointment directly relates to this pregnancy and the health and wellbeing of the fetus. Collection methods: Collect the total number of antenatal care visits for which there is documentation included in the health record of pregnancy and/or birth. To be collected once, after the onset of labour. Include all medical specialist appointments or medical specialist clinic appointments where the provider of the service event has documented the visit on the health record. Multiple visits on the same day should be recorded as one visit.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Registered nurse		

Related data items (this section):	Discipline of antenatal care provider
Related business rules (Section 4):	Discipline of antenatal care provider and Number of antenatal care visits valid combinations; Gestational age at first antenatal care visit and Number of antenatal care visits valid combinations; Mandatory to report

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. July 2015
Codeset source	NHDD	Collection start date	July 2015

Number of records following

Specification

Definition	The total numbers of records in the submission file		
Representation class	Total	Data type	Number
Format	N[NNNN]	Field size	5
Location	Header record	Position	Not applicable
Permissible values	Range: one to 99999 (inclusive)		
Reporting guide	Software-system generated. This is the total number of records, excluding the header record, in a VPDC electronic submission file. The submission file will be rejected and not be processed by VPDC if the number of records following in the header record does not match the actual count of the relevant records.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	None specified		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Obstetric complications – free text

Specification

Definition	Complications arising during the pregnancy that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	51
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Report conditions in this field when there is no ICD-10-AM code available for selection in the software. Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension. Excludes conditions arising during the intrapartum period: these are to be reported in Events of labour and birth – ICD-10-AM code and/or Events of labour and birth – free text.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where an obstetric complication is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items, Date of admission – mother and Date of birth – baby conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982
Codeset source	Not applicable	Collection start date	1982

Obstetric complications – ICD-10-AM code

Specification

Definition	Complications arising during the pregnancy that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (x15)
Location	Episode record	Position	52
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>. An additional code has been created solely for VPDC reporting in this data element: **Code** **Descriptor** Z223 Carrier of streptococcus group B (GBS+)		
Reporting guide	Examples of these conditions include threatened abortion, gestational diabetes and pregnancy-induced hypertension. Excludes conditions arising during the intrapartum period: these are to be reported in Events of labour and birth – ICD-10-AM code and/or Events of labour and birth – free text		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where an obstetric complication is present		
Related concepts (Section 2):	None specified		
Related data items (this section):	Obstetric complications – free text		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items; Date of admission – mother and Date of birth – baby conditionally mandatory data items		

Administration

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

Outcome of last pregnancy

Specification

Definition	Outcome of the most recent pregnancy preceding the current pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	43

Permissible values

Code	Descriptor
1	Live birth
2	Spontaneous abortion
3	Not stated / inadequately described
4	Stillbirth
5	Induced abortion
6	Neonatal death
7	Ectopic pregnancy

Reporting guide	In the case of a multiple pregnancy with fetal loss before 20 weeks, report the outcome of the surviving fetus(es) beyond 20 weeks. In multiple pregnancies with more than one type of outcome, select the appropriate outcome based on the following hierarchy: neonatal death, stillbirth, live birth.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Birth episodes where Gravidity is greater than code 01 Primigravida
Related concepts (Section 2):	None specified
Related data items (this section):	Date of completion of last pregnancy; Gravidity; Last birth – caesarean section indicator; Total number of previous abortions – induced; Total number of previous abortions – spontaneous; Total number of previous ectopic pregnancies; Total number of previous live births; Total number of previous neonatal deaths; Total number of previous stillbirths (fetal deaths); Total number of previous unknown outcomes of pregnancy
Related business rules (Section 4):	Gravidity ‘Multigravida’ conditionally mandatory data items; Gravidity ‘Primigravida’ and associated data items valid combinations; Outcome of last pregnancy and associated data item valid combinations; Outcome of last pregnancy and Last birth – caesarean section indicator conditionally mandatory data items; Parity and associated data items valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD METeOR identifier: 270006	Version	1. January 1982 2. January 1999
Codeset source	NHDD (DH modified)	Collection start date	1982

Parity

Specification

Definition	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	35
Permissible values	Range: zero to 20 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	To calculate parity, count all previous pregnancies that resulted in a live birth or a stillbirth of at least 20 weeks gestation or at least 400 grams birth weight. Excluded from the count are: • the current pregnancy, • pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and • ectopic pregnancies. A primigravida (woman giving birth for the first time) has a parity of 00. A pregnancy with multiple fetuses is counted as one pregnancy.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Live birth, Neonatal death, Stillbirth (fetal death)		
Related data items (this section):	Gravidity; Outcome of last pregnancy; Total number of previous live births; Total number of previous neonatal deaths; Total number of previous stillbirths (fetal deaths)		
Related business rules (Section 4):	Gravidity 'Primigravida' and associated data items valid combinations; Gravidity and Parity valid combinations; Mandatory to report data items; Parity and associated data items valid combinations; Parity and related data items		

Administration

Principal data users	Consutative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD METeOR identifier: 302013	Version	1. January 2009 2. July 2015
Codeset source	NHDD	Collection start date	2009

Patient identifier – baby

Specification

Definition	An identifier, unique to the baby within the hospital or campus (patient's record number / unit record number)		
Representation class	Identifier	Data type	String
Format	A(10)	Field size	10
Location	Episode record	Position	6
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system. For planned births occurring outside the hospital system, enter the birth number or an equivalent number used to identify the mother.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where available		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Patient identifier – baby not reported		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. July 2022
Codeset source	Not applicable	Collection start date	2009

Patient identifier – mother

Specification

Definition	An identifier, unique to the mother within the hospital or campus (patient's record number / unit record number)		
Representation class	Identifier	Data type	String
Format	A(10)	Field size	10
Location	Episode record	Position	5
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

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

Perineal/genital laceration – degree/type

Specification

Definition	The degree or type of laceration/tear to the perineum and/or genital tract following birth		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x3)
Location	Episode record	Position	86

Permissible values

Code	Descriptor
1	First degree laceration/tear/vaginal graze
2	Second degree laceration/tear
3	Third degree laceration /tear
4	Fourth degree laceration /tear
5	Labial / clitoral laceration/tear
6	Vaginal wall laceration/tear
7	Cervical laceration/tear
8	Other perineal laceration, rupture or tear
0	Laceration, rupture or tear of other genital tract location
9	Not stated / inadequately described

Reporting guide

Code 1 First degree laceration/vaginal graze:
Graze, laceration, rupture or tear of the perineal skin during delivery that may be considered to be slight or that involves one or more of the following structures: fourchette, labia, periurethral tissue (excluding involvement of urethra), vagina (low), skin and / or vulva.

Code 2 Second degree laceration:
Perineal laceration, rupture or tear as in Code 1 occurring during delivery, also involving: pelvic floor, perineal muscles, vaginal muscles. Excludes lacerations involving the anal sphincter.

Code 3 Third degree laceration:
Perineal laceration, rupture or tear as in Code 2 occurring during delivery, also involving: anal sphincter, rectovaginal septum and / or sphincter not otherwise specified. Excludes laceration involving the anal or rectal mucosa.

Code 4 Fourth degree laceration:
Perineal laceration, rupture or tear as in Code 3 occurring during delivery, also involving: anal mucosa and / or rectal mucosa.

Code 8 Other perineal laceration, rupture or tear:
May include haematoma or unspecified perineal tear.

Code 0 Laceration, rupture or tear of other genital tract location:
Other genital tract location not reported by other codes, including urethra.

	Where multiple perineal lacerations, ruptures or tears of different degrees are documented, assign the code for the highest (most severe) degree only.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where the perineum is not intact following the birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Episiotomy – indicator; Method of birth; Perineal laceration – indicator; Perineal laceration – repair		
Related business rules (Section 4):	Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items		

Administration

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

Perineal laceration – indicator

Specification

Definition	The state of the perineum following birth		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	85

Permissible values

Code	Descriptor
1	Laceration/tear of the perineum following birth
2	No laceration/tear of the perineum following birth
9	Not stated / inadequately described

Reporting guide	For episiotomies extended by laceration or laceration extended by episiotomy, record Perineal laceration – indicator as code 1 Laceration of the perineum following birth and Episiotomy indicator as code 1 Incision of perineum and vagina made. Specify the degree of the tear in Perineal/genital laceration – degree/type.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Episiotomy – indicator, Method of birth; Perineal / genital laceration – degree / type; Perineal laceration – repair
Related business rules (Section 4):	Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations; Mandatory to report data items; Perineal laceration – indicator and Method of birth valid combinations; Perineal laceration – indicator and Perineal/genital laceration – degree/type conditionally mandatory data items; Perineal laceration – indicator and Perineal/genital laceration – degree/type valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1999 2. January 2009
Codeset source	DH	Collection start date	1999

Perineal laceration – repair

Specification

Definition	Whether a repair to a laceration/tear or incision to the perineum during birth was undertaken		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	87

Permissible values

Code	Descriptor
1	Repair of perineum undertaken
2	Repair of perineum not undertaken
9	Not stated / inadequately described

Reporting guide	Suturing of any injury to the perineum, including repair to perineal lacerations/tears and/or episiotomy.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes where the perineum is not intact following the birth
Related concepts (Section 2):	None specified
Related data items (this section):	Episiotomy – indicator; Method of birth; Perineal/genital laceration – degree/type; Perineal laceration – indicator
Related business rules (Section 4):	Episiotomy – indicator, Perineal laceration – indicator and Perineal laceration – repair valid combinations; Perineal laceration – indicator and Perineal / genital laceration – degree / type conditionally mandatory data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Pertussis (whooping cough) vaccination status

Specification

Definition	Whether or not the mother has received a pertussis containing vaccine during this pregnancy		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	126
Permissible values	**Code** **Descriptor** 1 Pertussis containing vaccine received at any time during this pregnancy 2 Pertussis containing vaccine not received at any time during this pregnancy 9 Not stated / inadequately described		
Reporting guide	Report the statement that best describes the woman's understanding of her pertussis (whooping cough) vaccine status for this pregnancy. If the vaccination was received prior to this pregnancy, report code 2 - Pertussis containing vaccine not received at any time during this pregnancy.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. July 2015
Codeset source	DH	Collection start date	July 2015

Plan for vaginal birth after caesarean

Specification

Definition	Where, at the time of admission to hospital for the birth, the woman planned to have a vaginal birth after one or more previous caesarean sections.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	46

Permissible values

Code	Descriptor
1	Vaginal birth after caesarean section was planned
2	Vaginal birth after caesarean section was not planned
9	Not stated / inadequately described

Reporting guide	Where a woman is planning to have a VBAC and then becomes overdue at 42 weeks and has a caesarean section, the plan for VBAC should be recorded as VBAC not planned.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	Birth episodes where total number of previous caesareans is greater than 00
Related concepts (Section 2):	None specified
Related data items (this section):	Last birth – caesarean section indicator; Total number of previous caesareans
Related business rules (Section 4):	Total number of previous caesareans and Plan for VBAC conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Postpartum complications – free text

Specification

Definition	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	91
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Report conditions in this field when there is no ICD-10-AM code available for selection in the software. Postpartum complications arising after the delivery of the placenta up until the time of separation from care.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where complications are present in the postpartum period		
Related concepts (Section 2):	None specified		
Related data items (this section):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother, Postpartum complications – ICD-10-AM code		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Postpartum complications – ICD-10-AM code

Specification

Definition	Medical and obstetric complications of the mother occurring during the postnatal period, up to the time of separation from care		
Representation class	Code	Data type	String
Format	ANN[NN]	Field size	5 (x6)
Location	Episode record	Position	92
Permissible values	Codes relevant to this data element are listed in the 12th edition ICD-10-AM/ ACHI code set, which includes VPDC-created codes. To obtain a copy of this code set, email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>.		
Reporting guide	Postpartum complications arising after the delivery of the placenta up until the time of separation from care.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where complications are present in the postpartum period		
Related concepts (Section 2):	None specified		
Related data items (this section):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother		
Related business rules (Section 4):	Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother conditionally mandatory data items		

Administration

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

Presence or history of mental health condition – indicator

Specification

Definition	Whether a woman is experiencing, or has previously experienced, a mental health condition		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	158
Permissible values	**Code** **Descriptor** 1 Yes 2 No 9 Not stated stated/inadequately described		
Reporting guide	This data may be self-reported or derived from medical information. Code 1 Yes The woman is currently experiencing, or has previously experienced, a mental health condition Code 2 No The woman is not currently experiencing, and has not previously experienced, a mental health condition		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Antenatal mental health risk screening status; Edinburgh Postnatal Depression Scale score		
Related business rules (Section 4):	Mandatory to report data items		

Administration

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

Procedure – ACHI code

Specification

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

Related business rules (Section 4):	Artificial reproductive technology – indicator conditionally mandatory data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. January 2009 3. July 2015 4. January 2018 5. January 2020 6. July 2022
Codeset source	ICD-10-AM/ACHI 12th edition plus CCOPMM additions	Collection start date	1982

Procedure – free text

Specification

Definition	The interventions used for the diagnosis and/or treatment of the mother during her pregnancy, the labour, delivery and the puerperium		
Representation class	Text	Data type	String
Format	A(300)	Field size	300
Location	Episode record	Position	55
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	A procedure should be reported only once, regardless of how many times it is performed. Report procedures and operations performed during the current pregnancy, labour, delivery and the puerperium. Give priority to invasive procedures and investigations. Examples of procedures to report include cholecystectomy, ligation of vessels for twin-to-twin transfusion, hysterectomy, amniocentesis, cervical suture. Procedures that are reported in other data elements (such as anaesthesia, augmentation or induction of labour, caesarean section, forceps or vacuum extraction, suture/repair of perineal laceration, episiotomy, allied health), do not need to be reported in the Procedure – ACHI code or Procedure – free text data fields. Do not report activities such as providing brochures to the mother.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Birth episodes where a medical procedure and/or operation is performed and/or a procedure related to the pregnancy, including assisted reproductive technology, occurred during the pregnancy		
Related concepts (Section 2):	Procedure		
Related data items (this section):	Artificial reproductive technology – indicator; Procedure – ACHI code		
Related business rules (Section 4):	Artificial reproductive technology – indicator conditionally mandatory data items		

Administration

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

Prophylactic oxytocin in third stage

Specification

Definition	Whether oxytocin was given prophylactically in the third stage of labour		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	83

Permissible values

Code	Descriptor
1	Oxytocin given prophylactically
2	Oxytocin not given prophylactically
9	Not stated / inadequately described

Reporting guide

Code 1 Oxytocin given prophylactically:
record when oxytocin is used in order to prevent heavy blood loss, for example, with the birth of the anterior shoulder, or very soon after the birth.

Code 2 Oxytocin not given prophylactically:

record if no oxytocin was given on a routine prophylactic basis. This includes cases where a decision was made to administer oxytocin only after heavy blood loss was observed.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Post-partum haemorrhage
Related data items (this section):	Blood loss (ml); Blood loss assessment – indicator; Main reason for excessive blood loss
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Reason for transfer out – baby

Specification

Definition	Reason why the baby is transferred following separation from the birth hospital campus		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	132
Permissible values	**Code** **Descriptor** 1 Higher level of care 2 Lower level of care 3 Same level of care 4 HITH		
Reporting guide	Code 1 Higher level of care: includes conditions where tertiary neonatal care is more appropriate to the baby's needs. It also includes transfer where the intended birth hospital doesn't have the capability level to care for this baby; for example, prematurity, multiple pregnancy, complications at birth. Code 2 Lower level of care: includes babies transferred back to their intended birth hospital following tertiary care, or from a hospital with increased capability to the intended birth hospital. Code 3 Same level of care: includes babies who may have been born at the nearest hospital whilst mother was on holidays or travelling and is now transferred to the intended birth hospital. Code 4 HITH: includes babies referred to HITH. Please choose transferred rather than discharged in the baby's separation status.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All episodes where Separation status – baby is code 3 Transferred		
Related concepts (Section 2):	Separation; Transfer		
Related data items (this section):	Separation status – baby; Transfer destination – baby		
Related business rules (Section 4):	Separation status – baby and Transfer destination – baby conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2018
Codeset source	DH	Collection start date	2018

Reason for transfer out – mother

Specification

Definition	Reason of the hospital campus to why the mother is transferred following separation from this hospital campus		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	133

Permissible values

Code	Descriptor
1	Higher level of care
2	Lower level of care
3	Same level of care
4	HITH

Reporting guide

Code 1 Higher level of care:
includes conditions where tertiary maternity care is more appropriate to the mother's needs. It also includes transfer where the intended birth hospital doesn't have the capability level to care for this mother; for example, prematurity, multiple pregnancy, complications at birth.

Code 2 Lower level of care:
includes mothers transferred back to their intended birth hospital following tertiary care, or from a hospital with increased capability to the intended birth hospital

Code 3 Same level of care:
includes mothers who may have given birth at the nearest hospital whilst on holidays or travelling and is now transferred to the intended birth hospital.

Code 4 HITH:
includes mothers referred to HITH. Please choose transferred rather than discharged in the mother's separation status.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All episodes where Separation status – mother is code 3 Transferred
Related concepts (Section 2):	Separation; Transfer
Related data items (this section):	Separation status – mother; Transfer destination – mother
Related business rules (Section 4):	Separation status – mother and Transfer destination – mother conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2018
Codeset source	DH	Collection start date	2018

Residential locality

Specification

Definition	The geographic location of the woman's usual residence (suburb/town/locality for Australian residents, country for overseas residents), not the postal address		
Representation class	Code	Data type	String
Format	A(46)	Field size	46
Location	Episode record	Position	11
Permissible values	Please refer to the 'Postcode - Locality reference file' available at the HDSS website < https://www.health.vic.gov.au/data-reporting/reference-files>		
Reporting guide	Locality must be blank if the postcode is 1000 (No fixed abode) or 9988 (Unknown). Where the postcode is 8888 (overseas), report the country where the patient lives in Locality. The four-digit country code must be one that corresponds with a code listed against 8888 (overseas) in the postcode/locality reference file.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential postcode; Residential road name – mother; Residential road number – mother; Residential road suffix code – mother; Residential road type – mother		
Related business rules (Section 4):	Mandatory to report data items; Residential locality and Residential postcode valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	ABS National Locality Index (Cat. no. 1252) (DH Modified)	Collection start date	1982

Residential postcode

Specification

Definition	Postcode or locality in which the woman usually resides (not postal address)		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	12
Permissible values	Please refer to the 'Postcode - Locality reference file' available at the HDSS website < https://www.health.vic.gov.au/data-reporting/reference-files>		
Reporting guide	The hospital may collect the woman's postal address for its own purposes. However, for data submission, the postcode must represent the woman's residential address. Data validation will reject non-residential postcodes (such as mail delivery centres). Where the postcode is 8888 (overseas), report the country the patient lives in under Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode / locality reference file.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential locality; Residential road name – mother; Residential road number – mother; Residential road suffix code – mother; Residential road type – mother		
Related business rules (Section 4):	Mandatory to report data items; Residential locality and Residential postcode valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	ABS National Locality Index (Cat. no. 1252) (DH Modified)	Collection start date	1982

Residential road name – mother

Specification

Definition	The name of the road or thoroughfare of the mother's normal residential address		
Representation class	Text	Data type	String
Format	A(45)	Field size	45
Location	Episode record	Position	14
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	The name of the road on which the mother normally resides.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential locality; Residential postcode; Residential road number – mother; Residential road suffix code – mother; Residential road type – mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Residential road number – mother

Specification

Definition	The number in the road or thoroughfare of the mother's normal residential address		
Representation class	Text	Data type	String
Format	A(12)	Field size	12
Location	Episode record	Position	13
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	The number of the road on which the mother normally resides.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential locality; Residential postcode; Residential road name – mother; Residential road suffix – mother; Residential road type - mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Residential road suffix code – mother

Specification

Definition	The abbreviation code used to represent the suffix of the road or thoroughfare of the mother's normal residential address		
Representation class	Code	Data type	String
Format	AA	Field size	2
Location	Episode record	Position	15
Permissible values	Codeset available on request, please email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>		
Reporting guide	The type of road on which the mother normally resides		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential locality; Residential postcode; Residential road name – mother, Residential road number – mother; Residential road type – mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Residential road type – mother

Specification

Definition	The type of road or thoroughfare of the mother's normal residential address		
Representation class	Code	Data type	String
Format	AAAA	Field size	4
Location	Episode record	Position	16
Permissible values	Codeset available on request, please email the HDSS HelpDesk <hdss.helpdesk@health.vic.gov.au>		
Reporting guide	The type of road where the mother normally resides		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Geographic indicator		
Related data items (this section):	Residential locality; Residential postcode; Residential road name – mother, Residential road number – mother, Residential road suffix code – mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2018
Codeset source	Not applicable	Collection start date	2009

Resuscitation method – drugs

Specification

Definition	Drugs administered immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances		
Representation class	Code	Data type	Number
Format	N	Field size	1 (x5)
Location	Episode record	Position	106

Permissible values

Code	Descriptor
1	None (no drug therapy)
2	Narcotic antagonist
3	Sodium bicarbonate
4	Adrenalin
5	Volume expander
8	Other drugs
9	Not stated / inadequately described

Reporting guide

Report up to five codes.

Do not report any code more than once.

Code 2 Narcotic antagonist:
includes naloxone (Narcan)

Code 5 Volume expander:
includes normal saline and blood products

Code 8 Other:
includes all other drugs, for example, dextrose

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Apgar score at one minute; Apgar score at five minutes; Birth status; Neonatal morbidity – free text; Neonatal morbidity – ICD-10-AM code; Resuscitation method - mechanical
Related business rules (Section 4):	Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	Not applicable	Collection start date	2009

Resuscitation method – mechanical

Specification

Definition	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effort and to correct metabolic disturbances		
Representation class	Code	Data type	String
Format	NN	Field size	2 (x10)
Location	Episode record	Position	105

Permissible values

Code	Descriptor
01	None
02	Suction
03	Oxygen therapy
04	Intermittent positive pressure respiration bag and mask with air
05	Endotracheal intubation and IPPR with air
06	External cardiac massage and ventilation
07	Continuous positive airway pressure with air
14	Intermittent positive pressure respiration bag and mask with oxygen
15	Endotracheal intubation an IPPR with oxygen
17	CPAP with oxygen
88	Other
99	Not stated / inadequately described

Reporting guide

Report up to ten codes. Do not report any code more than once.

If during resuscitation both air and oxygen are given, report both codes.

A combination of up to ten valid types of mechanical resuscitation methods can be used.

Code 01 None: includes such strategies as tactile stimulation.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Apgar score at one minute; Apgar score at five minutes; Birth status; Neonatal morbidity – free text; Neonatal morbidity – ICD-10-AM code; Resuscitation method – drugs

Related business rules (Section 4):	Mandatory to report data items, Time to established respiration and Resuscitation method – mechanical valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1982 2. January 1999 3. January 2009
Codeset source	NHDD (DH modified)	Collection start date	1982

Separation date – baby

Specification

Definition	The date on which the baby is separated or transferred from the place of birth or on which they died		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	119
Permissible values	A valid calendar date		
Reporting guide	The relocation of the baby within the hospital of birth does not constitute a separation (or transfer). Transfers from a private hospital located within a public hospital, to the public hospital for special or intensive care, are considered transfers (and therefore the baby is separated). For babies who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs. In the case of planned homebirths, occurring at home, the separation date is the date that the baby's immediate post birth care is completed and the midwife leaves the place of birth. Please note that this date may be different to the baby's date of birth, for example if the birth occurs shortly before midnight. Do not report a value for stillbirth episodes, leave blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All live birth episodes		
Related concepts (Section 2):	Separation		
Related data items (this section):	Reason for transfer out – baby; Separation status – baby; Transfer destination – baby		
Related business rules (Section 4):	Birth status ‘Live born’ and associated conditionally mandatory data items; Birth status ‘Stillborn’ and associated data items valid combinations; Date and time data item relationships; Date of birth – baby and Separation date – baby conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. January 2018 3. July 2022
Codeset source	DH	Collection start date	1982

Separation date – mother

Specification

Definition	The date on which the mother is separated, transferred or died after the birth episode		
Representation class	Date	Data type	Date/time
Format	DDMMCCYY	Field size	8
Location	Episode record	Position	118
Permissible values	A valid calendar date		
	Code **Descriptor** 99999999 Not stated / inadequately described		
Reporting guide	The relocation of the mother within the hospital of birth does not constitute a separation (or transfer). For mothers who are transferred to Hospital in the Home (HITH), the separation date is the date the transfer to HITH occurs In the case of planned homebirths, occurring at home, the Separation date is the date that the mother's immediate post-birth care is completed and the midwife leaves the place of birth. Please note that this date may differ from the baby's date of birth, for example, if the birth occurs shortly before midnight.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Separation		
Related data items (this section):	Reason for transfer out – mother; Separation status – mother; Transfer destination – mother		
Related business rules (Section 4):	Date and time data item relationships; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. January 2018
Codeset source	DH	Collection start date	1982

Separation status – baby

Specification

Definition	Status at separation of baby (discharge/transfer/death)		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	121

Permissible values

Code	Descriptor
1	Discharged
2	Died
3	Transferred
9	Not stated / inadequately described

Reporting guide	Do not report a value for stillbirth episodes, leave blank. For babies who are transferred to Hospital in the Home (HITH), the Separation status – baby is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – baby should be left blank.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All live birth episodes
Related concepts (Section 2):	Infant death, Separation
Related data items (this section):	Birth status; Separation date – baby
Related business rules (Section 4):	Birth status 'Live born' and associated conditionally mandatory data items; Birth status 'Stillborn' and associated data items valid combinations; Separation status – baby, Reason for transfer out – baby and Transfer destination – baby conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. July 2015 3. January 2018
Codeset source	DH	Collection start date	1982

Separation status – mother

Specification

Definition	Status at separation of mother (discharge/transfer/ death)		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	120

Permissible values

Code	Descriptor
1	Discharged
2	Died
3	Transferred
9	Not stated / inadequately described

Reporting guide	For mothers who are transferred to Hospital in the Home (HITH), Separation status – mother is code 3 Transferred, the Separation date is the date the transfer to HITH occurs and the Transfer destination – mother should be left blank.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Separation
Related data items (this section):	Separation date - mother
Related business rules (Section 4):	Mandatory to report data items; Separation status – mother, Reason for transfer out – mother and Transfer destination – mother – conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982 2. July 2015 3. January 2018
Codeset source	DH	Collection start date	1982

Setting of birth – actual

Specification

Definition	The actual place where the birth occurred		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	27
Permissible values	Please refer to the 'Campus Code Table' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files>		

Code	Descriptor
0003	Home (other)
0005	In transit
0006	Home – Private midwife care
0007	Home – Public homebirth program
0008	Other - specify
0009	Not stated / inadequately described

Reporting guide

Code 0003 Home (other):
includes a birth not intended to occur at home. Excludes homebirth with a private midwife (use code 0006) and homebirth under the public homebirth program (use code 0007)

Code 0005 In transit:
includes births occurring on the way to the intended place of birth or the car park of a hospital

Code 0006 Home: private midwife care:
reported when a birth is attended by a private midwife practitioner in the mother's own home or a home environment

Code 0007 Home: Public homebirth program:
reported when a birth is attended by a public midwife in the mother's home under the Public homebirth program

Code 0008 Other – specify:
used when birth occurs at any location other than those listed above. May also include a community health centre. Report the location in Setting of birth – actual – other specified description

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Setting of birth – actual – other specified description; Setting of birth – change of intent; Setting of birth – change of intent -reason; Setting of birth – intended; Setting of birth – intended – other specified description

Related business rules (Section 4):	Date of birth – baby, Date of admission – mother and Setting of birth – actual valid combinations; Mandatory to report data items; Method of birth and Setting of birth – actual valid combinations; Setting of birth – actual and Admitted patient election status – mother valid combinations; Setting of birth – actual and Setting of birth – actual – other specified description conditionally mandatory data item; Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity			
Definition source	NHDD	Version	1 2 3	January 1982 July 2015 January 2020
Codeset source	NHDD (DH modified)	Collection start date	1982	

Setting of birth – actual – other specified description

Specification

Definition	The actual place where the birth occurred		
Representation class	Text	Data type	String
Format	A(20)	Field size	20
Location	Episode record	Position	28
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Only report the description of the place of birth if the place of birth is not one identified in the codeset of data element Setting of birth – actual.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Births where code 0008 Other – specify is reported in Setting of birth – actual		
Related concepts (Section 2):	None specified		
Related data items (this section):	Setting of birth – actual; Setting of birth – change of intent; Setting of birth – change of intent -reason; Setting of birth – intended; Setting of birth – intended – other specified description		
Related business rules (Section 4):	Setting of birth – actual and Setting of birth – actual – other specified description conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1999
Codeset source	Not applicable	Collection start date	1999

Setting of birth – change of intent

Specification

Definition	Whether the change of intent between where the mother intended to give birth and the actual birth setting took place before or during labour		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	29

Permissible values

Code	Descriptor
1	Before onset of labour
2	During labour
9	Not stated / inadequately described

Reporting guide

This field is to report when a change occurred in the intended model of care.

If the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended birth setting (see Setting of birth – intended). While holidaying on the coast at 38 weeks, she goes into labour and is admitted to Warrnambool Hospital – which becomes the actual birth setting (see Setting of birth – actual). Since the intended and actual birth settings differ, report Setting of birth – change of intent to indicate when the change of plan was made: for this scenario, report code 2 During labour; and Setting of birth – change of intent – reason: for this scenario, report code 2 Unintended/unplanned.

Or, if the woman is booked into a tertiary hospital, such as Monash Medical Centre, this is the intended place of birth (Setting of birth – intended). She moves to Warrnambool for her husband's work at 39 weeks where she gives birth at term (Setting of birth – actual). For this scenario, Setting of birth – change of intent is code 1 Before onset of labour, and Setting of birth – change of intent – reason is code 3 Social or geographic.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All episodes where the actual birth place differs from the intended place of birth
Related concepts (Section 2):	None specified
Related data items (this section):	Setting of birth – actual; Setting of birth – actual – other specified description; Setting of birth – change of intent – reason; Setting of birth – intended; Setting of birth – intended – other specified description

Related business rules (Section 4):	Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999
Codeset source	DH	Collection start date	1999

Setting of birth – change of intent – reason

Specification

Definition	Reason for change of intent between where the mother intended to give birth and where the actual birth took place		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	30

Permissible values

Code	Descriptor
1	Recognition of higher risk
2	Actual complication of pregnancy
3	Social or geographic
4	Unintended/unplanned
8	Other
9	Not stated / inadequately described

Reporting guide

Code 1 Recognition of higher risk:
includes conditions or circumstances that suggest that maternity care would be better provided in a higher-level facility, for example, multiple pregnancy, thrombophilia

Code 2 Actual complication of pregnancy:
includes complications that have already occurred for example, threatened preterm labour, DVT, fetal growth restriction

Code 3 Social or geographic: :includes change in health insurance or change in local maternity service availability, moved house, preference

Code 4 Unintended/unplanned: :includes those in transit to booked hospital, on holidays

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All births where the actual birthplace differs from the birthplace initially booked
Related concepts (Section 2):	None specified
Related data items (this section):	Setting of birth – actual; Setting of birth – actual – other specified description; Setting of birth – change of intent; Setting of birth – intended; Setting of birth – intended – other specified description

Related business rules (Section 4):	Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Setting of birth – intended

Specification

Definition	The intended place of birth		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	25
Permissible values	Please refer to the 'Campus Code Table' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files>		

Code	Descriptor
0003	Home (other)
0006	Home – Private midwife care
0007	Home – Public homebirth program
0008	Other - specify
0009	Not stated / inadequately described

Reporting guide	Home in the context of this data element means the home of the woman or a relative or a friend. Code 0003 Home (other): excludes homebirth with a private midwife (use code 0006) and homebirth in a public homebirth program (use code 0007) Code 0008 Other – specify: includes community (health) centres. Record the location in Setting of birth – intended – other specified description Code 0009 Not stated / inadequately described: includes unbooked or unplanned
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Setting of birth – actual; Setting of birth – actual – other specified description; Setting of birth – change of intent, Setting of birth – change of intent – reason, Setting of birth – intended – other specified description
Related business rules (Section 4):	Mandatory to report data items; Setting of birth – actual, Setting of birth – intended, Setting of birth – change of intent and Setting of birth – change of intent – reason conditionally mandatory data items, Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity			
Definition source	NHDD	Version	1 2 3	January 1999 July 2015 January 2020
Codeset source	NHDD (DH modified)	Collection start date	1999	

Setting of birth – intended – other specified description

Specification

Definition	The intended place of birth at the onset of labour		
Representation class	Text	Data type	String
Format	A(20)	Field size	20
Location	Episode record	Position	26
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Only report the description of the intended place of birth if the intended place of birth is not one identified in the codeset of data element Setting of birth – intended.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	When Code 0008 Other – specify is reported in Setting of birth – intended birth		
Related concepts (Section 2):	None specified		
Related data items (this section):	Setting of birth – actual; Setting of birth – actual – other specified description; Setting of birth – change of intent; Setting of birth – change of intent – reason; Setting of birth – intended		
Related business rules (Section 4):	Setting of birth – intended and Setting of birth – intended – other specified description conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 1999
Codeset source	Not applicable	Collection start date	1999

Sex – baby

Specification

Definition	The biological distinction between a male and female baby		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	97

Permissible values

Code	Descriptor
1	Male
2	Female
3	Indeterminate
9	Not stated / inadequately described

Reporting guide	Sex is the biological distinction between male and female. Code 3 Indeterminate: infants with ambiguous genitalia or macerated fetus where the biological sex is unable to be or has not yet been determined (genetic testing not yet complete).
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	Congenital anomalies
Related data items (this section):	Congenital anomalies – ICD-10-AM code; Congenital anomalies – indicator
Related business rules (Section 4):	Mandatory to report data items; Sex – baby and Congenital anomalies – indicator conditionally mandatory data item

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD (modified)	Version	1. January 1982
Codeset source	NHDD	Collection start date	1982

Spoken English Proficiency

Specification

Definition	Self assessment by a mother, born in a country other than Australia, of her own English language fluency.		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	127

Permissible values

Code	Descriptor
1	Very well
2	Well
3	Not well
4	Not at all
9	Not stated / inadequately described

Reporting guide	Each woman should be asked “How well do you speak English”? Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes, where the Country of Birth is not Australia
Related concepts (Section 2):	None specified
Related data items (this section):	Country of Birth
Related business rules (Section 4):	None specified

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	METeOR ID 270203	Version	1. January 2017
Codeset source	NHDD	Collection start date	2017

Submission number

Specification

Definition	The number of times a particular piece of data is submitted or resubmitted		
Representation class	Identifier	Data type	String
Format	NNNN	Field size	4
Location	File name, Header record	Position	Not applicable
Permissible values	Range: one to 9999 (inclusive)		
Reporting guide	Software-system generated. The incrementing submission number must cycle back to '01' each time the Data submission identifier (submission end date) changes.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic submission file		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	None specified		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Surname / family name – mother

Specification

Definition	The surname of the mother		
Representation class	Text	Data type	String
Format	A(40)	Field size	40
Location	Episode record	Position	8
Permissible values	Permitted characters: • a–z and A–Z • special characters (a character which has a visual representation and is neither a letter, number, ideogram; for example, full stops, punctuation marks and mathematical symbols) • numeric characters • blank characters		
Reporting guide	Surname of the mother		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	First given name – mother; Middle name – mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	Not applicable	Collection start date	1982

Syphilis antenatal screening – mother

Specification

Definition	Whether the mother had any syphilis serology testing during this pregnancy, and if so, the results		
Representation class	Code	Data type	Number
Format	N	Field size	1
Location	Episode record	Position	162

Permissible values

Code	Descriptor
1	Syphilis serology was negative on all testing undertaken during this pregnancy
2	Syphilis serology was positive at any point during this pregnancy
3	Syphilis serology was not performed at any time during this pregnancy
9	Not stated stated/inadequately described

Reporting guide	Report the status based on the laboratory results of all syphilis screening during this pregnancy. Where syphilis serology screening was conducted, but no result can be located or it is indecipherable, attempts should be made to locate the result, including contacting the laboratory to re-issue the report. When all attempts to obtain a legible report have been unsuccessful, report code 9.
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	None specified
Related business rules (Section 4):	Mandatory to report data item

Administration

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

Time of birth

Specification

Definition	The time of birth measured as hours and minutes using a 24-hour clock		
Representation class	Time	Data type	Date/time
Format	HHMM	Field size	4
Location	Episode record	Position	96
Permissible values	A valid time value using a 24-hour clock (not 0000 or 2400) **Code** **Descriptor** 9999 Not stated / inadequately described		
Reporting guide	Report hours and minutes using a 24-hour clock.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Date of birth – baby; Time of onset of labour; Time of onset of second stage of labour; Time of rupture of membranes		
Related business rules (Section 4):	Date and time data item relationships; Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Time of decision for unplanned caesarean section

Specification

Definition	The time of decision for unplanned caesarean section		
Representation class	Time	Data type	Date/time
Format	HHMM	Field size	4
Location	Episode record	Position	150
Permissible values	A valid time value using a 24-hour clock (not 0000 or 2400)		
	Code **Descriptor**		
	9999 Not stated / inadequately described		
Reporting guide	The time at which the medical practitioner decides to deliver by urgent caesarean section where that was not the previously planned method of birth, for example where the plan was for a vaginal birth or planned caesarean section, but circumstances change and the decision is made to proceed to an urgent caesarean section. In cases of transfer to theatre for trial of forceps, report the time at which the plan changed to delivery by caesarean section.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes.		
Related concepts (Section 2):	Labour type		
Related data items (this section):	Category of unplanned caesarean section urgency; Date of decision for unplanned caesarean section; Method of birth		
Related business rules (Section 4):	Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; Date and time data item relationships; Labour type ‘Woman in labour’ and associated data items valid combinations; Labour type ‘Woman not in labour’ and associated data items valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. July 2021
Codeset source	DH	Collection start date	1 July 2021

Time of onset of labour

Specification

Definition	The time of onset of labour measured as hours and minutes using a 24-hour clock		
Representation class	Time	Data type	Date/time
Format	HHMM	Field size	4
Location	Episode record	Position	62
Permissible values	A valid time value using a 24-hour clock (not 0000 or 2400) **Code** **Descriptor** 7777 No record of time of onset of labour 8888 No labour 9999 Not stated / inadequately described		
Reporting guide	Report hours and minutes using a 24-hour clock. Code 8888 No labour is to be used when the mother has a planned or unplanned caesarean section with no labour. There is little consensus regarding definitions of labour onset. Most definitions include the presence of regular, painful contractions accompanied by effacement and/or dilatation of the cervix. Many women find it difficult to state the time labour started. Where the woman cannot provide a specific time, asking her when she noticed the change that prompted her to seek advice or care (eg backache, a show, SROM, etc), will aid in deciding on the commencement date and time. It will often be necessary to make an 'educated guess or best estimate' when given the history (Hanley, G et al. 2016, BMC Pregnancy and Childbirth). Not all midwives would make the same judgement call about the 'exact' commencement time and date of labour. Therefore, it is generally accepted as an 'educated guess'. The above points are intended to assist in determining the date and time of onset of labour.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Labour type		
Related data items (this section):	Date of onset of labour; Method of birth; Time of onset of second stage of labour; Time of rupture of membranes		
Related business rules (Section 4):	Date and time data item relationships; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in		

	labour' and associated data items valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Time of onset of second stage of labour

Specification

Definition	The time of the start of the second stage of labour measured as hours and minutes using a 24-hour clock		
Representation class	Time	Data type	Date/time
Format	HHMM	Field size	4
Location	Episode record	Position	64

Permissible values

A valid time value using a 24-hour clock (not 0000 or 2400).

Code	Descriptor
8888	No labour
9999	Not stated / inadequately described

Reporting guide

Report hours and minutes using a 24-hour clock.

Code 8888 No second stage of labour is to be used when the mother has a planned or unplanned caesarean section and did not reach second stage of labour.

In the instance of a woman who presents with a baby on view or in arms, a history of events may be found by asking the following questions:

1. Had she had a show or ROM?
2. Had she vomited at all within the hour prior to giving birth or think she was going to vomit?
3. Had there been any noticeable urge to push?
4. Did she notice if she had bowel pressure prior to having the baby and how long before?
5. Had any family members noticed any change in her behaviour (restless, agitated) prior to having the baby?

If none of these questions can be answered then a reasonable assumption would be that the birth occurred within one to two contractions prior to the birth and second stage may be judged to be two and five minutes prior to the birth.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Date of onset of second stage of labour; Method of birth; Time of onset of labour; Time of rupture of membranes

Related business rules (Section 4):	Date and time data item relationships; Labour type ‘Woman in labour’ and associated data items valid combinations; Labour type ‘Woman not in labour’ and associated data items valid combinations; Mandatory to report data items

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009
Codeset source	DH	Collection start date	2009

Time of rupture of membranes

Specification

Definition	The time at which the mother's membranes ruptured (spontaneously or artificially) measured as hours and minutes using a 24-hour clock		
Representation class	Time	Data type	Date/time
Format	HHMM	Field size	4
Location	Episode record	Position	66
Permissible values	A valid time value using a 24-hour clock (not 0000 or 2400)		

Code	Descriptor
7777	No record of rupture of membranes
8888	Membranes ruptured at caesarean
9999	Not stated / inadequately described

Reporting guide

Report hours and minutes using a 24-hour clock.

Report the time at which the membranes were believed to have ruptured, whether spontaneously or artificially.

If there is a verified hindwater leak that is followed by a forewater rupture, record the earlier date.

If there is some vaginal loss that is suspected to be ruptured membranes, but in hindsight seems unlikely, record the time at which the membranes convincingly ruptured.

In the case of a caul birth, report the date and time of ROM as the date and time of birth.

Code 7777 No record of rupture of membranes
Use of code 7777 No record of rupture of membranes should be limited to situations where there is absolutely no evidence in the medical record to indicate the timing of the rupture of membranes.

If date of ROM is known but time of ROM is not, report the known date and report time as 7777 No record of rupture of membranes.

An estimate of at least the date of ROM is far preferable to no record. Use of the no record codes (77777777 and 7777 for Date and Time of ROM respectively) will be monitored and sites reporting a high frequency of those codes will be followed up.

Code 8888 Membranes ruptured at caesarean:
to be used when the mother has a planned or unplanned caesarean section and membranes were ruptured during caesarean.

Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners
Reported for	All birth episodes
Related concepts (Section 2):	None specified
Related data items (this section):	Date of rupture of membranes; Method of birth; Time of onset of labour; Time of onset of second stage of labour
Related business rules (Section 4):	Date and time data item relationships; Labour type 'Woman in labour' and associated data items valid combinations; Labour type 'Woman not in labour' and associated data items valid combinations; Mandatory to report data items

Administration

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

Time to established respiration

Specification

Definition	Time in minutes taken to establish regular, spontaneous breathing. This is not the same as the time of first breath.		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	104
Permissible values	Range: zero to 30 (inclusive) **Code** **Descriptor** 98 Newborn does not take a breath is intubated and ventilated 99 Not stated / inadequately described		
Reporting guide	Most newborns establish spontaneous respirations within one to two minutes of birth. If spontaneous respirations are not established within this time, active intervention is required. Round up the time the baby took to establish regular spontaneous breathing to the next whole minute. For example a baby who takes 2.5 minutes to establish regular breathing should have three minutes recorded. If the baby breathes immediately and continues to have regular spontaneous breathing upon delivery the TER is one minute. If the baby does not take a breath and is intubated and ventilated and accurate assessment of time is not possible report 98 Newborn does not take a breath – is intubated and ventilated. If the baby is born before arrival, where the time to established respiration is unknown report 99 Not stated / inadequately described. For stillbirth episodes, report the time to established respiration as 00.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Apgar score at one minute; Apgar score at five minutes; Birth status; Resuscitation method – drugs; Resuscitation method – mechanical		

Related business rules (Section 4):	Birth status ‘Stillborn’ and associated data items valid combinations; Mandatory to report data items; Time to established respiration and Resuscitation method – mechanical valid combinations

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous abortions – induced

Specification

Definition	The total number of previous pregnancies resulting in induced abortion (termination of pregnancy before 20 weeks' gestation)		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	39
Permissible values	Range: zero to 30 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Report the number of previously induced abortions. Aborted pregnancies of multiple fetuses should be counted as only one pregnancy. That is, a twin pregnancy, for example, is counted as one pregnancy. In the case of No previous abortions – induced, report 0 No previous abortions – induced.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Gravidity; Total number of previous abortions – spontaneous		
Related business rules (Section 4):	Gravidity 'Primigravida' and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous abortions – spontaneous

Specification

Definition	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 grams birthweight if gestational age is unknown, and showed no sign of life after birth)		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	38
Permissible values	Range: zero to 30 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Report the number of previous spontaneous abortions. Aborted pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy. In the case of no previous abortions – spontaneous, report 0 No previous abortions – spontaneous.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Gravidity; Total number of previous abortions - induced		
Related business rules (Section 4):	Gravidity 'Primigravida' and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous caesareans

Specification

Definition	Total number of previous pregnancies where the method of delivery was caesarean section		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	45
Permissible values	Range: zero to 9 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	This relates to all births including the last (previous) birth. If the mother has had any previous births, check and report the total number of births by caesarean section, regardless of whether the last birth was a caesarean section or not. If neither the last birth nor any other previous births were by caesarean section, report 0. For multiple births, if one baby is delivered via caesarean section and the other baby or babies via any other form of delivery (excluding caesarean), record that pregnancy as a previous caesarean.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Gravidity; Last birth – caesarean section indicator; Plan for vaginal birth after caesarean		
Related business rules (Section 4):	Gravidity ‘Multigravida’ conditionally mandatory data items; Gravidity ‘Primigravida’ and associated data items valid combinations; Mandatory to report data items; Total number of previous caesareans and Plan for VBAC conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1998
Codeset source	DH	Collection start date	1998

Total number of previous ectopic pregnancies

Specification

Definition	The total number of previous pregnancies that were ectopic		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	40
Permissible values	Range: zero to 20 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Report the number of previous ectopic pregnancies. Ectopic pregnancies of multiple fetuses should be counted as only one pregnancy. For example, a twin pregnancy is counted as one pregnancy. In the case of no previous ectopic pregnancies, report 0 No previous ectopic pregnancies.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Gravidity; Total number of previous abortions – induced; Total number of previous abortions – spontaneous		
Related business rules (Section 4):	Gravidity 'Primigravida' and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999
Codeset source	DH	Collection start date	1999

Total number of previous live births

Specification

Definition	The total number of live births that resulted from each previous pregnancy and who lived at least 28 days		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	34
Permissible values	Range: zero to 20 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Report the number of known previous live births, excluding those who die in the first 28 days. For those who die in the first 28 days, they are reported as a neonatal death. This includes all multiples. For example live born twins are reported as two.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Live birth		
Related data items (this section):	Gravidity; Parity		
Related business rules (Section 4):	Gravidity ‘Primigravida’ and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations; Parity and related data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous neonatal deaths

Specification

Definition	The total number of live births that died during the first 28 days of life from each previous pregnancy		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	37
Permissible values	Range: zero to 20 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	A neonatal death refers to the death of a live born which occurs during the first 28 days of life. A live born resulting in a neonatal death should be recorded only as a neonatal death. This includes all multiples. For example twins that died during the first 28 days of life are reported as two.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Neonatal death		
Related data items (this section):	Gravidity		
Related business rules (Section 4):	Gravidity ‘Primigravida’ and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations; Parity and related data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous stillbirths (fetal deaths)

Specification

Definition	The total number of stillbirths from previous pregnancies (at least 20 weeks gestational age or 400g birthweight)		
Representation class	Code	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	36
Permissible values	Range: zero to 20 (inclusive) **ode** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	This includes all multiples. For example, stillborn twins are reported as two.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	Stillbirth (fetal death)		
Related data items (this section):	Gravidity		
Related business rules (Section 4):	Gravidity ‘Primigravida’ and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations; Parity and related data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Total number of previous unknown outcomes of pregnancy

Specification

Definition	Total number of previous pregnancies where the outcome is unknown		
Representation class	Total	Data type	Number
Format	NN	Field size	2
Location	Episode record	Position	41
Permissible values	Range: zero to 20 (inclusive) **Code** **Descriptor** 99 Not stated / inadequately described		
Reporting guide	Record the number of previous outcomes that do not meet the criteria of live birth, stillbirth, neonatal death, spontaneous or induced abortions or ectopic pregnancies.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Gravidity		
Related business rules (Section 4):	Gravidity ‘Primigravida’ and associated data items valid combinations; Gravidity and related data items; Mandatory to report data items; Outcome of last pregnancy and associated data item valid combinations		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1982
Codeset source	DH	Collection start date	1982

Transaction type flag

Specification

Definition	An indicator that identifies the type of transaction to the VPDC		
Representation class	Code	Data type	String
Format	A	Field size	1
Location	Episode record	Position	3
Permissible values	**Code** **Descriptor** C Confirmation of previously accepted record N New record U Updated/corrected record X Record to be deactivated R Reinstate record that was previously deactivated		
Reporting guide	Software-system generated. Code X: Record to be deactivated: Report when a record that was previously submitted is found to be in error and is required to be removed from the VPDC: resubmitting the record with code X marks the record for 'deactivation' (removal) from the final VPDC Code R: Reinstate record that was previously deactivated report only for a record that was previously submitted (ie Code N), and then later deactivated (ie Code X), and now needs to be reinstated to the VPDC database		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	Each VPDC electronic episode record		
Related concepts (Section 2):	None specified		
Related data items (this section):	None specified		
Related business rules (Section 4):	Mandatory to report data items; Transaction Type Flag processing against prior data held, not held or deactivated		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 2009 2. January 2020
Codeset source	DH	Collection start date	2009

Transfer destination – baby

Specification

Definition	Identification of the hospital campus to which the baby is transferred following separation from this hospital campus		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	123
Permissible values	Please refer to the 'Campus Code Table' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files> **Code** **Descriptor** 9999 Not stated / inadequately described		
Reporting guide	For babies transferred to Hospital in the Home (HITH), the transfer destination should be left blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All episodes where Separation status – baby is code 3 Transferred and Reason for transfer out – baby is not code 4 HITH		
Related concepts (Section 2):	Transfer		
Related data items (this section):	Reason for transfer out – baby; Separation status – baby		
Related business rules (Section 4):	Separation status – baby, Reason for transfer out - baby and Transfer destination – baby conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2009 3. July 2015 4. January 2018
Codeset source	DH	Collection start date	1999

Transfer destination – mother

Specification

Definition	Identification of the hospital campus to which the mother is transferred following separation from the original hospital campus		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	122
Permissible values	Please refer to the 'Campus Code Table' available at the HDSS website <https://www.health.vic.gov.au/data-reporting/reference-files> **Code** **Descriptor** 9999 Not stated / inadequately described		
Reporting guide	For mothers transferred to Hospital in the Home (HITH), the transfer destination should be left blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All episodes where Separation status – mother is code 3 Transferred and Reason for transfer out – mother is not code 4 HITH		
Related concepts (Section 2):	Transfer		
Related data items (this section):	Reason for transfer out – mother; Separation status – mother		
Related business rules (Section 4):	Separation status – mother, Reason for transfer out – mother and Transfer destination – mother – conditionally mandatory data item		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	DH	Version	1. January 1999 2. January 2009 3. July 2015 4. January 2018
Codeset source	DH	Collection start date	1999

Version identifier

Specification

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

Administration

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

Weight – self-reported – mother

Specification

Definition	Mother's self-reported weight (body mass) about the time of conception		
Representation class	Total	Data type	Number
Format	NN[N]	Field size	3
Location	Episode record	Position	24
Permissible values	Range: 20 to 300 (inclusive) **Code** **Descriptor** 999 Not stated / inadequately described		
Reporting guide	A weight in kilograms (kg).		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes		
Related concepts (Section 2):	None specified		
Related data items (this section):	Height – self-reported – mother		
Related business rules (Section 4):	Mandatory to report data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	NHDD	Version	1. January 2009
Codeset source	NHDD	Collection start date	2009

Year of arrival in Australia

Specification

Definition	The year a person (born outside of Australia) first arrived in Australia, from another country.		
Representation class	Code	Data type	Number
Format	NNNN	Field size	4
Location	Episode record	Position	128
Permissible values	Valid year, between 1960 and current year 9998 Not intending to stay in Australia for one year or more 9999 Not stated/inadequately described		
Reporting guide	Recommended question: In what year did you/the person first arrive in Australia to live here for one year or more? It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. An instruction such as 'Please indicate the year of first arrival only' should be included with the question. If mother is born in Australia, leave blank.		
Reported by	All Victorian hospitals where a birth has occurred and homebirth practitioners		
Reported for	All birth episodes where Country of Birth is not Australia		
Related concepts (Section 2):	Migrant status		
Related data items (this section):	Country of Birth		
Related business rules (Section 4):	Country of birth and Year of arrival in Australia conditionally mandatory data items		

Administration

Principal data users	Consultative Council on Obstetric and Paediatric Mortality and Morbidity		
Definition source	METeOR ID 269929	Version	1. January 2017 2. January 2020
Codeset source	NHDD	Collection start date	2017