**Maternity Care Summary Standard**

**HISO 10050.2:2019**

Draft for public comment 2019

**Contributors**

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# Introduction

To provide high quality maternity care in New Zealand we need to underpin maternity practice with information that supports the care of women, babies and their family/whanaū, continuity of care, best practice, and analytics.

## Purpose

This standard is designed to ensure that information related to maternity care is consistently recorded. Standardised data will enable services to be meaningfully benchmarked against each other. A meaningful data set reflecting maternity information and services can be shared between community and hospital providers to support continuity of care.

This standard, HISO 10050.2:2019 Maternity Care Summary Standard, will supersede HISO 10050.1:2016 Maternity Care Summary Standard (Booking Information), which will be placed in a ‘Contained’ state (only able to be used for existing systems but not for any significant enhancement to systems). A time frame for this action is yet to be determined. There will be a period of overlap, after which HISO 10050.1:2016 will be ‘Withdrawn’ and not used for any related systems.

## Scope

The standard defines the minimum data to be recorded by maternity service providers in New Zealand.

The maternity care summary identifies the pregnant woman and includes administrative and clinical information about the pregnancy, the labour and birth, the baby(ies), and the postnatal period. The summary standard covers the time period from first contact with a health professional in regards to the current pregnancy, up until around six weeks after the birth of the baby(ies).

The maternity care summary standard does not include referrals and discharge summaries.

## New Zealand Legislation

The following Acts of Parliament and Regulations are relevant to this standard. Readers must consider other Acts and Regulations and any amendments that are relevant to their own organisation, when implementing or using this standard.

* Health Act 1956
* Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996
* Health Information Privacy Code 1994
* Health Practitioners Competence Assurance Act 2003
* New Zealand Public Health and Disability Act 2000
* Privacy Act 1993 (revised 2008)
* Public Records Act 2005
* Retention of Health Information Regulations 1996.

## Related specifications

The following documents were used to develop or are referenced in, this standard:

* HISO 10042.1 Medication Charting Standard published September 2012
* HISO 10042.2 Medicine Reconciliation standard published September 2012

Both documents are available at:  
https://[www.health.govt.nz\publication\hiso-10042-medication-charting-and-medicine-reconciliation-standards](http://www.health.govt.nz\publication\hiso-10042-medication-charting-and-medicine-reconciliation-standards)-charting-and-medicine-reconciliation-standards

* HISO 10045:2019 Healthcare Provider Index Standard (the HPI standard).

**Note:** this standard is currently in development, with an expectation that the draft version will be out for public comment during the latter part of 2019.

The current HISO Health Practitioner Index standards are listed below. These standards were published in 2008 and while they can provide guidance on the particular HPI values referred to in this standard, they are not suitable for any other purpose.

* HISO 10005:2008 Health Practitioner Index (HPI) Data Set  
  <https://www.health.govt.nz/publication/hiso-100052008-health-practitioner-index-hpi-data-set>
* HISO 10006:2008 Health Practitioner Index (HPI) Code Set  
  <https://www.health.govt.nz/publication/hiso-100062008-health-practitioner-index-hpi-code-set>
* HISO 10046 Consumer Health Identity Standard   
  <https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard>

HISO has [endorsed](https://www.health.govt.nz/publication/hiso-10033-snomed-ct) SNOMED CT as the clinical terminology for use in New Zealand. Accordingly, the SNOMED code system is used in the data elements documented in this standard. Access to the detail behind each SNOMED CT code is available via the SNOMED CT browser. SNOMED International (<http://www.snomed.org/>)

**Note:** Where a SNOMED code has not been provided, either a suitable code does not currently exist, or code choices for the particular domain option are still under consideration and will be added at a later date. These entries are indicated by ‘To Be Advised’ (TBA) in the SNOMED CT Code column.  
  
To review individual SNOMED codes (Internet Explorer):

* + open the browser (https://browser.ihtsdotools.org/index-ie.html?) and confirm acceptance of the access terms
  + select ‘Go browsing International Edition’ (under the “International Editions” heading, Blue box, left edge, middle of screen)
  + select ‘Search’ (second option, near top left of screen)
  + copy and paste the SNOMED CT Code (from the Data element / Data Domain to be reviewed) into the search box (under the text “Type at least 3 characters”). The system will provide a list of available options
  + Select (click) one option; review the ‘Concept detail’ presented in the right-hand side of the screen

New Zealand is obliged to contribute to the World Health Organization programme to provide national and subnational tuberculosis surveillance information. For more detail, refer to the bottom of Page 3 in the following report: https://[www.who.int/tb/publications/global\_report/high\_tb\_burdencountrylists2016-2020.pdf](file:///C:\Users\bmarwick\AppData\Local\Temp\notes2D2695\www.who.int\tb\publications\global_report\high_tb_burdencountrylists2016-2020.pdf)

## Information interoperability messaging

This standard provides the data set specification for maternity care. It does not specify how information sharing is to occur. This will be described in a separate implementation guide that defines the data structures and exchange protocols required to share the data.

HISO has endorsed the use of HL7 FHIR as the messaging standard.

See https://[www.health.govt.nz/our-work/ehealth/digital-health-sector-architecture-standards-and-governance/health-information-standards/approved-standards/interoperability-standards?page=1](file:///C:\Users\bmarwick\AppData\Local\Temp\notes2D2695\www.health.govt.nz\our-work\ehealth\digital-health-sector-architecture-standards-and-governance\health-information-standards\approved-standards\interoperability-standards%3fpage=1)

## Data element definitions

Data element specifications in this standard conform to the requirements of *ISO/IEC 11179* *Information Technology – Metadata Registries (MDR)*.[[1]](#footnote-2)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A statement that expresses the essential nature of the data element and its differentiation from other elements in the data set. | | |
| **Source standards** | Established data definitions or guidelines pertaining to the data element. | | |
| **Data type** | Alphabetic (A)  Date  Date/time  Numeric (N)  Alphanumeric (X)  Boolean | **Representational class** | Code, free text, value or identifier.  For date and time data types, use full date or partial date. |
| **Field size** | Maximum number of characters | **Representational layout** | The formatted arrangement of characters in alphanumeric elements, eg:   * ‘A(50)’ means up to 50 alphabetic characters * ‘NNAAAA’ means two numeric followed by four alphabetic characters * Full date/time representation is CCYYMMDD HH:MM All times are recorded in a 24 hour format i.e. 8:30 pm is recorded as 20:30 |
| **Data domain** | The valid values or codes that are acceptable for the data element.  Each coded data element has a specified code set. | | |
| **Obligation** | Indicates if the data element is mandatory or optional in the context, or whether its appearance is conditional | | |
| **Guide for use** | Additional guidance to inform the use of the data element. Where a ‘multiple instance’ is noted, this requires the system to be able to capture up to the specified number of instances | | |
| **Verification rules** | Quality control mechanisms that preclude invalid values. | | |

# Maternity care summary related information

The following sections define the data elements that constitute supporting detail related to a maternity event. This contains information related to both the woman’s individual data, those involved in health care provision (people, organisations, facilities) and medicines.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 2.1 | Personal information | 2.3 | Medicines information |
| 2.2 | Health care provider information |  |  |

## Personal information

Personal information related to the woman should only be obtained from the National Health Index (NHI) system. Similarly, personal information related to the baby is or will, in due course, be available in the NHI system – in particular the baby’s NHI number and sex.

This information is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in HISO 10046:2019 Consumer Health Identity Standard

The following fields relate to the woman (and for some fields, the baby) and are appropriate for use in the maternity situation. This information must be recorded as part of each maternity event.

|  |  |
| --- | --- |
| **Data element** | **HISO 10046:2019 reference** |
| NHI number | 2.1 |
| Name | 2.2 |
| Date and place of birth | 2.3 |
| Ethnicity | 2.5 |
| Address information | 3.1.3 |
| Language | 4.0 |
| Contact information | 5.0 |

## Health care provider information

This section incorporates health care provider information that is related to the woman’s particular maternity event. It should only be obtained from the Healthcare Provider Index (HPI) system. This is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in HISO 10005:2008 Health Practitioner Index (HPI) Data Set and HISO 10006:2008 Health Practitioner Index (HPI) Code Set.

The following fields relate to the woman and are appropriate for use in the individual maternity situation. ‘Provider person’ is information related to the Lead Maternity Carer (LMC) and the woman’s General Practitioner. This information must be recorded as part of each maternity event. The source of the information is as documented below.

|  |  |  |
| --- | --- | --- |
| **Data element** | **HISO 10005:2008 Data set** | **HISO 10006:2008 Code set** |
| **Provider person:** |  |  |
| Common Person Number (CPN) | 3.3 | 2.1 |
| Address | 6.0 | 4.0 |
| Language | 3.9 | 2.5 |
| Contact | 7.0 | 5.0 |
| Qualifications | 3.10 |  |
| Registration and related information | 3.7 |  |
| **Provider organisation:** |  |  |
| Identification Number | 4.3.1 | 3.2 |
| Name | 4.4.2 | 3.1 |
| Address |  | 4.0 |
| Contact |  |  |
| **Provider facility:** |  |  |
| Identification Number | 5.2.1 | 3.2 |
| Name | 5.3.2 | 3.1 |
| Address |  | 4.0 |
| Contact |  |  |

Blank fields in this table are under development and expected to be published as part of a major update to the two standards. The update is intended to merge these standards and is expected to be issued in 2019 and called HISO 10046:2019 Provider Health Index Standard.

## Medicines information

This section covers medicine information directly related to the woman and baby. Medicines information is to be managed as described in the related HISO standards (see below).

Specific medication information about a woman and baby(ies) must be sourced from existing electronic records held in the New Zealand ePrescription Service (NZePS) and accessed via an Application Program Interface (API). The maternity system must be capable of capturing and recording the process of medicines reconciliation.

Prescribing must:

* integrate with the NZePS

<https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-eprescription-service>

* the NZePS API

<Web reference to be provided>

* use the New Zealand Universal List of Medicines (NZULM).

https://[www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/nz-universal-list-medicines](file:///C:\Users\bmarwick\AppData\Local\Temp\notes2D2695\www.health.govt.nz\our-work\ehealth\other-ehealth-initiatives\emedicines\nz-universal-list-medicines)

Further assistance is available at: <http://info.nzulm.org.nz/contact/>

* conform to HISO standards,

<https://www.health.govt.nz/our-work/ehealth/digital-health-sector-architecture-standards-and-governance/health-information-standards/approved-standards/medicines-information-standards>

* [HISO 10030.1:2008 Electronic Pharmaceutical Business Process Standard](https://www.health.govt.nz/publication/hiso-1003012008-electronic-pharmaceutical-business-process-standard)
* [HISO 10030.2:2008 Electronic Pharmaceutical Messaging Standard](https://www.health.govt.nz/publication/hiso-1003022008-electronic-pharmaceutical-messaging-standard)
* [HISO 10042 Medication Charting and Medicine Reconciliation Standards](https://www.health.govt.nz/publication/hiso-10042-medication-charting-and-medicine-reconciliation-standards)
* Conform to Medical Council of New Zealand prescribing guidelines

<https://www.mcnz.org.nz/our-standards/current-standards/>

More information on the inclusion of data is available from the New Zealand Formulary.

<https://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-formulary>

# Booking information

This section covers core data elements recording information about the woman’s current pregnancy, including the estimated due date (EDD).

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 3.1 | Pregnancy intention | 3.9 | Estimated due date by ultrasound scan (USS) |
| 3.2 | Assisted reproduction | 3.10 | Agreed estimated due date |
| 3.3 | Method of assisted reproduction | 3.11 | Height |
| 3.4 | Method of assisted reproduction – ‘Other’ – detail | 3.12 | Weight |
| 3.5 | Gravida | 3.13 | Body Mass Index |
| 3.6 | Parity | 3.14 | Eligibility |
| 3.7 | Last menstrual period (LMP) | 3.15 | Lead Maternity Carer type (LMC) |
| 3.8 | Estimated due date by dates (EDD) |  |  |

## Pregnancy intention

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Pregnancy planning | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Planned pregnancy | 169565003 | | Unplanned pregnancy | 83074005 | | Ambivalent | 169569009 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Assisted reproduction

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether this pregnancy was conceived via assisted reproduction | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Method of assisted reproduction

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Method of assisted reproduction | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Hormonal stimulation | TBA | | Intrauterine insemination (IUI) | 265064001 | | In vitro fertilisation (IVF) | 52637005 | | Other | 63487001 | |  |  | | | |
| **Obligation** | Conditional on a ‘1 – Yes’ response to section 3.2 Assisted reproduction | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Method of assisted reproduction – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Other method of assisted reproduction | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘Other’ for section 3.3 Method of assisted reproduction | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Gravida

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The total number of times the woman has been pregnant | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 01 to 99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This includes the current pregnancy. For example, a woman who has had one prior pregnancy and is currently pregnant is designated Gravida 2 (G2)  This number is self-reported and may not be accurate, as the woman may not know or wish to disclose the full number  An integer greater than zero | | |
| **Verification rules** |  | | |

## Parity

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Parity is the number of previous pregnancies where the outcome was a birth with a gestation greater than or equal to 20 weeks and zero days | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 01 to 99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Count twins or multiple births as one birth  This number is self-reported and may not be accurate, as the woman may not wish to disclose the full number | | |
| **Verification rules** | An integer value required | | |

## Last menstrual period (LMP)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | First day of the last menstrual period | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date |
| **Field size** | Max: 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid date | | |
| **Obligation** | Optional | | |
| **Guide for use** | This is reliant on the woman recalling the date, and may not be accurate | | |
| **Verification rules** | This must be a valid date that is less than or equal to the current date | | |

## Estimated due date by dates (EDD)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date (EDD) as calculated from the first day of the last menstrual period (LMP) (EDD by LMP) | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full Date |
| **Field size** | Max: 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid dates | | |
| **Obligation** | Conditional on a valid response to section 3.7 Last menstrual period (LMP) | | |
| **Guide for use** |  | | |
| **Verification rules** | This must be a valid date | | |

## Estimated due date by ultrasound scan (USS)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date based on ultrasound scan calculations (EDD by USS) | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full Date |
| **Field size** | Max: 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid dates | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | This must be a valid date | | |

## Agreed estimated due date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Estimated due date as agreed by the woman and the Lead Maternity Carer considering all pertinent information | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full Date |
| **Field size** | Max: 8 | **Representational layout** | CCYYMMDD |
| **Data domain** | Valid dates | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | This must be a valid date greater than or equal to the current date | | |

## Height

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The measured height of the woman in metres | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | N.NN |
| **Data domain** | Metres | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record height to two decimal places | | |
| **Verification rules** | A value greater than zero | | |

## Weight

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The pre-pregnancy weight of the woman in kilograms | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 5 | **Representational layout** | NNN.N |
| **Data domain** | Kilograms | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | If this is not available, capture the earliest recorded weight of the woman during this pregnancy | | |
| **Verification rules** | A value greater than zero | | |

## Body Mass Index

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Calculation of Body Mass Index (BMI) | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NN.N |
| **Data domain** | Calculated on the basis of BMI = kg/m2 – that is: kilograms of weight (see section 3.12 Weight) divided by height in metres squared (see section 3.11 Height) | | |
| **Obligation** | Optional | | |
| **Guide for use** | The BMI calculation is recorded if requested by the LMC. The result of the calculation may be stored within the maternity database or created ‘on-the-fly’ as a result of the LMC request | | |
| **Verification rules** |  | | |

## Eligibility

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman is eligible for publicly funded maternity care in New Zealand | | |
| **Source Standards** | https://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services/pregnancy-services | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | A |
| **Data domain** | 'Y' – Eligible  'N' – Not eligible | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Lead Maternity Carer type (LMC)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The registration of the Lead Maternity Carer (LMC) with the Medical Council or the Midwifery Council | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Registrant with the Medical Council of New Zealand  2 – Registrant with the Midwifery Council of New Zealand | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

# Previous pregnancies

This section covers information about the woman’s obstetric history, ie, her previous pregnancies and births. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

This section contains the data elements that must be captured for each previous pregnancy. The corresponding text block for display is structured as a table, with one row of cells per pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 4.1 | Previous miscarriage | 4.11 | Maternal complications in previous labours |
| 4.2 | Previous termination | 4.12 | Maternal complications in previous labours – ‘Other’ – detail |
| 4.3 | Termination reason | 4.13 | Mode of birth |
| 4.4 | Termination reason – ‘Other reason’ – detail | 4.14 | Type of Caesarean section |
| 4.5 | Maternal antenatal complications in previous pregnancy | 4.15 | Indications for planned Caesarean section |
| 4.6 | Maternal complication – Other complication – detail | 4.16 | Indications for planned Caesarean section – ‘Other malpresentation’ – detail |
| 4.7 | Onset of labour in previous pregnancy | 4.17 | Indications for unplanned Caesarean section |
| 4.8 | Induction reason | 4.18 | Previous labour analgesia |
| 4.9 | Induction reason – ‘Other clinical reason’ – detail | 4.19 | Previous labour anaesthesia |
| 4.10 | Length of previous labour(s) | 4.20 | Maternal complications immediately postpartum |

## Previous miscarriage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The miscarriages the woman has had (if known) | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | First trimester miscarriage | 19169002 | | Second trimester miscarriage | 85116003 | | Ectopic pregnancy | 34801009 | | Molar pregnancy | 44782008 | |  |  | | | |
| **Obligation** | Conditional on a value greater than 1 for section 3.5 Gravida | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Previous termination

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of termination | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Medical termination of pregnancy | 285409006 | | Surgical termination of pregnancy | 302375005 | |  |  | | | |
| **Obligation** | Conditional on a termination having occurred | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Termination reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason(s) a previous pregnancy was terminated | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Congenital anomaly | 702709008 | | Chromosomal anomaly | 267253006 | | Unplanned pregnancy | 83074005 | | Other reason | 289203002 | |  |  | | | |
| **Obligation** | Mandatory on a response for section 4.2 Previous termination | | |
| **Guide for use** | One response should be recorded for each instance identified in section 4.2 Previous termination | | |
| **Verification rules** | Valid code only | | |

## Termination reason – ‘Other reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other reason’ for termination | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘Other reason’ for section 4.3 Termination reason | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 4.3 Termination reason | | |
| **Verification rules** |  | | |

## Maternal antenatal complications in previous pregnancy

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced during any previous pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No previous complications | TBA | | Antenatal depression | TBA | | Antepartum haemorrhage | 161804005 | | Eclampsia | 161806007 | | Gestational diabetes | 472971004 | | Infection | 161413004 | | Influenza | TBA | | Obstetric cholestasis | 16216781000119107 | | Placental abruption | TBA | | Pre-eclampsia | 105651000119100 | | Preterm labour | 441493008 | | Other complication occurring during pregnancy | 161803004 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The last option above is only to be selected when none of the preceding options in this category are clearly correct  Up to six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Maternal complication – Other complication – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other complication’ that occurred during the pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other complication occurring during pregnancy’ for section 4.5 Maternal antenatal complications in previous pregnancy | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Onset of labour in previous pregnancy

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How labour began for the previous pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Induction of labour | 725954003 | | No labour | 301728005 | | Spontaneous labour | 726597008 | |  |  | | | |
| **Obligation** | Conditional on a response greater than ‘zero’ for section 3.6 Parity | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Induction reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason for the previous induction of labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Pre-labour rupture of membranes without spontaneous labour | 44223004 | | Prolonged pregnancy | 310594001 | | Other clinical reason | TBA | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Induction of Labour’ for section 4.7 Onset of labour in previous pregnancy | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Induction reason – ‘Other clinical reason’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other clinical reason’ for induction | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other clinical reason’ for section 4.8 Induction reason | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Length of previous labour(s)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Length of previous labour(s) recorded in hours and minutes | | |
| **Source Standards** |  | | |
| **Data type** | Time | **Representational class** | Value |
| **Field size** | Max: 5 | **Representational layout** | HH:MM |
| **Data domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory on a response of ‘Spontaneous labour ‘ OR ‘Induction of labour’ to section 4.7 Onset of labour in previous pregnancy | | |
| **Guide for use** | This is a value provided by the woman | | |
| **Verification rules** |  | | |

## Maternal complications in previous labours

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any complications the woman may have experienced in previous labours | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No previous complications | TBA | | Third degree perineal tear | 10217006 | | Fourth degree perineal tear | 399031001 | | Hypertension | 38341003 | | Infection | 66844003 | | Intrapartum haemorrhage | 38010008 | | Obstructed labour | 199746004 | | Prolonged first stage of labour | 33627001 | | Prolonged ruptured membranes | 12729009 | | Prolonged second stage of labour | 77259008 | | Other | 118216002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to eight instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Maternal complications in previous labours – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ reason for Maternal complications in previous labours | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 4.11 Maternal complications in previous labours | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the previous baby(ies) was/were born | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Spontaneous vaginal birth | 48782003 | | Caesarean section | 200144004 | | Forceps | 200130005 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory on a response for section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to three instances of this field may be recorded  This is to be reported in terms of spontaneity or assistance required | | |
| **Verification rules** | Valid code only | | |

## Type of Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of Caesarean section incision the woman had in any previous pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Classical | 84195007 | | Lower uterine segment (LUSCS) | 398307005 | |  |  | | | |
| **Obligation** | Conditional on a response of ‘Caesarean section’ to section 4.13 Mode of birth | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Indications for planned Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The clinical indication for performing a planned Caesarean section as an elective procedure when the woman was not in labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Breech presentation | 712654009 | | Congenital anomaly | 276654001 | | Chromosomal anomaly | 409709004 | | Medical or obstetric complication | 609496007 | | Previous third degree perineal tear | 10217006 | | Previous fourth degree perineal tear | 399031001 | | Previous Caesarean section | 200151008 | | Transverse lie | TBA | | Unstable lie | TBA | | Other malpresentation (e.g. brow) | TBA | |  |  | | | |
| **Obligation** | Conditional on a response of ‘Caesarean section’ to section 4.13 Mode of birth | | |
| **Guide for use** | Up to eight instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Indications for planned Caesarean section – ‘Other malpresentation’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other malpresentation’ reason for Indications for planned Caesarean section | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘Other malpresentation’ for section 4.15 Indications for planned Caesarean section | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Indications for unplanned Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The clinical indication for performing an unplanned Caesarean section during labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Antepartum haemorrhage | 34842007 | | Failed induction of labour | 42571002 | | Failed instrumental/assisted delivery | 772006002 | | Fetal distress | 130955003 | | Intrapartum haemorrhage | 38010008 | | Malposition | 199747008 | | Malpresentation | 15028002 | | Obstructed Labour | 199746004 | |  |  | | | |
| **Obligation** | Conditional on a response of ‘Caesarean section’ to section 4.13 Mode of birth | | |
| **Guide for use** | Up to eight instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Previous labour analgesia

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of analgesia the woman may have had during previous labours | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No previous analgesia  2 – Pharmacological – non opiate  3 – Pharmacological – opiate  4 – Non pharmacological | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid value only | | |

## Previous labour anaesthesia

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of anaesthesia the woman may have had during previous labours | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Epidural | 27372005 | | Spinal | 231249005 | | Combined spinal/epidural | 231261002 | | General anaesthetic | 50697003 | | No previous anaesthesia | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Maternal complications immediately postpartum

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any complications the woman may have experienced in the first 2-4 hours following previous births | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No previous complications | TBA | | Perineal haematoma | 199945007 | | Postpartum haemorrhage (greater than 1000mls or treated) | 161809000 | | Retained placenta | 725948004 | | Other | 80113008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

# Previous babies

This section covers information related to babies from previous pregnancies. It should be left blank unless the woman has previously given birth at 20 weeks gestation or later. Information must be collected at the booking visit unless the woman has had earlier contact with acute services during this pregnancy.

The section contains the data elements that are required to be captured for each previous baby. The corresponding text block for display is structured as a table, with one row of cells to be recorded for each baby.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 5.1 | Outcome of previous baby(ies) | 5.10 | Stillbirth cause |
| 5.2 | Antenatal fetal complications | 5.11 | Neonatal concerns |
| 5.3 | Antenatal fetal complications – ‘Other’ – detail | 5.12 | Neonatal concerns – ‘Other’ – detail |
| 5.4 | Intrapartum fetal complications | 5.13 | Neonatal care admissions |
| 5.5 | Intrapartum fetal complications – ‘Other’ – detail | 5.14 | Reason for admission to neonatal care |
| 5.6 | Mode of birth | 5.15 | Feeding history |
| 5.7 | Gestation previous baby(ies) | 5.16 | Duration of breastfeeding |
| 5.8 | Sex of previous baby(ies) | 5.17 | Cause of death |
| 5.9 | Birth weight previous baby(ies) |  |  |

## Outcome of previous baby(ies)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The outcome for each baby in previous pregnancies | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Live born | 726001007 | | Stillborn | 161743003 | | Neonatal death | 726626004 | | Infant death | 739682007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Antenatal fetal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications related to the fetus during the previous pregnancy(ies) | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | None | TBA | | Fetal heart rate abnormality | 312668007 | | Fetal growth abnormality | 276604007 | | Congenital anomaly | 276654001 | | Chromosomal anomaly | 409709004 | | Polyhydramnios | 86203003 | | Oligohydramnios | 59566000 | | Other | 206035009 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Antenatal fetal complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ reason for Indications for Antenatal fetal complications section | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 5.2 Antenatal fetal complications | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 5.2 Antenatal fetal complications | | |
| **Verification rules** |  | | |

## Intrapartum fetal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications related to the fetus during previous labour(s) | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | None | TBA | | Fetal heart rate abnormality | 267257007 | | Fetal blood sample abnormality | 199597005 | | Meconium stained liquor | 199595002 | | Other | 76012002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Intrapartum fetal complications – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ reason for Indications for Intrapartum fetal complications section | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 5.4 Intrapartum fetal complications | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 5.4 Intrapartum fetal complications | | |
| **Verification rules** |  | | |

## Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the previous baby(ies) was/were born | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Spontaneous vaginal birth | 48782003 | | Caesarean section | 200144004 | | Forceps | 200130005 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory on a response to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to three instances of this field may be recorded  This is to be reported in terms of spontaneity or assistance required | | |
| **Verification rules** | Valid code only | | |

## Gestation previous baby(ies)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The gestation of previous babies, in weeks and days | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NN.N |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to 20 instances of this field may be recorded | | |
| **Verification rules** |  | | |

## Sex of previous baby(ies)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The sex of a previous baby(ies) as recorded at birth | | |
| **Source Standards** | Refer to the gender code set of HISO 10046 Consumer Health Identity Standard | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | A |
| **Data domain** | ‘M’ – Male  ‘F’ – Female  ‘I’ – Indeterminate | | |
| **Obligation** | Mandatory on a response not equal to ‘N/A – No previous baby(ies)’ for section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | **Note:** Values to populate this field are to be obtained from the NHI system. This will require knowledge of the baby’s NHI number as this is the access key to the correct record.  At this time, the NHI does not record a value for Sex. However, the NHI does populates a Gender field with a Sex value. A change is being planned to rectify this situation  Up to 20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Birth weight previous baby(ies)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The birth weight in grams of previous babies | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NNNN |
| **Data domain** | Grams | | |
| **Obligation** | Mandatory on a response to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to 20 instances of this field may be recorded | | |
| **Verification rules** | An integer greater than zero | | |

## Stillbirth cause

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The causes or factors that contributed to or led to the stillbirth of a previous baby | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Stillborn’ for section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Record this information if known | | |
| **Verification rules** |  | | |

## Neonatal concerns

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications with the baby(ies) in the immediate postpartum period | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | None | 102500002 | | Large for gestational age | 15635491000119102 | | Low birth weight | 276610007 | | Respiratory distress syndrome (RDS) | 46775006 | | Small for gestational age | 199612005 | | Transient tachypnoea | 7550008 | | Other | 276707008 | |  |  | | | |
| **Obligation** | Mandatory on a response to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Neonatal concerns – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ reason for Indications for Neonatal concerns | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 5.11 Neonatal concerns | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 5.11 Neonatal concerns | | |
| **Verification rules** |  | | |

## Neonatal care admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | This is to record if previous baby(ies) required admission to the neonatal intensive care or special care baby unit | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No, not needed  2 – Yes, admitted to Neonatal Intensive Care Unit (NICU)  3 – Yes, admitted to Special Care Baby Unit (SCBU)  4 – Yes, but remained on Ward | | |
| **Obligation** | Mandatory on a response to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** | Up to 20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Reason for admission to neonatal care

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason previous babies were admitted to the neonatal intensive care or special care baby unit | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Asphyxia | 413654009 | | Cardiovascular disease | 49601007 | | Congenital anomaly | 276654001 | | Chromosomal anomaly | 409709004 | | Hypoglycaemia | 52767006 | | Hypothermia | 13629008 | | Infection | 128271002 | | Jaundice | 387712008 | | Respiratory distress syndrome (RDS) | 46775006 | | Seizures | 87476004 | | Weight loss | 267024001 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘1 – No, not needed’ for section 5.13 Neonatal care admissions | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Feeding history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The feeding history of previous babies in the first six months of life | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed  2 – Fully breastfed  3 – Partially breastfed  4 – Artificially fed | | |
| **Obligation** | Mandatory on a response other than ‘Stillborn’ to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Duration of breastfeeding

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of months previous babies were breastfed | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response other than ‘Stillborn’ to section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer greater than zero | | |

## Cause of death

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The cause of death of previous baby(ies) or child(ren) | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Neonatal death’ OR ‘Infant death’ for section 5.1 Outcome of previous baby(ies) | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

# Woman’s comprehensive health history

This section covers information related to the woman’s health history. It has four categories – medical, surgical, gynaecological and mental health information. It records relevant current or past conditions to help recognise maternity risk factors.

This information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 6.1 | Medical history | 6.3 | Gynaecological history |
| 6.2 | Surgical history | 6.4 | Mental health history |

## Medical history

This section only covers information related to the woman’s medical history. It includes relevant current or past medical conditions, and risk factors for congenital abnormalities.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 6.1.1 | Medical conditions | 6.1.2 | Medical conditions – ‘Other’ – detail |

### Medical conditions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any medical conditions the woman has | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Autoimmune disorder | 85828009 | | Cardiac disorder | 56265001 | | Congenital abnormality(ies) | 276654001 | | Diabetes mellitus type 1 | 46635009 | | Diabetes mellitus type 2 | 44054006 | | Endocrine disorder | 362969004 | | Gastrointestinal disorder | 119292006 | | Haematological disorder | 34093004 | | Hypertension | 38341003 | | Infectious diseases | 40733004 | | Liver disorder | 235856003 | | Malignancy | 363346000 | | Mental health disorder | 74732009 | | Monogenic diabetes (MODY) | 609561005 | | Musculoskeletal disorder | 928000 | | Neurological disorder | 118940003 | | Respiratory disorder | 50043002 | | Skin disorder | 95320005 | | Thrombosis and related disorder | 439127006 | | Other medical disorder | 64572001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to 20 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Medical conditions – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other medical disorder’ reason for Indications for Medical conditions | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other medical disorder’ for section 6.1.1 Medical conditions | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Surgical history

This section covers information related to the woman’s surgical history.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 6.2.1 | Operations | 6.2.4 | Anaesthetic complications |
| 6.2.2 | Operations – ‘Other’ – detail | 6.2.5 | Anaesthetic complications detail |
| 6.2.3 | Previous anaesthetic |  |  |

### Operations

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of operations the woman has undergone | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No previous surgery | TBA | | Breast | 392090004 | | Genital tract | 12658000 | | Uterine | 79876008 | | Other | 387713003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Operations – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ reason for Operations | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 6.2.1 Operations | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 6.2.1 Operations | | |
| **Verification rules** |  | | |

### Previous anaesthetic

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of anaesthetic previously administered to the woman, except during childbirth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Epidural | 27372005 | | Spinal | 231249005 | | Combined spinal/epidural | 231261002 | | General anaesthetic | 50697003 | | No previous anaesthesia | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Anaesthetic complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the woman had complications when she was previously administered an anaesthetic | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### Anaesthetic complications detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Detail of anaesthetic complications | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 6.2.4 Anaesthetic complications | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Gynaecological history

This section covers gynaecological history information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 6.3.1 | Cervical smear date | 6.3.3 | Gynaecological history – diagnosis |
| 6.3.2 | Cervical smear results | 6.3.4 | Gynaecological history – procedures |

### Cervical smear date

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | To record when the most recent cervical smear was taken | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Within last year  2 – Within the last 2 years  3 – Within the last 3 years  4 – More than 3 years ago  5 – Never had smear  6 – Not documented  7 – Unknown | | |
| **Obligation** | Optional – This information is recorded when available | | |
| **Guide for use** | The default is ‘7 – Unknown’ | | |
| **Verification rules** | Valid code only | | |

### Cervical smear results

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The results from the most recent previous cervical smear | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 269958004 | | Abnormal (not specified) | 309081009 | | ACIS Adenoma carcinoma in situ | TBA | | Cervical intraepithelial neoplasia (CIN I) | 285836003 | | Cervical intraepithelial neoplasia (CIN II) | 285838002 | | Cervical intraepithelial neoplasia (CIN III) | 92564006 | | Invasive carcinoma | 423973006 | | Unknown | 3219008 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘7 – Unknown’ being recorded for section 6.3.1 Cervical smear date | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Gynaecological history – diagnosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The woman’s gynaecological history | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Bacterial vaginosis | 419760006 | | Bicornuate uterus | 31401003 | | Chlamydia | 105629000 | | Endometriosis | 129103003 | | Female Genital Mutilation (FGM) | 129103003 | | Fibroids | 95315005 | | Gonorrhoea | 15628003 | | Polycystic ovarian syndrome (PCOS) | 237055002 | | Syphilis | 76272004 | | Trichomonas vaginalis | 276877003 | | Uterine anomalies | 37849005 | | Vaginismus | 79012001 | | Other gynaecological disorder | 310789003 | | Unknown | 3219008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to 16 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

### Gynaecological history – procedures

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The history of the woman’s gynaecological procedures | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Cone biopsy | 108941000119102 | | Hysterotomy | 275573000 | | Large loop excision of transformation zone (LLETZ/LEEP) | TBA | | Myomectomy | 275574006 | | Other uterine surgery | TBA | | Unknown | 281337006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to 16 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Mental health history

This section covers information related to the woman’s mental health history. If the woman has had previous mental health issues they are more likely to become ill again during pregnancy or in the year following birth.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 6.4.1 | Mental health risk factors | 6.4.3 | Current mental illness treatment |
| 6.4.2 | Previous mental illness treatment | 6.4.4 | Serious mental illness treatment |

### Mental health risk factors

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any mental health risk factors | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

### Previous mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the woman previously received treatment for mental illness | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Current mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Is the woman currently receiving treatment for mental illness | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

### Serious mental illness treatment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indication of whether the woman has received any treatment from a psychiatrist or specialist mental health team in the past | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

# Allergies and adverse reactions

This section records any allergies and adverse reactions the woman has experienced. This includes the type of reaction, the type of substance that caused the reaction and the severity of the reaction. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 7.1 | Allergies present | 7.4 | Allergies – substances – ‘Other’ – detail |
| 7.2 | Allergies – medicines | 7.5 | Adverse reactions |
| 7.3 | Allergies – substances |  |  |

## Allergies present

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any allergies to medicines or other substances that the woman is known to have | | |
| **Source Standards** | HISO 10042.2 Medicine Reconciliation standard published September 2012  SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No known allergies | 716186003 | | Allergy to medicine | 416098002 | | Allergy to substance | 419199007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Use section 7.3 Allergies – substances for any substance other than medicine. | | |
| **Verification rules** | Valid code only | | |

## Allergies – medicines

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Specific medicines that the woman is known to be allergic to | | |
| **Source Standards** | HISO 10042.2 Medicine Reconciliation standard published September 2012  https://www.health.govt.nz/system/files/documents/publications/medication-reconciliation-standard-v3-sep12.pdf | | |
| **Data type** | Alphanumeric | **Representational class** | Value |
| **Field size** | Max: 250 | **Representational layout** | X(250) |
| **Data domain** | Record the relevant medicine | | |
| **Obligation** | Conditional on a response of Allergy to medicine’ to section 7.1 Allergies present | | |
| **Guide for use** | Up to nine instances of this field may be recorded for this field | | |
| **Verification rules** | Valid code only | | |

## Allergies – substances

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Substances that the woman is known to be allergic to | | |
| **Source Standards** | HISO 10042.2 Medicine Reconciliation standard published September 2012  SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Dairy allergy | 226760005 | | Egg allergy | 102263004 | | Latex allergy | 111088007 | | Nuts allergy | 13577000 | | Seafood allergy | 44027008 | | Other | TBA | |  |  | | | | |
| **Obligation** | Conditional on a response of ‘Allergy to substance’ for section 7.1 Allergies present | | |
| **Guide for use** | Record the substances the women is allergic to, other than medicines.  Up to five instances of this field may be recorded for this field | | |
| **Verification rules** |  | | |

## Allergies – substances – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ substance allergies | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 7.3 Allergies – substances | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 7.3 Allergies – substances | | |
| **Verification rules** |  | | |

## Adverse reactions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Any adverse drug reaction (ADR) to a medicine the woman has experienced | | |
| **Source Standards** | HISO 10042.2 Medicine Reconciliation standard published September 2012 | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response other than ‘No known allergies’ to section 7.1 Allergies present | | |
| **Guide for use** | Up to nine instances may be recorded for this field | | |
| **Verification rules** |  | | |

# Alcohol and other drugs

This section includes information about the woman’s consumption of alcohol and other drugs. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 8.1 | Alcohol consumption | 8.6 | Referred to alcohol free services |
| 8.2 | Current consumption | 8.7 | Drug use |
| 8.3 | Timing of alcohol cessation | 8.8 | History of drug use |
| 8.4 | Amount of alcohol consumed | 8.9 | Current drugs used |
| 8.5 | Brief alcohol reduction advice | 8.10 | Current drugs used – ‘Other’ – detail |

## Alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the woman has consumed alcohol in the six months before this pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Non-drinker | 228274009 | | Admits alcohol use | 704197006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Current consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the woman currently drinks alcohol | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Does not drink alcohol | 105542008 | | Current drinker | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Timing of alcohol cessation

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | When the woman stopped drinking alcohol | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Pre-pregnancy  2 – First trimester of pregnancy  3 – Second trimester of pregnancy  4 – Third trimester of pregnancy | | |
| **Obligation** | Mandatory on a response of ‘Admits alcohol use’ in section 8.1 Alcohol consumption | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Amount of alcohol consumed

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The units of alcohol consumed by the woman per week | | |
| **Source Standards** | https://www.alcohol.org.nz/help-advice/standard-drinks/whats-a-standard-drink | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 3 | **Representational layout** | NNN |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘Current drinker’ to section 8.2 Current consumption | | |
| **Guide for use** | An approximate number of units is acceptable | | |
| **Verification rules** |  | | |

## Brief alcohol reduction advice

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Brief advice offered regarding reducing alcohol consumption | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Conditional on a response of ‘Current drinker’ to section 8.2 Current consumption | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Referred to alcohol free services

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Were alcohol free services offered to the woman | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Conditional on a response of ‘Current drinker’ to section 8.1 Alcohol consumption | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has used drugs in the six months before this pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Yes  2 – No  3 – Declined to answer | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## History of drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has used drugs in the past | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Does not misuse drugs | 228367002 | | Current drug user | 417284009 | | Ex-drug user | 44870007 | | Misuse of prescription drugs | 191939002 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Current drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The drug(s) the woman is currently using | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Drug or medicament | 410942007 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Other | TBA | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Current drug user’ to section 8.8 History of drug use | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Current drugs used – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ drugs currently in use | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 8.9 Current drugs used | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 8.9 Current drugs used | | |
| **Verification rules** |  | | |

# Smoking status

This section records information about the smoking status of the woman. Smoking tobacco during pregnancy can have harmful effects on both the woman and baby. Pregnancy also provides motivation to stop smoking. For both these reasons it is important to collect information on the tobacco smoking rates of pregnant women and to offer them support and smoking cessation advice. Information about the tobacco smoking status (amount of cigarettes smoked per day) of the woman and smoking cessation support received is collected at the booking visit.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 9.1 | Ever smoked | 9.5 | Referred to smoke free services |
| 9.2 | Current smoker | 9.6 | Brief smoking advice |
| 9.3 | Date quit smoking | 9.7 | Exposure to second hand smoke |
| 9.4 | Number of cigarettes smoked per day | 9.8 | Change to vaping |

## Ever smoked

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the woman ever smoked tobacco | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Never smoked | 266919005 | | Ex smoker, greater than 12 months abstinent | 48031000119106 | | Ex smoker, less than 12 months abstinent | 735128000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This information is recorded when available | | |
| **Verification rules** | Valid value only | | |

## Current smoker

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Does the woman currently smoke tobacco or vaping substance | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Current smoker | 77176002 | | Current non-smoker | 160618006 | | Vaper with nicotine electronic cigarette user | TBA | | Vaper with non-nicotine electronic cigarette user | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Date quit smoking

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date the woman stopped smoking tobacco | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full or Partial Date |
| **Field size** | Max: 8 | **Representational layout** | CCYY[MM[DD]] |
| **Data domain** | Valid date or valid partial date | | |
| **Obligation** | Optional – This information is recorded when available | | |
| **Guide for use** | Conditional on a response other than ‘Never smoked’ to section 9.1 Ever smoked  The day or month can be left blank if either cannot be ascertained with reasonable accuracy and in a timely manner, or the full date is unknown at time of data entry. If the day is populated, the month must be populated. If the month is populated, the year must be recorded | | |
| **Verification rules** | This field must be a valid date that is less than or equal to the current date | | |

## Number of cigarettes smoked per day

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of tobacco cigarettes smoked by the woman per day | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 3 | **Representational layout** | NNN |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Current smoker’ for section 9.2 Current smoker | | |
| **Guide for use** | An approximate number is acceptable | | |
| **Verification rules** | An integer greater than zero | | |

## Referred to smoke free services

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has been referred to smoke free services | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Current smoker’ for section 9.2 Current smoker | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Brief smoking advice

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has been given brief advice regarding smoking cessation | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of ‘Current smoker’ for section 9.2 Current smoker | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Exposure to second hand smoke

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Identifies if and where the woman has been exposed to second hand tobacco smoke on a regular basis | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No known exposure to tobacco smoke | 711563001 | | Yes at home | 228524006 | | Yes at place of work | 228523000 | | Yes in the car or while commuting | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Change to vaping

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman changed from smoking cigarettes to vaping during this pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory on a response of either ‘Vaper with nicotine electronic cigarette user’ or ‘Vaper with non-nicotine electronic cigarette user’ to section 9.2 Current smoker | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

# Family health

This section records the medical history of both the woman’s family members and the family members of the baby’s father. Current and past medical conditions and any risk factors for congenital abnormalities should be noted. The information must be collected at the first full contact the woman has with maternity services. This is likely to be the booking visit or earlier contact with acute services during this pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 10.1 | Maternal family history | 10.4 | Paternal family history – Other |
| 10.2 | Maternal family history – other | 10.5 | Consanguinity |
| 10.3 | Paternal family history | 10.6 | Degree of relationship |

## Maternal family history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The relevant medical history of the woman’s close family | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Allergies | 160417009 | | Asthma | 160377001 | | Congenital anomaly | 160417009 | | Chromosomal anomaly | 160425006 | | Diabetes mellitus | 160303001 | | Hypertensive disorders of pregnancy | 160401003 | | Intellectual disability | 763598005 | | Mental illness | 160324006 | | Multiple pregnancy | 266906006 | | Not known | 407559004 | | No relevant family history | 160266009 | | Other relevant condition | 281666001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Maternal family history – other relevant condition

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other relevant conditions’ related to maternal family history | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other relevant condition’ for section 10.1 Maternal family history | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Paternal family history

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The relevant medical history of the baby’s father and his close family | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Allergies | 160469004 | | Congenital anomaly | 64731000119106 | | Chromosomal anomaly | 160425006 | | Intellectual disability | 763598005 | | Mental illness | 160324006 | | No relevant family history | 160266009 | | Not known | 407559004 | | Other relevant condition | 281666001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Paternal family history – Other relevant condition

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other relevant condition’ related to paternal family history | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘Other relevant condition’ for section 10.3 Paternal family history | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Consanguinity

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Are the baby’s parents related to each other | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Not known | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Degree of relationship

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The degree of blood relationship between the parents of the baby | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | First cousin | 4577005 | | Second cousin | 13443008 | | Other | 125679009 | |  |  | | | |
| **Obligation** | Mandatory on a response of '2 – Yes’ to section 10.5 Consanguinity | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

# Tuberculosis risk assessment

Information about tuberculosis (TB) risk factors is collected to determine whether the baby will require the BCG vaccine. This information is collected at the booking visit.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 11.1 | Lives with person with tuberculosis | 11.3 | Lived in country with tuberculosis |
| 11.2 | Lives in country with tuberculosis |  |  |

## Lives with person with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Information to record if the infant will be living in a house or with a person with either current TB or a past history of TB | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Unknown | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Lives in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether during their first five years, the infant will be living for three months or longer in a country with high rates of tuberculosis | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Unknown | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Lived in country with tuberculosis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether one or both parents or household members or carers, has within the last five years, lived in a country with high rates of TB | | |
| **Source Standards** | [https://www.who.int/tb/publications/global\_report/high\_tb\_burdencountrylists2016-2020.pdf](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.who.int\tb\publications\global_report\high_tb_burdencountrylists2016-2020.pdf) (page 3) | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Unknown | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | As per page 3 of the report specified above, the World Health Organization considers the following “high burden countries” for tuberculosis:  Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, the United Republic of Tanzania, Viet Nam, Zambia and Zimbabwe | | |
| **Verification rules** | Valid value only | | |

# Current pregnancy

This section collates information about the woman’s current pregnancy. The information is collected throughout the pregnancy and must be summarised at the end of the pregnancy.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 12.1 | Blood tests | 12.11 | Current alcohol consumption |
| 12.2 | Antenatal screening | 12.12 | Drug use |
| 12.3 | Family violence screening | 12.13 | Current drugs used |
| 12.4 | Fetal anomaly screening | 12.14 | Current smoker |
| 12.5 | Chorionic villus sampling (CVS) | 12.15 | Antenatal prescriptions |
| 12.6 | Amniocentesis | 12.16 | Antenatal prescriptions – other |
| 12.7 | Pregnancy complications | 12.17 | Antenatal complementary therapies |
| 12.8 | Antenatal referrals | 12.18 | Antenatal visits – first trimester |
| 12.9 | Antenatal referral code | 12.19 | Antenatal visits – second trimester |
| 12.10 | Antenatal admissions | 12.20 | Antenatal visits – third trimester |

## Blood tests

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Blood tests the woman has had during the current pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Antenatal first blood tests (AN1) | TBA | | Antenatal subsequent blood tests (AN2) | TBA | | Coagulation studies | 3116009 | | Iron studies (IR) | TBA | | OGTT - Oral glucose tolerance test | 113076002 | | Pre-eclampsia tests (PET) | TBA | | Other blood tests | 396550006 | | Declined blood tests | 116471000119100 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to seven instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Antenatal screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Screening tests the woman has had during the pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Red blood cell antibodies | 89754000 | | Declined screening tests | 31021000119100 | | Gestational diabetes | TBA | | Group B streptococcus | 118001005 | | Hepatitis A (Hep A) | 252404004 | | Hepatitis B (Hep B) | 252405003 | | Hepatitis C (Hep C) | 413107006 | | Human immunodeficiency virus (HIV) | 390786002 | | Multi-drug resistant organisms (MDRO) | 14788002 | | Syphilis (VDRL) | 169698000 | | Other | 243787009 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Family violence screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has been screened for family violence | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Declined to answer | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Fetal anomaly screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Fetal anomaly screening tests the woman had during the pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Declined fetal anomaly screening  2 – Non-invasive prenatal screening (NIPS)  3 – First trimester combined screening  4 – Second trimester maternal serum screening | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Chorionic villus sampling (CVS)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has undergone a CVS | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Amniocentesis

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has undergone an amniocentesis | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Pregnancy complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman experienced during the current pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Antepartum haemorrhage | 34842007 | | Eclampsia | 198992004 | | Gestational diabetes | 11687002 | | Hypertensive disorders of pregnancy | 20753005 | | Infection | 40609001 | | Mental health concerns | 10211000132109 | | No complications | TBA | | Placental conditions | 273983009 | | Preterm labour | 6383007 | | Other | 609496007 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Antenatal referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman has been referred to specialist services during her pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Antenatal referral code

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Unique antenatal referral code | | |
| **Source Standards** | <https://www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines>  see table 2 Conditions and referral categories | | |
| **Data type** | Number | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | Codes as per table 2 | | |
| **Obligation** | Conditional on a ‘1 – Yes’ response to section 12.8 Antenatal referrals | | |
| **Guide for use** | The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes | | |
| **Verification rules** | Valid code only | | |

## Antenatal admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman had been admitted to hospital for antenatal care during the current pregnancy | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Current alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Does the woman currently drink alcohol | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Does not drink alcohol | 105542008 | | Drinks alcohol | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 8.2 Current consumption. That is, this section (12.11 Current alcohol consumption), records a value at the end of the pregnancy | | |
| **Verification rules** | Valid code only | | |

## Drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the woman currently uses drugs | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Current drug user | 417284009 | | Declined to answer | 426544006 | | Does not misuse drugs | 228367002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 8.8 History of drug use. That is, this section (12.12 Drug use), records a value at the end of the pregnancy | | |
| **Verification rules** | Valid value only | | |

## Current drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Drugs the woman is currently using | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Drug or medicament | 410942007 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Current drug user’ to section 12.12 Drug use | | |
| **Guide for use** | Up to nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Current smoker

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Does the woman currently smoke tobacco | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Current smoker | 77176002 | | Current non-smoker | 160618006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 9.2 Current smoker. That is, this section (12.14 Current smoker), records a value at the end of the pregnancy | | |
| **Verification rules** | Valid value only | | |

## Antenatal prescriptions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The prescriptions supplied to the woman by the LMC during the current pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Analgesics | 373265006 | | Antacids | 372794006 | | Antibacterials | 419241000 | | Antifungals | 373219008 | | Minerals | 373460003 | | Non-steroidal anti-inflammatories (NSAIDs) | 372665008 | | Vitamins | 87708000 | | Other | 105590001 | | No prescriptions | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Antenatal prescriptions – other

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ Antenatal prescriptions | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 12.15 Antenatal prescriptions | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Antenatal complementary therapies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of complementary therapies used by the woman during the current pregnancy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Chiropractic | 182548004 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Massage | 387854002 | | Naturopathy | 439809005 | | Osteopathy | 182549007 | | No complementary therapies | TBA | | Rongoā Māori | TBA | | Other | 225423004 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Antenatal visits – first trimester

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of antenatal visits received by the woman during the first trimester | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Antenatal visits – second trimester

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of antenatal visits received by the woman during the second trimester | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Antenatal visits – third trimester

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of antenatal visits received by the woman during the third trimester | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

# Labour and birth

Information regarding the details of the labour and birth relating to the woman.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 13.1 | Onset of labour | 13.18 | Date and time pushing commenced |
| 13.2 | Planned place of birth | 13.19 | Complications – second stage |
| 13.3 | Planned place of birth – Other | 13.20 | Length of second stage of labour |
| 13.4 | Actual place of birth | 13.21 | Date and time of rupture of membranes |
| 13.5 | Actual place of birth – Other | 13.22 | Meconium present |
| 13.6 | Gestation at onset of labour | 13.23 | Number of babies born |
| 13.7 | Date and time labour established | 13.24 | Type of birth |
| 13.8 | Maternity facility admission date/time | 13.25 | Birth position |
| 13.9 | Labour augmented – first stage | 13.26 | Water birth |
| 13.10 | Reason labour augmented – first stage | 13.27 | Vaginal birth after Caesarean |
| 13.11 | Reason labour augmented – other | 13.28 | Length of third stage of labour |
| 13.12 | Complications – first stage | 13.29 | Analgesia in labour |
| 13.13 | Date and time cervix fully dilated | 13.30 | Anaesthesia in labour |
| 13.14 | Length of active first stage of labour | 13.31 | Analgesia for the birth |
| 13.15 | Labour augmentation – second stage | 13.32 | Anaesthesia for the birth |
| 13.16 | Reason labour augmented – second stage | 13.33 | Coping strategies |
| 13.17 | Reason labour augmented – second stage – other | 13.34 | Coping strategies – Other |

## Onset of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The manner by which the woman’s labour started | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Induced | 112070001 | | Planned Caesarean section before labour | 177141003 | | Spontaneous | 84457005 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Planned place of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The place or facility where the woman planned to give birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Home  2 – Primary facility  3 – Secondary facility  4 – Tertiary facility  5 – Other | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Planned place of birth – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ planned place of birth | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘5 – Other’ for section 13.2 Planned place of birth | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Actual place of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The actual place or facility where the woman gave birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Home  2 – Primary facility  3 – Secondary facility  4 – Tertiary facility  5 – In transit  6 – Other | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Actual place of birth – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ actual place of birth | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘6 – Other’ for section 13.4 Actual place of birth | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Gestation at onset of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Gestation at the onset of labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record the number of completed weeks of this pregnancy | | |
| **Verification rules** | Valid value only  The value must be greater than or equal to 20 | | |

## Date and time labour established

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time labour established, as measured by duration, frequency, and strength of contractions | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Conditional on response of ‘Spontaneous’ OR ‘Induced’ for section 13.1 Onset of labour | | |
| **Guide for use** | Used to calculate the length of the first stage of labour | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Maternity facility admission date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the woman was admitted to a maternity facility, if admitted to a facility | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Labour augmented – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the first stage of labour was augmented with an artificial rupture of membranes (ARM) and/or oxytocin | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No augmentation  2 – Augmented with ARM  3 – Augmented with oxytocin  4 – Augmented with both ARM and oxytocin | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Reason labour augmented – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason the woman’s labour was augmented during the first stage of labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Delay in first stage of labour  2 – Other | | |
| **Obligation** | Mandatory on a response other than ‘1 – No augmentation’ for section 13.9 Labour augmented – first stage | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Reason labour augmented – other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ reason for the augmentation of labour | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 250 | **Representational layout** | X(250) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘2 – Other’ for section 13.10 Reason labour augmented – first stage | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Complications – first stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of complications experienced during the first stage of labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Complications of an anaesthetic | 200046004 | | Cord prolapse | 270500004 | | Deep transverse arrest | 1343000 | | Fetal distress | 130955003 | | Infection | 32801000119106 | | Intrapartum haemorrhage | 38010008 | | Malposition | 698554000 | | Malpresentation | 698791008 | | Meconium liquor | 199595002 | | No fetal complications | TBA | | No maternal complications | TBA | | Obstructed labour | 199746004 | | Other | 199745000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Date and time cervix fully dilated

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the cervix was fully dilated | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Length of active first stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The calculated length of first stage of labour – presented and stored in hours and minutes | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 5 | **Representational layout** | HH:MM |
| **Data domain** | Up to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory if a valid date/time is provided at section 13.13 Date and time cervix fully dilated | | |
| **Guide for use** | **Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created ‘on-the-fly’ as a result of the LMC request  The value for this field is created by:  subtracting the:  time labour commenced (a time value recorded in section 13.7 Date and time labour established)  from the  recorded time for the end of first stage labour  (a value recorded in section 13.13 Date and time cervix fully dilated) | | |
| **Verification rules** |  | | |

## Labour augmentation – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the labour was augmented with an artificial rupture of membranes (ARM) and/or oxytocic during the second stage of labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No augmentation  2 – Augmented with ARM  3 – Augmented with oxytocin  4 – Augmented with both ARM and oxytocin | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Reason labour augmented – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason the woman’s labour was augmented during the second stage of labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Delay in second stage of labour  2 – Other | | |
| **Obligation** | Mandatory on any other response than ‘1 – No augmentation’ for section 13.15 Labour augmentation – second stage | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Reason labour augmented – second stage – other

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ reason labour augmented – second stage | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Conditional on a response of ‘2 – Other’ for section 13.16 Reason labour augmented – second stage | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Date and time pushing commenced

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the woman actively started pushing during the second stage | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Complications – second stage

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of complications the woman had during the second stage of labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Complications of an anaesthetic | 200046004 | | Cord prolapse | 270500004 | | Deep transverse arrest | 1343000 | | Fetal distress | 130955003 | | Infection | 32801000119106 | | Intrapartum haemorrhage | 38010008 | | Malposition | 698554000 | | Malpresentation | 698791008 | | Meconium liquor | 199595002 | | No fetal complications | TBA | | No maternal complications | TBA | | Obstructed labour | 199746004 | | Other | 199745000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Length of second stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The calculated length of second stage of labour – presented and stored in hours and minutes | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 5 | **Representational layout** | HH:MM |
| **Data domain** | Zero to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory if a valid date/time is provided at section 13.13 Date and time cervix fully dilated | | |
| **Guide for use** | **Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created ‘on-the-fly’ as a result of the LMC request  The value for this field is created by:  Subtracting the  time value recorded for the start of the second stage of labour (a time value recorded in 13.13 Date and time cervix fully dilated)  from the  recorded time of the birth of the baby (a time value recorded in section 17.1 Date and time of birth) | | |
| **Verification rules** |  | | |

## Date and time of rupture of membranes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time of the membranes rupturing | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Meconium present

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was there any meconium present in the amniotic fluid | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Yes  2 – No  3 – Amniotic fluid not present | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Number of babies born

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of babies born during this labour and birth, including stillbirths | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer greater than zero | | |

## Type of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Type of birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Spontaneous vaginal birth | 48782003 | | Caesarean section | 200144004 | | Forceps | 200130005 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to four instances may be recorded for this field | | |
| **Verification rules** | Valid code only | | |

## Birth position

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The position the woman gave birth in | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Supine | 40199007 | | Semi-reclined | 272580008 | | Lithotomy | 14205002 | | Standing | 10904000 | | Squatting | 408797004 | | Kneeling | 277773003 | | Lateral | 32185000 | | Sitting (eg birth stool) | 33586001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record one entry for each baby born | | |
| **Verification rules** | Valid code only | | |

## Water birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Indicates whether the baby was born into water | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Record one entry for each baby born | | |
| **Verification rules** | Valid code only | | |

## Vaginal birth after Caesarean

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Identifies whether the birth was the first vaginal birth after a previous Caesarean section | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Length of third stage of labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The calculated length of third stage of labour – presented and stored in hours and minutes | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 5 | **Representational layout** | HH:MM |
| **Data domain** | Zero to 99 hours, 59 minutes | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | **Note:** This is a system calculation that is conditional on the request of the LMC. The result of the calculation may be stored within the maternity database or created ‘on-the-fly’ as a result of the LMC request.  The value for this field is created by:  subtracting the  recorded time of the birth of the baby (a value recorded in 17.1 Date and time of birth)  from the  recorded time for the end of third stage of labour (a time value recorded in section 16.3 Placenta delivery date and time | | |
| **Verification rules** |  | | |

## Analgesia in labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of analgesia used by the woman during labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No analgesia  2 – Pharmacological – non opiate  3 – Pharmacological – opiate  4 – Non pharmacological | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Anaesthesia in labour

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of anaesthesia administered to the woman during labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Epidural | 27372005 | | Spinal | 231249005 | | Combined spinal/epidural | 231261002 | | General anaesthetic | 50697003 | | No previous anaesthesia | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Analgesia for the birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of analgesia used by the woman for the birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No analgesia  2 – Pharmacological – non opiate  3 – Pharmacological – opiate  4 – Non pharmacological | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Anaesthesia for the birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The types of anaesthesia administered to the woman for the birth of the baby(ies) | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Local anaesthetic | 386761002 | | Pudendal block | 231208005 | | Epidural | 27372005 | | Spinal | 231249005 | | Combined spinal/epidural | 231261002 | | General anaesthetic | 50697003 | | No previous anaesthesia | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Coping strategies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the types of coping strategies and complementary therapies used by the woman during labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Aromatherapy | 394615007 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Hypnobirthing techniques | 19997007 | | Massage | 387854002 | | Naturopathy | 439809005 | | Positional techniques | 226048001 | | Rongoā Māori | TBA | | Support people | TBA | | TENS machine | 229559001 | | Water immersion | 229204004 | | Other | TBA | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Up to 13 instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Coping strategies – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Additional field to describe the ‘Other’ coping strategies | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 13.33 Coping strategies | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

# Induction of labour

Information about the woman’s induction of labour, if she had one during this labour and birth.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 14.1 | Induction date and time | 14.3 | Induction reason |
| 14.2 | Induction method(s) |  |  |

## Induction date and time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time induction of labour was commenced | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory on a response of ‘Induced’ for section 13.1 Onset of labour | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Induction method(s)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The method(s) by which the labour was induced | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Artificial rupture of membranes (ARM) | 408816000 | | Cervical ripening balloon | 425861005 | | Oxytocin infusion | 177135005 | | Prostaglandin | 177136006 | |  |  | | | |
| **Obligation** | Mandatory on a valid response being recorded for section 14.1 Induction date and time | | |
| **Guide for use** | Up to four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Induction reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Reason for the induction of labour | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Abnormal cardiotochogram (CTG) | 735205007 | | Abnormal dopplers | 312370006 | | Advanced maternal age | 416413003 | | Antepartum haemorrhage | 34842007 | | Blood group antibodies | 166167002 | | Congenital anomalies | 64731000119106 | | Diabetes mellitus | 10754881000119104 | | Eclampsia | 15938005 | | Gestational hypertension | 288250001 | | Hypertension | 106005003 | | In vitro fertilisation | 10231000132102 | | Intrauterine fetal death | 14022007 | | Intrauterine growth restriction (IUGR) | 22033007 | | Large for gestational age | 199616008 | | Long latent phase | 387700009 | | Maternal medical condition | 106007006 | | Maternal request | 408855004 | | Multiple pregnancy | 16356006 | | Obesity | 10750551000119100 | | Obstetric cholestasis | 10750161000119106 | | Oligohydramnios | 59566000 | | Polyhydramnios | 86203003 | | Poor obstetric history | 161803004 | | Pre-eclampsia | 398254007 | | Prelabour rupture of membranes | 44223004 | | Preterm rupture of membranes | 237266003 | | Previous shoulder dystocia | TBA | | Prolonged pregnancy | 90968009 | | Reduced fetal movements | 276369006 | | Congenital anomaly of fetus | 702709008 | | Chromosomal anomaly of fetus | 267253006 | | Termination of pregnancy | 57797005 | | Unstable lie | 86356004 | | Other | 106007006 | |  |  | | | |
| **Obligation** | Mandatory on a valid response being recorded for section 14.1 Induction date and time | | |
| **Guide for use** | Up to five instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

# Caesarean section

Information about the woman’s Caesarean section, if she had one during this labour and birth.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 15.1 | Caesarean section type | 15.7 | Caesarean section primary indication – Other fetal reason – detail |
| 15.2 | Caesarean grade | 15.8 | Caesarean section primary indication – Other maternal detail |
| 15.3 | Caesarean category | 15.9 | Complications during Caesarean section |
| 15.4 | Dilation before Caesarean section | 15.10 | Complications during Caesarean section – Other |
| 15.5 | Caesarean section primary indication | 15.11 | Complications post Caesarean section |
| 15.6 | Caesarean section primary indication – detail |  |  |

## Caesarean section type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of uterine incision if there was a Caesarean section for this birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Classical | 84195007 | | Lower uterine segment (LUSCS) | 398307005 | | Other | 11466000 | |  |  | | | |
| **Obligation** | Conditional on a response of ‘Caesarean section’ for section 13.24 Type of birth | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Caesarean grade

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The grade of urgency under which the Caesarean section was initiated | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Planned (elective) | 177141003 | | Unplanned (emergency) | 274130007 | |  |  | | | |
| **Obligation** | Conditional on a valid response being recorded for section 15.1 Caesarean section type | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Caesarean category

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The category of the Caesarean section | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Category 1 – Urgent threat to the life 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 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 | | |
| **Obligation** | Conditional on a response of ‘Unplanned (emergency)’ for section 15.2 Caesarean grade | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Dilation before Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The extent of cervical dilation in centimetres as last measured prior to Caesarean section. | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** |  | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer | | |

## Caesarean section primary indication

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Primary indication for Caesarean section | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Planned/prelabour (Maternal)  2 – Planned/prelabour (Fetal)  3 – Unplanned (Maternal)  4 – Unplanned (Fetal) | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Caesarean section primary indication – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the primary indication for performing the Caesarean section | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Antepartum haemorrhage | 34842007 | | Augmentation causing uterine hyperstimulation | 34981006 | | Chorioamnionitis | 11612004 | | Chronic hypertension | 8218002 | | Cord presentation | 237305004 | | Cord prolapse | 270500004 | | Diabetes mellitus type 1 | 46635009 | | Diabetes mellitus type 2 | 44054006 | | Efficient uterine action – obstructed labour | TBA | | Failed induction of labour | 42571002 | | Failed instrumental delivery | 772006002 | | Fetal anomaly | 702709008 | | Fetal distress | 12867002 | | Fetal distress – intolerance of augmented labour | TBA | | Fetal distress – spontaneous labour | 288274003 | | Gestational diabetes | 11687002 | | Inefficient uterine action – no oxytocin | TBA | | Large for gestational age | 199616008 | | Malposition | 289365005 | | Malpresentation | 15028002 | | Maternal age | 416413003 | | Maternal medical condition | 106007006 | | Multiple pregnancy | 16356006 | | Other fetal reason | 106009009 | | Other maternal reason | 106008001 | | Placenta praevia | 36813001 | | Placental abruption | 415105001 | | Poor uterine response to optimal augmentation | TBA | | Pre-eclampsia | 398254007 | | Previous Caesarean section | 200151008 | | Small for gestational age | 267258002 | | Suboptimal augmentation | 91484005 | | Unknown | 281337006 | | Uterine rupture | 34430009 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Caesarean section primary indication – Other fetal reason – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other fetal reason’ caesarean information | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other fetal reason’ in section 15.6 Caesarean section primary indication – detail | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Caesarean section primary indication – Other maternal detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other maternal’ caesarean information | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other maternal reason’ in section 15.6 Caesarean section primary indication – detail | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Complications during Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications that occurred during the Caesarean section | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No complications | TBA | | Eclampsia | 15938005 | | Uterine complications | 289618005 | | Bowel injury | 125625000 | | Bladder injury | 77165001 | | Ureteric injury | 24850009 | | Adhesions | TBA | | Intrapartum haemorrhage | 38010008 | | Other | 78408007 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** | Up to nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Complications during Caesarean section – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other’ complications during Caesarean section | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ’Other’ for section 15.9 Complications during Caesarean section | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Complications post Caesarean section

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications that occurred in the first six weeks post operatively as a result of the Caesarean section | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Wound infection | 76844004 | | Uterine infection | 301775005 | | UTI - Urinary tract infection | 68566005 | |  |  | | | |
| **Obligation** | Optional | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

# Post birth

Information about the woman during the third stage of labour and up to 24 hours postnatally. There is one set of coded entries and the corresponding text block for display is structured as a table.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 16.1 | Placenta mode of delivery | 16.8 | Non perineal genital tract trauma type |
| 16.2 | Uterotonic drug | 16.9 | Repair required |
| 16.3 | Placenta delivery date and time | 16.10 | Placenta and membranes |
| 16.4 | Perineal status | 16.11 | Placenta appearance |
| 16.5 | Episiotomy type | 16.12 | Number of cord vessels |
| 16.6 | Episiotomy reason | 16.13 | Placenta kept by the woman |
| 16.7 | Episiotomy reason– Other | 16.14 | Total blood loss |

## Placenta mode of delivery

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The mode of delivery of the placenta | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Caesarean section | TBA | | Controlled cord traction with uterotonic | 302384005 | | Manual removal | 28233006 | | Physiological | 177212000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Uterotonic drug

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Uterotonic drugs administered as part of the third stage of labour | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – None  2 – Yes, as part of active management  3 – Yes, as treatment | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Placenta delivery date and time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the placenta was delivered | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | This field is also the ‘end of third stage labour’ | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Perineal status

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The status of the woman’s perineum after the birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Perineum intact | 289854007 | | First degree tear  – injury to perineal skin and vaginal wall only | 57759005 | | Second degree tear  – injury to perineal skin, vaginal wall and superficial perineal muscles | 6234006 | | Third degree tear (3a)  – injury to perineal skin, vaginal wall and perineal muscles and less than 50% of external anal sphincter (EAS) thickness torn | 449807005 | | Third degree tear (3b)  – injury to perineal skin, vaginal wall and perineal muscles and more than 50% of EAS thickness torn | 449808000 | | Third degree tear (3c)  – both EAS and internal anal sphincter (IAS) torn | 449809008 | | Fourth degree tear  – anal sphincter complex (EAS and IAS) and anal epithelium torn | 399031001 | | Episiotomy | TBA | | Not known | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to four instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Episiotomy type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The episiotomy type | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Anterior | 255549009 | | J shaped | 260666003 | | Mediolateral | 261129000 | | Midline | 399488007 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Episiotomy’ for section 16.4 Perineal status | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Episiotomy reason

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The clinical indication for performing the episiotomy | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Fetal distress | 130955003 | | Female Genital Mutilation (FGM) | 95041000119101 | | Instrumental birth | TBA | | Maternal distress | 87383005 | | Previous perineal damage | 15758941000119102 | | Rigid perineum | 289875004 | | Shoulder dystocia | 89700002 | | Other | TBA | |  |  | | | |
| **Obligation** | Mandatory on response of ‘Episiotomy’ to section 16.4 Perineal status | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Episiotomy reason– Other

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other’ episiotomy reason | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other’ for section 16.6 Episiotomy reason | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Non perineal genital tract trauma type

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of any non-perineal genital tract trauma | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Cervical laceration | 289794001 | | Labial graze or tear | 289488005 | | Vaginal laceration | 410062001 | |  |  | | | |
| **Obligation** | Conditional on non-perineal genital tract trauma being present | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Repair required

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Perineal or genital tract trauma suturing or repair | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | No repair required | 418014008 | | Repair episiotomy | 177222006 | | Repair perineal tear | 237026005 | | Repair genital tract laceration | 372455009 | |  |  | | | |
| **Obligation** | Mandatory on a response other than ‘Perineum intact’ OR ‘Not known’ for section 16.4 Perineal status | | |
| **Guide for use** | Up to three instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Placenta and membranes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the placenta complete | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Complete | 249170006 | | Incomplete | 268479002 | | Ragged membranes | 249182002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to two instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Placenta appearance

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Description of the appearance of the placenta | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Calcifications | 249174002 | | Fetus papyraceous | 90127001 | | Gritty | 249173008 | | Infarctions | 271403007 | | Normal | 289279004 | | Oedematous | 56425003 | | Offensive | 289275005 | | Retroplacental clot | 249177009 | | Succenturiate lobe | 82664003 | | Velamentous insertion of cord | 77278008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to five instances of this field may be captured | | |
| **Verification rules** | Valid code only | | |

## Number of cord vessels

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of vessels identified in the umbilical cord | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 2 or 3 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Placenta kept by the woman

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the placenta kept by the woman | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Total blood loss

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The estimated and/or measured total blood loss within two hours of the birth recorded in millilitres | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NNNN |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer greater than zero | | |

# Newborn baby

Information about the baby(ies) resulting from the birth. This includes information about each baby and its care immediately after birth. There is one set of coded entries per baby born.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 17.1 | Date and time of birth | 17.18 | Apgar 1 minute |
| 17.2 | Gestation at birth | 17.19 | Apgar 5 minutes |
| 17.3 | Birth outcome | 17.20 | Apgar 10 minutes |
| 17.4 | Place of birth | 17.21 | Neonatal resuscitation |
| 17.5 | Place of birth – Other | 17.22 | Vitamin K |
| 17.6 | Mode of birth | 17.23 | Skin to skin |
| 17.7 | Presenting part of baby | 17.24 | Skin to skin – start date/time |
| 17.8 | Presenting part of baby – other – detail | 17.25 | Skin to skin – end date/time |
| 17.9 | Type of breech | 17.26 | Skin to skin – reason for end |
| 17.10 | Mode of breech birth | 17.27 | Skin to skin end – Other – detail |
| 17.11 | Shoulder dystocia | 17.28 | Infant feeding method |
| 17.12 | Shoulder dystocia procedures | 17.29 | Breastfeeding – start date/time |
| 17.13 | Shoulder dystocia procedures – Other manoeuvre – detail | 17.30 | Initial breastfeed – end date/time |
| 17.14 | Cord blood sample | 17.31 | Consultations or referrals |
| 17.15 | Baby sex | 17.32 | Reason for referral to specialist |
| 17.16 | Birth weight | 17.33 | Admission to neonatal intensive care (NICU) or special care baby unit (SCBU) |
| 17.17 | Baby NHI number |  |  |

## Date and time of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the baby was born | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Gestation at birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The gestation of the baby at birth, recorded in weeks and days | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NN:N |
| **Data domain** |  | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | For example: 38 weeks and 4 days would be recorded as 38:4 (W:D) | | |
| **Verification rules** | Weeks and days | | |

## Birth outcome

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | What was the outcome of the birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Live born | 281050002 | | Stillborn – antepartum | 44174001 | | Stillborn – intrapartum | 1762004 | | Neonatal death | 276506001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Place of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of place where the birth occurred | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Home  2 – Primary maternity facility  3 – Secondary maternity facility  4 – Tertiary maternity facility  5 – In transit  6 – Other | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Place of birth – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other’ place of birth | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘6 – Other’ for section 17.4 Place of birth | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Mode of birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | How the baby(ies) was/were born | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Spontaneous vaginal birth | 48782003 | | Caesarean section | 200144004 | | Forceps | 200130005 | | Vacuum extraction | 200138003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Presenting part of baby

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The presenting part of the baby at time of birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Breech | 6096002 | | Cephalic | 70028003 | | Compound | 124736009 | | Shoulder | 23954006 | | Other | 15028002 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Presenting part of baby – other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other’ presenting part of the baby | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other’ for section 17.7 Presenting part of baby | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Type of breech

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The type of breech presentation | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Complete | 49168004 | | Extended (frank) | 18559007 | | Footling | 249097002 | | Kneeling | TBA | | Incomplete | 38049006 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Breech’ for section 17.7 Presenting part of baby | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Mode of breech birth

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The mode of the breech birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Assisted vaginal breech | 177158008 | | Caesarean section | 712654009 | | Spontaneous vaginal breech | 271373005 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘Breech’ for section 17.7 Presenting part of baby | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Shoulder dystocia

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was there a shoulder dystocia during the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Shoulder dystocia procedures

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The procedures required to deliver the baby during the shoulder dystocia | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Maternal position change | 229824005 | | McRoberts’ position | 237009004 | | Suprapubic pressure (Rubin’s I) | 23701000 | | Internal manoeuvres (Rubin’s II/Wood’s screw/Reverse Wood’s screw) | 237011008 | | Delivery of posterior arm | 237012001 | | Other manoeuvre | 237008007 | |  |  | | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 17.11 Shoulder dystocia | | |
| **Guide for use** | Up to six instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Shoulder dystocia procedures – Other manoeuvre – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A description of the type of ‘Other manoeuvre’ | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘Other manoeuvre’ for section 17.12 Shoulder dystocia procedures | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Cord blood sample

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | To record the cord blood tests taken if any | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Blood gases | 167018008 | | Blood group type and antibodies | 20099001 | | Lactate | 3926003 | | Laboratory test not necessary | 165330008 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Baby sex

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Baby sex is recorded as either male, female or indeterminate | | |
| **Source Standards** | HISO 10046 Consumer Health Identity Standard, section 2.4 Gender  [https://www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.health.govt.nz\publication\hiso-10046-consumer-health-identity-standard) | | |
| **Data type** | Alphabetic | **Representational class** | Code |
| **Field size** | Max:1 | **Representational layout** | A |
| **Data domain** | ‘M’ – Male  ‘F” – Female  ‘I’ – Indeterminate | | |
| **Obligation** | Mandatory  This value is to be obtained directly from the NHI system. This will require knowledge of the baby’s NHI number as a key – see section 17.17 Baby NHI number  At this time, the NHI does not record a value for Sex. However, the NHI does populate a Gender field with a Sex value. A change is being planned to address this situation | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value | | |

## Birth weight

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The weight of the baby at birth (or the earliest weight recorded) in grams | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 4 | **Representational layout** | NNNN |
| **Data domain** | Grams | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | An integer greater than 400 grams | | |

## Baby NHI number

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | National Health Index (NHI) number – a unique identifier allocated by the NHI system to all babies | | |
| **Source standards** | HISO 10046 Consumer Health Identity Standard: www.health.govt.nz/publication/hiso-10046-consumer-health-identity-standard  See also NHI data dictionary: [www.health.govt.nz/publication/national-health-index-data-dictionary](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.health.govt.nz\publication\national-health-index-data-dictionary) | | |
| **Data type** | Alphanumeric | **Representational class** | Identifier |
| **Field size** | Max: 7 | **Representational layout** | AAANNNN |
| **Data domain** | NHI numbers | | |
| **Obligation** | Mandatory. This number must be obtained from the NHI system | | |
| **Guide for use** | Only the NHI system generates the NHI number that is allocated to a baby. NHI numbers are not re-used once allocated to an identity  Where more than one number exists for an identity, one number is declared ‘live’ and all other numbers are made ‘dormant’ and attached to the live record. The NHI number is the primary key for the woman’s records | | |
| **Verification rules** | See the source standards for the check digit algorithm and NHI number validation rules | | |

## Apgar 1 minute

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The Apgar score the baby received at one minute of age | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-10 | | |
| **Obligation** | Optional | | |
| **Guide for use** | Apgar scores indicate the physical health of a newborn infant, determined after examination of the adequacy of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| **Verification rules** | Valid code only | | |

## Apgar 5 minutes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The Apgar score the baby received at five minutes of age | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-10 | | |
| **Obligation** | Optional | | |
| **Guide for use** | Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| **Verification rules** | Valid code only | | |

## Apgar 10 minutes

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The Apgar score the baby received at ten minutes of age | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-10 | | |
| **Obligation** | Optional | | |
| **Guide for use** | Apgar scores indicate the physical health of a newborn infant, determined after assessment of respiration, heart rate, muscle tone, skin colour and reflexes | | |
| **Verification rules** | Valid code only | | |

## Neonatal resuscitation

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was neonatal resuscitation required, including the outcome | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Not performed | 262008008 | | Successful | 385669000 | | Unsuccessful | 385671000 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Vitamin K

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Prophylactic Vitamin K administration, including the route of administration | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Intramuscular | 736388004 | | Oral | 698350008 | | Declined | 15651391000119108 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Skin to skin

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the baby(ies) receive skin to skin contact with the woman at the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Skin to skin – start date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The start time of the initial skin to skin contact with the woman | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 17.23 Skin to skin | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than the current date and time | | |

## Skin to skin – end date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The end time of the initial skin to skin contact with the woman | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 17.23 Skin to skin | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time andgreater than the date and time specified in section 17.24 Skin to skin – start date/time | | |

## Skin to skin – reason for end

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason why initial skin to skin contact was ended | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – One hour or more skin to skin contact had been achieved  2 – Maternal request  3 – Health professional decision  4 – Medical reason  5 – Other reason | | |
| **Obligation** | Conditional on a response of ‘1 – Yes’ for section 17.23 Skin to skin | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Skin to skin end – Other – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | To record the ‘Other reason’ that the skin to skin time ended | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory upon a response of ‘5 – Other reason’ for section 17.26 Skin to skin – reason for end | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Infant feeding method

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The method by which the baby was first fed after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)  2 – Freshly expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  3 – Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  4 – Breastfeeding at someone else’s breast (‘exclusively breastfed’)  5 – Donor breast milk, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  6 – Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’)  7 – Parenteral nutrition | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Breastfeeding – start date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time that breastfeeding was initiated after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory on any response other than ‘6 – Infant formula …’ or ‘7 – Parenteral nutrition’ to section 17.28 Infant feeding method | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Initial breastfeed – end date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the initial breastfeed ended after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Mandatory on a valid response to section 17.29 Breastfeeding – start date/time | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is:   * less than or equal to the current date and time, and * greater than the date and time recorded in section 17.29 Breastfeeding – start date/time | | |

## Consultations or referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the baby(ies) require a consultation with, or referral to, a specialist in the immediate post birth period | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Reason for referral to specialist

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The reason for a consultation with or referral to a specialist in the immediate post birth period | | |
| **Source Standards** | https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.health.govt.nz\publication\guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines): (Table 2 Conditions and referral categories) | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 17.31 Consultations or referrals | | |
| **Guide for use** | The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes  Up to ten instances for this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Admission to neonatal intensive care (NICU) or special care baby unit (SCBU)

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the baby require admission to a NICU or SCBU following birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Yes, but kept on the ward | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

# Postnatal baby

Postnatal information about the baby(ies) resulting from the birth. This summarises information about each baby over the six weeks following the birth. There is one set of coded entries per baby born.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 18.1 | Maternity facility discharge date/time | 18.11 | Infant feeding – 48 hours |
| 18.2 | Infant feeding on discharge from facility | 18.12 | Infant feeding – 2 weeks |
| 18.3 | Baby sleep information | 18.13 | Infant feeding at discharge from LMC |
| 18.4 | Baby sleep environment | 18.14 | Neonatal referrals |
| 18.5 | Red eye reflex screening – right eye | 18.15 | Neonatal referral code |
| 18.6 | Red eye reflex screening – left eye | 18.16 | Neonatal admission |
| 18.7 | Metabolic screening | 18.17 | Well Child provider referral |
| 18.8 | Right ear hearing | 18.18 | Well Child provider |
| 18.9 | Left ear hearing | 18.19 | General practice referral |
| 18.10 | Infant feeding | 18.20 | Neonatal death |

## Maternity facility discharge date/time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the baby was discharged from a maternity facility, if admitted to a facility | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Conditional on the baby’s admission to a maternity facility | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Infant feeding on discharge from facility

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Infant feeding method on discharge from maternity facility | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)  2 – Freshly expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  3 – Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  4 – Breastfeeding at someone else’s breast (‘exclusively breastfed’)  5 – Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  6 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours (‘fully breastfed’)  7 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula (‘partially breastfed’)  8 – Infant formula, fed via bottle (‘artificially fed’) | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Baby sleep information

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was safe sleep information provided to the parents | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Baby sleep environment

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the baby’s sleep environment assessed for safety | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Red eye reflex screening – right eye

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The result of the baby’s red eye reflex screening test, right eye | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 439064003 | | Abnormal | 247079003 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Red eye reflex screening – left eye

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The result of the baby’s red eye reflex screening test, left eye | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 439063009 | | Abnormal | 247079003 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Metabolic screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The result of the baby’s newborn metabolic screening test (also known as the heel prick or Guthrie test) | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 17621005 | | Abnormal | 263654008 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Right ear hearing

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The result of the baby’s newborn hearing screening for the right ear. | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 17621005 | | Abnormal | 263654008 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Left ear hearing

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The result of the baby’s newborn hearing screening for the left ear | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Normal | 17621005 | | Abnormal | 263654008 | | Screening declined | 31021000119100 | | Not completed | 394908001 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Infant feeding

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the baby ever fed at the mother’s breast | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** |  | | |

## Infant feeding – 48 hours

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The method by which the baby was being fed at 48 hours of age | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)  2 – Freshly expressed breast milk from the mother’s breast, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  3 – Antenatally expressed breast milk from the mother’s breast, fed via syringe, cup, spoon nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  4 – Breastfeeding at someone else’s breast (‘exclusively breastfed’)  5 – Donor breast milk, fed via syringe, cup, spoon, nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  6 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours (‘fully breastfed’)  7 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula (‘partially breastfed’)  8 – Infant formula, fed via bottle (‘artificially fed’) Infant formula, fed via syringe, cup, spoon or nasogastric (NG) feeding tube (‘artificially fed’) | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Infant feeding – 2 weeks

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The method by which the baby was being fed at two weeks of age | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)  2 – Expressed breast milk from the mother’s breast, fed via supplemental nursing system (SNS) tube  3 – Breastfeeding at someone else’s breast (‘exclusively breastfed’)  4 – Donor breast milk, fed via bottle or nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  5 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours (‘fully breastfed’)  6 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula (‘partially breastfed’)  7 – Infant formula, fed via bottle (‘artificially fed’) | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Infant feeding at discharge from LMC

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The method by which the baby was being fed at the time of discharge from LMC | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Exclusively breastfed at the mother’s breast (‘exclusively breastfed’)  2 – Expressed breast milk from the mother’s breast, fed via supplemental nursing system (SNS) tube (‘exclusively breastfed’)  3 – Breastfeeding at someone else’s breast (‘exclusively breastfed’)  4 – Donor breast milk, fed via bottle or nasogastric (NG) feeding tube, or supplemental nursing system (SNS) tube (‘exclusively breastfed’)  5 – Fully breastfed, where the infant has only taken breast milk, except a minimal amount of water or prescribed medicines in the past 48 hours (‘fully breastfed’)  6 – Mixed feeding, where the infant has taken a mixture of breast milk and infant formula (‘partially breastfed’)  7 – Infant formula, fed via bottle (‘artificially fed’) | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Neonatal referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has the baby been referred to specialist services during the six weeks following the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Neonatal referral code

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | To capture the referral unique code | | |
| **Source Standards** | https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.health.govt.nz\publication\guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines)e: Table 2 Conditions and referral categories) | | |
| **Data type** | Number | **Representational class** | Code |
| **Field size** | Max: 4 | **Representational layout** | N(4) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a ‘1 – Yes’ response to section 18.14 Neonatal referrals | | |
| **Guide for use** | The above source reference provides access to a separate code list. This list is in the process of being updated to provide SNOMED codes  See table 2 from the above source | | |
| **Verification rules** | Valid code only | | |

## Neonatal admission

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | To record if the baby was admitted to a facility at any time in the six weeks following the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Well Child provider referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the baby referred to a Well Child provider | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Yes  2 – No  3 – Declined | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Well Child provider

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The Well Child provider the baby was referred to | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – General practice  2 – Māori provider  3 – Pasifika provider  4 – Plunket | | |
| **Obligation** | Mandatory on a response of ‘1 – Yes’ for section 18.17 Well Child provider referral | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## General practice referral

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was the baby referred to general practice | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – Yes  2 – No  3 – Declined | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Neonatal death

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the baby die during the 28 days after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

# Postnatal woman

Postnatal summary of information about the woman, over the six weeks following the birth.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data element** | | **Data element** | |
| 19.1 | Maternity facility discharge date and time | 19.9 | Current smoker |
| 19.2 | Postnatal complications | 19.10 | Current drug use |
| 19.3 | Postnatal referrals | 19.11 | Drugs used |
| 19.4 | Postnatal admissions | 19.12 | Drugs used – ‘Other’ – detail |
| 19.5 | Postnatal prescriptions | 19.13 | Postnatal visits |
| 19.6 | Postnatal complementary therapies | 19.14 | General practice notification |
| 19.7 | Family violence screening | 19.15 | Maternal death |
| 19.8 | Current alcohol consumption |  |  |

## Maternity facility discharge date and time

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The date and time the woman was discharged from a maternity facility, if she was admitted to a facility during the labour and birth or in the immediate postpartum period | | |
| **Source Standards** |  | | |
| **Data type** | Date | **Representational class** | Full date and time |
| **Field size** | Max: 14 | **Representational layout** | CCYYMMDD HH:MM |
| **Data domain** | Valid date and time | | |
| **Obligation** | Conditional on the admission of the woman to a maternity facility | | |
| **Guide for use** |  | | |
| **Verification rules** | This field must be a valid date and time that is less than or equal to the current date and time | | |

## Postnatal complications

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Complications the woman may have experienced during the six weeks after the birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | None | TBA | | Breastfeeding issues | 289084000 | | Breast infection | 198108005 | | Wound infection | 76844004 | | Uterine infection | 301775005 | | Urinary tract infection | 68566005 | | Other infection | 40733004 | | Postnatal depression | 58703003 | | Postnatal distress | 300894000 | | Postpartum psychosis | 18260003 | | Secondary postpartum haemorrhage | 23171006 | | Other | 198609003 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to nine instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Postnatal referrals

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Has there been a referral to specialist services for the woman during the six weeks after the birth | | |
| **Source Standards** | https://[www.health.govt.nz/publication/guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines](file:///C:\Users\cpollock\AppData\Local\Temp\notes2D1DBD\www.health.govt.nz\publication\guidelines-consultation-obstetric-and-related-medical-services-referral-guidelines)  (see: Table 2 Conditions and referral categories) | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The above source reference provides access to a separate code list of specialist services. This is as a guide to aid the Yes/No response required for this data element  This list is in the process of being updated to provide SNOMED codes | | |
| **Verification rules** | Valid value only | | |

## Postnatal admissions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Were there any postnatal admissions for the woman to a facility in the six weeks after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Postnatal prescriptions

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of prescriptions supplied to the woman by the LMC in the six weeks after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Postnatal complementary therapies

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The complementary therapies used by the woman in the six weeks after the birth | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Acupressure | 231107005 | | Acupuncture | 231081007 | | Chiropractic | 182548004 | | Herbal medicine | 414392008 | | Homeopathy | 182968001 | | Massage | 387854002 | | Lactation support | 408883002 | | Naturopathy | 439809005 | | No complementary therapies | TBA | | Rongoā Māori | TBA | | Osteopathy | 182549007 | | Other | 243120004 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | Up to ten instances of this field may be recorded | | |
| **Verification rules** | Valid code only | | |

## Family violence screening

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of whether the woman has been screened postnatally for family violence | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 1 | **Representational layout** | N |
| **Data domain** | 1 – No  2 – Yes  3 – Declined to answer | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Current alcohol consumption

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Does the woman currently drink alcohol | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Does not drink alcohol | 105542008 | | Current drinker | 219006 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 12.11 Current alcohol consumption, in that this section 19.8 Current alcohol consumption, records a value at the end of the postnatal period | | |
| **Verification rules** | Valid value only | | |

## Current smoker

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Does the woman currently smoke tobacco or vaping substance | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Current smoker | 77176002 | | Current non-smoker | 160618006 | | Vaper with nicotine electronic cigarette user | TBA | | Vaper non-nicotine electronic cigarette user | TBA | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 12.14 Current smoker, in that this section 19.9 Current smoker, records a value at the end of the postnatal period | | |
| **Verification rules** | Valid value only | | |

## Current drug use

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Whether the woman currently uses drugs | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Does not misuse drugs | 228367002 | | Current drug user | 417284009 | | Declined to answer | 426544006 | |  |  | | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | The information is distinct from that recorded in section 8.8 History of drug use. That is, this section (19.10 Current drug use), records a value at the end of the pregnancy | | |
| **Verification rules** | Valid value only | | |

## Drugs used

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | A record of the drug(s) the woman is currently using | | |
| **Source Standards** | SNOMED International | | |
| **Data type** | Numeric | **Representational class** | Code |
| **Field size** | Max: 18 | **Representational layout** | N(18) |
| **Data domain** | |  |  | | --- | --- | | **SNOMED Concept** | **SNOMED CT Code** | | Amphetamines | 703842006 | | Aromatic solvent | 117499009 | | Benzodiazepine sedative | 372616003 | | Cannabis | 398705004 | | Cocaine | 387085005 | | Codeine phosphate | 261000 | | Crack cocaine | 229003004 | | Drug or medicament | 410942007 | | Gas (nitrous oxide) | 111132001 | | Hallucinogenic agent | 373469002 | | Heroin | 387341002 | | Methadone | 387286002 | | Methamphetamine | 387499002 | | Morphine | 373529000 | | Other | TBA | |  |  | | | |
| **Obligation** | Conditional on a response of ‘Current drug user’ to section 19.10 Current drug use | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid value only | | |

## Drugs used – ‘Other’ – detail

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The detail of the ‘Other’ drugs currently in use | | |
| **Source Standards** |  | | |
| **Data type** | Alphanumeric | **Representational class** | Free text |
| **Field size** | Max: 1000 | **Representational layout** | X(1000) |
| **Data domain** |  | | |
| **Obligation** | Mandatory on a response of ‘Other’ for section 19.11 Drugs used | | |
| **Guide for use** | One response should be recorded for each ‘Other’ instance identified in section 19.11 Drugs used | | |
| **Verification rules** |  | | |

## Postnatal visits

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | The number of postnatal visits received by the woman from the LMC in the six weeks after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Numeric | **Representational class** | Value |
| **Field size** | Max: 2 | **Representational layout** | NN |
| **Data domain** | 00-99 | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## General practice notification

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Was notification forwarded to the woman’s general practice | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** |  | | |
| **Verification rules** | Valid code only | | |

## Maternal death

|  |  |  |  |
| --- | --- | --- | --- |
| **Definition** | Did the woman die during the pregnancy or during the six weeks after the birth | | |
| **Source Standards** |  | | |
| **Data type** | Boolean | **Representational class** | N/A |
| **Field size** | Max: 1 | **Representational layout** | N(1,0) |
| **Data domain** | 1 – Yes  0 – No | | |
| **Obligation** | Mandatory | | |
| **Guide for use** | A maternal death is the death of a woman while pregnant or within 42 days of birth, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management  It does not include accidental or incidental causes of death of a pregnant woman | | |
| **Verification rules** | Valid value only | | |

1. See <https://standards.iso.org/ittf/PubliclyAvailableStandards/index.html> [↑](#footnote-ref-2)