Maternity Care Data Dictionary

Data Item Definitions and Category Values within Entity

Maternity Care Data Dictionary Version 3.0

As found on the Internet (Same text: Original 215 pages!)
at http://www.nhsia.nhs.uk/mcd/pages
on 3rd March 2003

Report Version: 1.0

Maternity Care Data Project
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Strongly supported by Professor Phil Steer as the basis for progress in Maternity IT
But eventually (Thank goodness) rejected by NHS-IT standards board.

Introduction
This is the third version of the Maternity Care Data Dictionary to be published by the NHS Information Authority’s, Maternity Care Data Project. The changes included in this version have been made as a result of a wide consultation process undertaken by the project on the previous two draft versions of the dictionary. The principal additions to this version include those agreed with the British Association of Perinatal Medicine.

The Maternity Care Data Dictionary is the key deliverable of the project. Formal approval of this version of the Maternity Care Data Dictionary will be sought from the Information Standards Board. Two sub-boards, the Clinical Data Standards Board and the Management Information Standards Board will examine the Maternity Care Data Dictionary from a clinical and management information perspective. The data items in the Maternity Care Data Dictionary will then replace the current definitions in the NHS Data Dictionary. For more information on the NHS Data Dictionary please visit − http://www.standards.nhsia.nhs.uk/ds/dd.htm

The consultation process has involved piloting within maternity units and a series of maternity community workshops which:

- Assessed requirements for wider implementation of the dictionary across whole organizations;
- Audited the data collected as far as practicable for accuracy and interpretation;
- Reported the data collected and demonstrated its potential uses in the support of care planning, delivery and review as well as its ability to support the realisation of benefits;
- Identified any gaps, inconsistencies or ambiguous entries within the Dictionary.

The Maternity Care Data Project has also continued to work with relevant professional bodies and other groups with an interest in maternity information.

The purpose of the project is to determine the information that needs to be recorded to support the planning and delivery of maternity care for both the mother and her child, and wherever possible, to standardise this data. This will enable standardised and consistent recording of data relating to maternity and childbirth, for women and infants, within Electronic Patient Record systems in all affected NHS organisations. This is intended to enable or improve:

- Patient understanding and involvement in their care;
- Seamless care planning;
- Integrated care delivery;
- Clinical governance; and
- Service commissioning and development.

Maternity Care Data Dictionary
The Design and Development Stage of the Maternity Care Data project has focused on identifying the key data items required to support the process of delivering maternity care with particular emphasis on those that have been identified by professional bodies as useful for service monitoring, planning and review. However, it should be emphasised that the project is not attempting to deliver a minimum data set.

The Maternity Care Data Dictionary represents an “overall pool” of data that should be consistently recorded across health organisations. The current version of the Dictionary does not contain every data item that would be needed to fully support the Electronic Patient Record, nor does it attempt to provide the wide and diverse set of information required for local purposes. It is recognised that the Dictionary will expand over time and that local organisations and healthcare professionals may choose to record additional information for local purposes and benefits. The Dictionary is therefore not designed to restrict what is recorded but to standardise some of the key data items, which may be required for data sets.

Data Sets
A data set is a view of some or all of the data available, based on the needs of the enquirer at any point in time. Given the wide range of stakeholders and many reasons for needing data on maternity care, there are almost infinite data set requirements. By identifying and standardising an overall data pool, this Dictionary provides a set of data items that should be recorded because they are relevant to the planning and delivery of maternity care and have benefits from being used and shared where appropriate. Stakeholder data sets should be obtainable with minimal effort by selection from the data pool available.

Data Recording
The Maternity Care Data Dictionary does not therefore contain every data item required to support clinical records, nor does it prescribe the methods of data collection, the layout and format of data collection screens and fields or specific data sets to be recorded. However, it does provide a set of data items which, if collected by organisations, can now be recorded, and therefore reported, in a consistent way using common terminology and understanding. Some organisations will be unable to record all of the items within this Dictionary due to the constraints of current systems. However, where data items contained within the Dictionary are recorded locally, this can now be done in a consistent way.

Format of the Maternity Care Data Dictionary
The Dictionary has been developed as an Access database to facilitate manipulation and presentation of the data. This report has been produced from the database and is available in Word and PDF format from the project’s website.

Data Items
Each individual data item contains a data definition and category values to ensure consistent recording. In some cases data items may be derived from data collected elsewhere for example, Mother: Body Mass Index may be derived from the collection of Mother: Height and Mother: Weight.

Multiple Values
Many data items contain a mutually exclusive list of category values so that only one value may be selected and recorded for a data item. For example, only one grade of Urgency can be recorded for a Caesarean Section and only one Sex for the baby. Other items may have multiple values where more than one category value may be recorded. An example is Antenatal Complications where more than one complication may be recorded during pregnancy.

Further Information.
For further information please contact the Maternity Care Data Team, telephone: 01962 844588 or use the web site at http://www.nhsia.nhs.uk/mcd/
**Entity: Address**

**Item:** Association Type  
**Definition:** The classification of an address.  
**Category Values:**  
- Correspondence (non-residence)  
- Invoice  
- Main permanent residence  
- Other permanent residence  
- Safe haven address  
- Temporary residence

**Item:** Format Type  
**Definition:** The classification of an address format (e.g. Post Office Preferred Format). The classification b - Vernacular Format should be used for those ADDRESSES that are structured but have not been matched with the Post Office Address File.  
**Category Values:**  
- a. Post Office Preferred Format  
- b. Vernacular Format

**Item:** Line 1  
**Definition:** The first text string comprising one line of an address.  
**Category Values:** - Text

**Item:** Line 2  
**Definition:** The second text string comprising one line of an address.  
**Category Values:** - Text

**Item:** Line 3  
**Definition:** The third text string comprising one line of an address.  
**Category Values:** - Text

**Item:** Line 4  
**Definition:** The fourth text string comprising one line of an address.  
**Category Values:** - Text

**Item:** Line 5  
**Definition:** The fifth text string comprising one line of an address.  
**Category Values:** - Text

**Item:** Postcode  
**Definition:** The postcode of an address.  
**Category Values:** - Alpha-numeric code

**Entity: Administered Pharmaceutical Product**

**Item:** Administered Product Subject Type  
**Definition:** The subject of an administered pharmaceutical product.  
**Category Values:**  
- Baby  
- Mother

**Item:** Administration Dose  
**Definition:** The dose of an administered pharmaceutical product.  
**Category Values:** - Positive decimal

**Item:** Administration Time  
**Definition:** The time of administration of a pharmaceutical product.  
**Category Values:** - Time (24 hour clock)

**Item:** Form of Product  
**Definition:** The physical form of an administered pharmaceutical product.  
**Category Values:**  
- Capsule  
- Gel  
- Infusion solution  
- Inhaler  
- Injectable solution  
- Nasal drops  
- Nebuliser  
- Oral solution  
- Patch  
- Pessary  
- Spray  
- Suppository  
- Tablet  
- Topical solution

**Item:** Product Administration Date  
**Definition:** The date of administration of a pharmaceutical product.  
**Category Values:** - Date
<table>
<thead>
<tr>
<th>Item:</th>
<th>Product Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The unique identifier of an administered pharmaceutical product.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Numeric code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Route Product Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The route by which a pharmaceutical product is administered.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Epidural</td>
</tr>
<tr>
<td></td>
<td>- Infusion</td>
</tr>
<tr>
<td></td>
<td>- Inhalational</td>
</tr>
<tr>
<td></td>
<td>- Intramuscular</td>
</tr>
<tr>
<td></td>
<td>- Intrathecal</td>
</tr>
<tr>
<td></td>
<td>- Intravenous injection</td>
</tr>
<tr>
<td></td>
<td>- Nasal</td>
</tr>
<tr>
<td></td>
<td>- Oral</td>
</tr>
<tr>
<td></td>
<td>- Patch</td>
</tr>
<tr>
<td></td>
<td>- Per rectum</td>
</tr>
<tr>
<td></td>
<td>- Per vaginal</td>
</tr>
<tr>
<td></td>
<td>- Sub-lingual</td>
</tr>
<tr>
<td></td>
<td>- Subcutaneous</td>
</tr>
<tr>
<td></td>
<td>- Suppository</td>
</tr>
<tr>
<td></td>
<td>- Topical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Strength of Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The strength of an administered pharmaceutical product.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Text/numerals</td>
</tr>
</tbody>
</table>

**Entity: Admission**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The date of admission as an in-patient.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The time of admission as an in-patient</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Time</td>
</tr>
</tbody>
</table>

**Entity: Admission in Established Labour**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Admission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The date on which a mother is admitted in established labour.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Admission Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The time a mother is admitted in established labour.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Time (24 hour clock)</td>
</tr>
</tbody>
</table>

**Entity: Agency Type Involved**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Agency Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Agencies involved with the mother and/or her family i.e. partner and children. This can include any agency, including non-health agencies, which may indicate a cause for concern.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Child Protection Team</td>
</tr>
<tr>
<td></td>
<td>- Drug agencies</td>
</tr>
<tr>
<td></td>
<td>- None</td>
</tr>
<tr>
<td></td>
<td>- NSPCC</td>
</tr>
<tr>
<td></td>
<td>- Other indicating cause for concern</td>
</tr>
<tr>
<td></td>
<td>- Probation/prison service</td>
</tr>
<tr>
<td></td>
<td>- Psychiatric services</td>
</tr>
<tr>
<td></td>
<td>- Social services</td>
</tr>
<tr>
<td></td>
<td>- Surestart</td>
</tr>
<tr>
<td></td>
<td>- Womens refuge</td>
</tr>
</tbody>
</table>

**Entity: Amniocentesis**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Amniocentesis Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The date on which an amniocentesis is performed.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Amniocentesis Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The result of the amniocentesis as reported by the laboratory. Only recorded if amniocentesis undertaken.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Downs syndrome (Trisomy 21)</td>
</tr>
<tr>
<td></td>
<td>- Edwards syndrome (Trisomy 18)</td>
</tr>
<tr>
<td></td>
<td>- Klinefelters syndrome (Sex chromosome aneuploidy 47,XXY)</td>
</tr>
<tr>
<td></td>
<td>- Normal</td>
</tr>
<tr>
<td></td>
<td>- Other</td>
</tr>
<tr>
<td></td>
<td>- Patau syndrome (Trisomy 13)</td>
</tr>
<tr>
<td></td>
<td>- Turner syndrome (Sex chromosome aneuploidy 45x)</td>
</tr>
</tbody>
</table>
Item: Undertaken or Not
Definition: The process of undertaking an amniocentesis in terms of its successful completion.
Category Values: - Not required/not recommended
- Successful
- Test offered but declined
- Unsuccessful - failed diagnosis
- Unsuccessful - technical failure of specimen collection

Entity: Amniotic Fluid - Worst Case
Item: Observation
Definition: Observation of the amniotic fluid following rupture of membranes. The worst observation at any time is recorded.
Category Values: - Blood-stained
- Clear/straw coloured
- Meconium stained Grade 1 - minor, green-stained.
- Meconium stained Grade II - moderate, particulate matter seen
- Meconium stained Grade III - thick, lumpy
- None seen
- Other discolouration
- Purulent

Entity: Anaesthesia
Item: Anaesthesia Consultation Type
Definition: The type of anaesthetic consultation where a patient/anaesthetist interaction occurs in the absence of a physical intervention.
Category Values: - Antenatal
- Intrapartum - delivery
- Intrapartum - labour
- Postnatal

Entity: Anaesthesia for Caesarean Section
Item: Reason for General Anaesthetic
Definition: The reasons why a general anaesthetic is administered for a caesarean.
Category Values: - Anaesthetists preferred technique
- Failed regional block
- Insufficient time for regional block
- Maternal request
- Obstetric considerations
- Other
- Previous history of regional block complications
- Unknown
- Unsuitable for regional block

Item: Reason for Regional Anaesthesia
Definition: The reasons why regional anaesthesia is administered for a caesarean section.
Category Values: - Anaesthetists preferred technique
- Failed general anaesthesia
- Labour epidural in situ
- Maternal request
- Obstetric considerations
- Other
- Other technique unsuitable
- Previous history of general anaesthetic complications
- Unknown

Entity: Anaesthesia: Adverse Event
Item: Event Date
Definition: The date of an adverse event.
Category Values: - Date

Item: Event Time
Definition: The time of an adverse event.
Category Values: - Time (24 hour clock)
**Item:** Event Type  
**Definition:** Critical incidents or untoward events occurring at any time.  
**Category Values:**  
- Accidental dural puncture  
- Anaphylaxis  
- Aspiration of gastric contents  
- Awareness or recall under GA  
- Backache  
- Cardiopulmonary arrest  
- Cholinesterase deficiency  
- Drug error  
- Equipment failure  
- Excessively high regional block (including total spinal)  
- Failed intubation  
- Failed regional anaesthesia (including conversion to general anaesthesia)  
- Haemorrhage (more than 500 mls)  
- Hypotension > 20mmHg decrease in systolic blood pressure  
- Hypoxia  
- Local anaesthetic toxicity  
- Malignant hyperpyrexia  
- Neurological deficit  
- Organisational error  
- Other  
- Pain during regional anaesthesia caesarean section  
- Post dural puncture headache  
- Unexpected HDU admission  
- Unexpected ITU admission  
- Urinary retention

**Entity:** Anaesthesia: Adverse Event  
**Item:** Severity  
**Definition:** A rating of the severity of an adverse event or critical incident. One severity rating should be recorded for each adverse event. This should be recorded for all anaesthetic events but may also be used for other events and incidents.  
**Category Values:**  
- 0 - No effect  
- 1 - Transient, abnormality not noticed by patient.  
- 2 - Transient abnormality with full recovery  
- 3 - Potentially permanent - not disabling  
- 4 - Potentially permanent - disabling  
- 5 - Death

**Entity:** Anaesthesia: Given Post Labour/Delivery  
**Item:** Post Labour/Delivery Anaesthesia Type  
**Definition:** The types of anaesthesia administered to a woman post labour/delivery.  
**Category Values:**  
- Caudal epidural  
- Combined spinal/epidural  
- Conscious sedation  
- Field block abdomen  
- General anaesthesia  
- Local anaesthetic infiltration - abdominal  
- Local anaesthetic infiltration - perineal  
- Lumbar epidural  
- Nerve block - pudendal  
- None  
- Other  
- Spinal  
- Unknown

**Entity:** Anaesthesia: Maternal Satisfaction  
**Item:** Anaesthesia: Maternal Satisfaction with Anaesthesia  
**Definition:** The mothers reported satisfaction with anaesthesia  
**Category Values:**  
- Dissatisfied  
- Satisfied  
- Unknown  
- Very satisfied
Entity: Anaesthesia: Previous Problems
Item: Previous Anaesthetic Problem Type
Definition: Records any problems with anaesthesia experienced in the past.
Category Values:
- Accidental dural puncture
- Anaphylaxis
- Aspiration of gastric contents
- Awareness or recall under GA
- Backache
- Cardiopulmonary arrest
- Cholinesterase deficiency
- Drug error
- Equipment failure
- Excessively high regional block (including total spinal)
- Failed intubation
- Failed regional anaesthesia (including conversion to general anaesthesia)
- Haemorrhage (more than 500 mls)
- Hypotension >20 mmHg decrease in systolic blood pressure
- Hypoxia
- Local anaesthetic toxicity
- Malignant hyperpyrexia
- Neurological deficit
- Organisational error
- Other
- Pain during regional anaesthetic Caesarean Section
- Post dural puncture headache
- Unexpected HDU admission
- Unexpected ITU admission
- Urinary retention

Entity: Anaesthetic Intervention
Item: Intervention Date
Definition: The date of an anaesthetic intervention.
Category Values: - Date

Item: Intervention Time
Definition: The time of an anaesthetic intervention.
Category Values: - Time (24 hour clock)

Item: Intervention Type
Definition: The type of anaesthetic intervention undertaken not directly related to anaesthesia.
Category Values:
- Arterial catheter
- Central venous catheter
- Epidural blood patch
- Investigation or treatment
- Regional anaesthesia

Entity: Analgesia - Quality Post-Caesarean Section
Item: Maternal Satisfaction Post Caesarean Section
Definition: The quality of analgesia post caesarean section as reported by the mother.
Category Values: - Good
- Moderate
- Poor
- Unknown

Entity: Analgesia for Labour/Delivery
Item: Maternal Satisfaction with Delivery Analgesia
Definition: The quality of analgesia for delivery as reported by the mother.
Category Values: - Good
- Moderate
- Poor
- Unknown

Item: Maternal Satisfaction with Labour Analgesia
Definition: The quality of analgesia in labour as reported by the mother.
Category Values: - Good
- Moderate
- Poor
- Unknown
**Entity: Analgesia for Labour/Delivery: Type Given**

**Item:** Non-pharmacological Type Used
**Definition:** Non-pharmacological methods of pain relief used by the mother.
**Category Values:**
- Acupuncture
- Aromatherapy
- Heat/hot packs
- Homeopathy
- Hypnosis
- Lamaze
- Massage
- None
- Other
- Psychoprophylaxis
- Reflexology
- Relaxation
- Shiatsu
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Water

**Item:** Pharmacological Type Given
**Definition:** Pharmacological methods of pain relief used by the mother.
**Category Values:**
- Adjuvants e.g. epinephrine, clonidine, dexmedetomidine
- Combination therapies e.g. co-dydramol
- Combined spinal/epidural analgesia
- Epidural - low dose
- Epidural - other
- Epidural - patient controlled
- Field block of abdomen
- Inhatalional Entonox
- Inhatalional Isxoxane
- Local anaesthetic infiltration
- Nerve block - paracervical
- Nerve block - pudendal
- Non-opioid e.g. paracetamol
- None
- Opioid bolus e.g. pethidine, codeine
- Opioids - Infusion
- Opioids - PCA
- Spinal

**Entity: Antenatal Care Medication**

**Item:** Medication Type
**Definition:** Key types of medication administered to the woman at any time during pregnancy.
**Category Values:**
- Antacids
- Antibiotics
- Antiemetics
- Heparin or low molecular weight heparins
- Insulin
- Other
- Steroids for fetal lung maturity
- Steroids other than for fetal lung maturity
- Tocolytics

**Entity: Antenatal Care Summary**

**Item:** Date of First Antenatal Assessment
**Definition:** The date on which the pregnant woman is assessed by a midwife or GP and arrangements made for antenatal care. This is not necessarily the occasion on which arrangements are made for delivery. If the mother is not fully assessed by her midwife or GP this may be the date of the first hospital visit.
**Category Values:**
- Date

**Item:** First Antenatal Contact Date
**Definition:** The date on which a woman first reports her suspicion that she is pregnant to the NHS.
**Category Values:**
- Date

**Item:** Number of Antenatal In-patient Nights
**Definition:** The total number of antenatal in-patient nights (in a bed at midnight) during the pregnancy regardless of the number of admissions.
**Category Values:**
- Positive integer
Item: Reason for Antenatal Care Discontinuation
Definition: The reason why the provision of antenatal care is discontinued by the current provider.
Category Values: - Maternal choice
- Mothers change of address
- Mothers change of care provider
- Not known
- Spontaneous abortion
- Termination of pregnancy
- Transfer to other care provider for clinical reasons
- Transfer to other care provider for other reasons

Item: Total Number of Antenatal Contacts
Definition: The total number of antenatal contacts during pregnancy.
Category Values: - Positive integer

Entity: Antenatal Complications
Item: Complications Type
Definition: Complications arising during pregnancy.
Category Values: - Glucose intolerance not requiring insulin
- Glucose intolerance requiring insulin
- Hypertension >= 140/90 on 2 occasions at least 4 hours apart
- Proteinuria (> or = ++ on 2 occasions, > 0.3g/24 hrs)
- Significant antepartum haemorrhage
- Thrombo-embolism requiring therapeutic anticoagulants

Entity: Anti-D Immunisation
Item: Administration
Definition: Records whether a Rhesus negative mother has received anti-D gamma globulin. Usually given within 72 hours of delivery or during pregnancy following invasive procedures and following any vaginal bleeding or abdominal trauma. May also be given prophylactically during pregnancy.
Category Values: - Declined by mother
- Given
- Not given - reason unknown
- Not required
- Other
- To be given at home

Item: Reason
Definition: The reason why Anti-D immunisation is administered to a woman. Only record if Anti-D administered.
Category Values: - Following amniocentesis/CVS
- Following antepartum bleed
- Following legal termination
- Following miscarriage
- Following other invasive procedures
- Routine after delivery
- Routine at 26-28 weeks
- Routine at 34 weeks

Entity: Apgar Score
Item: Apgar Total
Definition: The total Apgar Score for a baby.
Category Values: - Positive integer

Item: Colour
Definition: Apgar score for colour.
Category Values: -0 = Blue, pale
-1 = Body pink, extremities blue
-2 = Completely pink

Item: Heart Rate
Definition: Apgar score for heart rate.
Category Values: -0 = Absent
-1 = Slow (below 100)
-2 = Over 100

Item: Muscle Tone
Definition: Apgar score for muscle tone.
Category Values: -0 = Limp
-1 = Some flexion of extremities
-2 = Active motion - extremities well flexed

Item: Reflex Irritability
Definition: Apgar score for reflex irritability (response to handling).
Category Values: -0 = No response
-1 = Grimace
-2 = Cry
**Entity: Baby: BCG Vaccine**

**Item:** Administered
**Definition:** A record of whether a baby is given BCG vaccination during the neonatal period.
**Category Values:**
- Declined by parents
- Given
- Not given - to be arranged
- Not required

**Item:** Administration Date
**Definition:** The date on which BCG immunisation is administered to a baby.
**Category Values:** - Date

**Item:** Batch Number
**Definition:** The batch number of the dose of BCG Vaccine administered to the baby.
**Category Values:** - Alpha-numeric identifier

**Entity: Baby: Birth Weight**

**Item:** Weight
**Definition:** The weight of the baby immediately following delivery recorded in grams to the nearest gram and measured within the first hour of life.
**Category Values:** - Positive integer

**Entity: Baby: Congenital Anomaly**

**Item:** Anomaly Observed
**Definition:** Records whether any congenital anomaly has been observed.
**Category Values:**
- No anomaly observed
- Not known
- Yes - anomaly observed

**Item:** Congenital Anomaly Type
**Definition:** Any neonatal congenital anomaly identified.
**Category Values:** - Text

**Item:** Date Observed
**Definition:** The date on which a baby’s congenital anomaly is observed.
**Category Values:** - Date

**Entity: Baby: Cranial Scanning**

**Item:** Cranial Scanning Performed or Not
**Definition:** Whether the baby received cranial ultrasound scanning according to the local policy. Usually recorded at discharge.
**Category Values:**
- Not indicated
- Performed as per unit screening policy
- Performed for clinical indicators
- Unknown

**Item:** Cranial Scanning Result
**Definition:** The result of cranial ultrasound scanning
**Category Values:**
- Abnormal
- Normal

**Entity: Baby: Date Meconium First Passed**

**Item:** Date Meconium Passed
**Definition:** The date on which the baby first passes meconium following delivery.
**Category Values:** - Date

**Entity: Baby: Date Urine First Passed**

**Item:** Date Urine Passed
**Definition:** The date on which the baby is first observed to have passed urine.
**Category Values:** - Date
**Entity: Baby: Destination on Transfer/Discharge from Neonatal Unit**

**Item:** Transfer/Discharge Destination Type

**Definition:** The destination of the baby at discharge from the neonatal unit at completion of an episode of care.

**Category Values:**
- Died: before transfer elsewhere
- Discharge home; baby discharged to care of mother or to substitute carer
- Transfer to another hospital
- Transfer to another ward in the same hospital
- Unknown

**Entity: Baby: Discharge from Neonatal Unit on Oxygen**

**Item:** Discharge on Oxygen: Yes or No

**Definition:** Records whether a baby is discharged from NICU on oxygen.

**Category Values:**
- No
- Yes

**Entity: Baby: Early Onset Neonatal Encephalopathy**

**Item:** Severity of Encephalopathy

**Definition:** The presence of an early onset neonatal encephalopathy. Usually recorded at discharge.

**Category Values:**
- Grade 2 early onset encephalopathy
- Grade 3 early onset encephalopathy
- None/normal
- Other
- Unknown

**Entity: Baby: Exchange Blood Transfusion**

**Item:** Date Given

**Definition:** The date on which a baby is given an exchange blood transfusion (excluding dilutional exchange).

**Category Values:**
- Date

**Entity: Baby: Follow Up Care**

**Item:** Follow Up Care Type

**Definition:** Records the follow up arrangements that have been made for the baby. For local purposes, other hospitals at which follow-up arrangements have been made should be specified.

**Category Values:**
- By another hospital
- By this hospital
- None
- Other arrangements

**Entity: Baby: Head Circumference**

**Item:** Measurement in centimetres

**Definition:** The occipito-frontal circumference of a baby's head measured within 24 hours of birth and recorded in centimetres.

**Category Values:**
- Positive decimal

**Entity: Baby: Hepatitis B Vaccination**

**Item:** Batch Number Hepatitis B

**Definition:** The batch number of the dose of Hepatitis B Vaccine administered to a baby.

**Category Values:**
- Alpha-numeric code

**Item:** Hepatitis B Vaccine Given or Not

**Definition:** Records whether a baby receives Hepatitis B vaccine during the neonatal period.

**Category Values:**
- Declined by mother
- Given
- Not given - reason unknown
- Not required
- Other

**Entity: Baby: Hip Examination**

**Item:** Hip Examination Date

**Definition:** The date on which a hip examination is performed on a baby.

**Category Values:**
- Date

**Item:** Hip Examination Result

**Definition:** The result of a baby's hip examination.

**Category Values:**
- Abnormal - right side
- Abnormal both sides
- Abnormal left side
- Doubtful - right side
- Doubtful both sides
- Doubtful left side
- No examination
- Normal - right side
- Normal both sides
- Normal left side
<table>
<thead>
<tr>
<th>Item: Method Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: The method used to examine a baby's hips.</td>
</tr>
</tbody>
</table>
| Category Values: -Barlows test  
-Other  
-Ultrasound |

**Entity: Baby - Jaundice - Highest Level Within First 10 Days of Life**

<table>
<thead>
<tr>
<th>Item: Serum bilirubin, micromols/litre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: The highest level of jaundice in a baby within the first 10 days of life. Measured by serum bilirubin and recorded as micromols per litre.</td>
</tr>
<tr>
<td>Category Values: -Micromols per litre</td>
</tr>
</tbody>
</table>

**Entity: Baby - On Oxygen at 36 Weeks**

<table>
<thead>
<tr>
<th>Item: On Oxygen at 36 Weeks: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: Records whether a baby is still receiving oxygen therapy at 36 weeks corrected gestational age.</td>
</tr>
</tbody>
</table>
| Category Values: -No  
-Yes |

**Entity: Baby - Phototherapy in First 10 Days**

<table>
<thead>
<tr>
<th>Item: Phototherapy Given or Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: Any phototherapy given to the baby within the first 10 days of life regardless of period of treatment.</td>
</tr>
</tbody>
</table>
| Category Values: -No  
-Yes |

**Entity: Baby - Reason for Transfer/Discharge from Neonatal Unit**

<table>
<thead>
<tr>
<th>Item: Transfer Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: The reason why a baby is transferred from current Unit.</td>
</tr>
</tbody>
</table>
| Category Values: -Further specialist treatment  
-Insufficient equipment  
-Insufficient medical staff  
-Insufficient midwifery/nursing staff  
-Insufficient space  
-No transfer  
-To continue in-hospital care. |

**Entity: Baby - Respiratory Support**

<table>
<thead>
<tr>
<th>Item: Continuous Positive Airways Pressure (CPAP): Baby Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: Total number of days of CPAP via any route and of nasopharyngeal ventilation. Any use of CPAP in 24 hours where ventilation has not been used constitutes a day. The 24 hour period runs from midnight to midnight; however, units may use any other 24 hour period, eg 9am to 9am, as long as this remains consistent. Usually recorded at discharge.</td>
</tr>
<tr>
<td>Category Values: -Positive integer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item: Other Than CPAP: Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: Total number of days of ventilation via a tracheal tube (excludes CPAP), at any rate and of any type (excluding resuscitation). Any period of ventilation in 24 hours constitutes a day. The 24 hour period runs from midnight to midnight; however, units may use any other 24 hour period eg 9am to 9am, as long as this remains consistent. Recorded at discharge.</td>
</tr>
<tr>
<td>Category Values: -Positive integer</td>
</tr>
</tbody>
</table>

**Entity: Baby - Resuscitation**

<table>
<thead>
<tr>
<th>Item: Intubation Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: The actual time of intubation of a baby.</td>
</tr>
<tr>
<td>Category Values: -Time (24 hour clock)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item: Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition: The methods of resuscitation used for the baby at birth.</td>
</tr>
</tbody>
</table>
| Category Values: -Intermittent Positive Pressure Ventilation via bag-and-mask  
-Intermittent Positive Pressure Ventilation via tracheal tube  
-Mask and valve ventilation  
-None  
-Not known  
-Other  
-Oxygen only  
-Oxygen plus suction  
-Suction only  
-Tracheal suction  
-Tracheal ventilation with tracheal suction  
-Tracheal ventilation without tracheal suction |
Entity: Baby: Resuscitation Drugs Used
Item: Type of Drug
Definition: The drugs used for resuscitation of the newborn.
Category Values:
- Adrenaline
- Glucose
- Other - specify
- Sodium bicarbonate
- Surfactant

Entity: Baby: Resuscitation Staff Involved
Item: Staff Involved
Definition: The staff involved in resuscitation of the baby wherever birth and/or resuscitation takes place. The period of resuscitation will be recorded for a maximum of 30 minutes, or less if cardio-respiratory stability is achieved or death occurs.
Category Values:
- Anaesthetist
- Consultant obstetrician
- Consultant Paediatrician/Neonatologist
- General Practitioner
- Midwife
- Nurse practitioner
- Obstetrician - training grades
- Other
- Paediatric SHO
- Paediatric SpR
- Paramedic

Entity: Baby: Retinopathy of Prematurity Screening
Item: Examination Result
Definition: Worst stage of ROP in either eye prior to going home. Record the examination closest to discharge.
Category Values:
- Mild ROP - Stages 1 and 2
- No ROP
- Severe ROP - Stages 3 and above

Item: Examined or Not
Definition: Examination of the eyes for ROP completed, consistent with national recommendations. Record the examination closest to discharge.
Category Values:
- No, examination not completed
- Not appropriate, eye screening policy not applicable
- Yes, eyes examined consistent with recommendations

Entity: Baby: Retinopathy of Prematurity Therapy
Item: Type of Therapy Given
Definition: Any therapy used to treat ROP. Record as close to discharge as possible.
Category Values:
- Cryotherapy
- Laser treatment
- No treatment
- Other

Entity: Baby: Routine Blood Screening for Metabolic Disorders
Item: Screening Performed or Not
Definition: Records whether routine blood tests for metabolic disorders such as phenylketonuria, hypothyroidism and cystic fibrosis have been carried out.
Category Values:
- No
- Yes

Entity: Baby: Screened Early for Sensorineural Hearing Loss
Item: Screened Early Performed or Not
Definition: Screening for sensorineural hearing loss was completed consistent with local policy. Usually recorded at discharge.
Category Values:
- No, examination was not completed
- Not appropriate.
- Yes, screened.

Entity: Baby: Sex
Item: Sex
Definition: The sex of the baby.
Category Values:
- 0 Not known - information not available or not offered
- 1 Male
- 2 Female
- 9 Not specified - Ambiguous or indeterminate
Entity: Baby: Steroids
Item: Age at First Dose in Days
Definition: The age of a baby when the first dose of steroids is administered. Recorded in days.
Category Values: -Positive integer

Item: Number of Days Administered On
Definition: The total number of days after birth that steroids are administered to the baby.
Category Values: -Positive integer

Entity: Baby: Surfactant Replacement Therapy
Item: Surfactant Given or Not
Definition: Records whether surfactant replacement therapy is used, excluding resuscitation at birth.
Category Values: -Not applicable -Not known -Not used -Used

Entity: Baby: Suspected Congenital Anomaly
Item: Suspected or Not
Definition: Records whether or not a congenital anomaly is suspected.
Category Values: -No -Uncertain - further review required -Yes

Entity: Baby: Transfer
Item: Baby Transfer Date
Definition: The date on which a baby is transferred.
Category Values: -Date

Item: Baby Transfer Time
Definition: The time at which a baby is transferred.
Category Values: -Time (24 hour clock)

Item: From: Source Code
Definition: The NHS Organisation Code from which a baby has been transferred to the current facility. It is a code that is managed by the Corporate Data Administration Section of the Department of Health.
Category Values: -Numeric identifier/code

Item: To: Destination Code
Definition: The NHS Organisation Code of the destination to which a baby is transferred. This is a code managed by the Corporate Data Administration Section of the Department of Health.
Category Values: -Numeric identifier/code

Entity: Baby: Transfer Destination Post-Delivery
Item: Transfer/Destination Type
Definition: The type of location to which a baby is transferred following delivery.
Category Values: -Another hospital Neonatal Unit -Died -Home -Maternity unit without 24 hour medical cover -Maternity ward - routine care -Maternity ward - transitional care -Neonatal Intensive Care Unit/Special Care Baby Unit -Not transferred e.g. already at home -Other -Paediatric ward

Entity: Baby: Vitamin K (Prophylactic)
Item: Administration of Vitamin K
Definition: Records whether Vitamin K is administered to the baby immediately after birth.
Category Values: -Declined by parents -Given -Not given - clinical reasons -Not given - other reasons

Item: Date Vitamin K Administered
Definition: The date on which Vitamin K is administered to the neonate.
Category Values: -Date

Item: Route of Vitamin K Administration
Definition: The route by which Vitamin K is administered to the neonate.
Category Values: -Intra-muscular -Intravenous -Oral
**Entity: Baby: Weight (not at Birth)**

**Item:** Date Weighed  
**Definition:** The date on which a baby is weighed other than at birth.  
**Category Values:** -Date

**Item:** Weight in grams  
**Definition:** The weight of the baby recorded in grams to the nearest gram and recorded at any time other than Birth Weight.  
**Category Values:** -Positive integer

**Entity: Birth**

**Item:** Baby Delivered in Water Yes or No  
**Definition:** Records whether a baby is delivered in water.  
**Category Values:** -No  
-Yes

**Item:** Delivery Date  
**Definition:** The date of delivery of the baby.  
**Category Values:** -Date

**Item:** Delivery Time  
**Definition:** The time of delivery for each registrable birth.  
**Category Values:** -Time (24 hour clock)

**Item:** Health Authority of Birth  
**Definition:** The Health Authority within which the mother is resident.  
**Category Values:** -Alpha-numeric code

**Item:** Live or Stillbirth  
**Definition:** An indicator of whether a birth is a live, stillbirth or neonatal death. A stillbirth is a birth after a gestation of 24 weeks (168 days) where the baby shows no identifiable signs of life at delivery.  
**Category Values:** -Dead  
-Live  
-Stillbirth antepartum - where intrauterine death was confirmed prior to the onset of labour.  
-Stillbirth indeterminate - where it is not known whether the fetus was alive at the onset of labour  
-Stillbirth intrapartum - where the fetus was known to be alive at the onset of labour.

**Item:** Method: Breech (vaginal)  
**Definition:** The method by which a woman is vaginally delivered of a baby which is a breech presentation.  
**Category Values:** -Assisted birth  
-Forceps to the aftercoming head  
-No assistance  
-Other  
-Unknown

**Item:** Method: Cephalic (vaginal)  
**Definition:** The method by which a woman is vaginally delivered of a baby which is a cephalic presentation.  
**Category Values:** -Other  
-Other forceps  
-Outlet forceps  
-Rotational forceps  
-Spontaneous  
-Unknown  
-Ventouse

**Item:** Order of Infant  
**Definition:** The sequence in which the baby was born, if part of a delivery having multiple births. E.g. first born = 1, second born = 2.  
**Category Values:** -Positive integer
### Item: Person Supervising
**Definition:** The person who is supervising the delivery.
**Category Values:**
- Accredited specialist non consultant
- Acting obstetric registrar
- Consultant obstetrician
- Experienced obstetric SHO
- GP
- Midwife < 2 yrs experience
- Midwife > 2 yrs experience
- None
- Other
- Other non specialist doctor
- Paramedic
- SHO (> year 1)
- SHO (Year 1)
- SpR 1/2
- SpR 3/4/5
- Staff grade obstetrician

### Item: Persons Present
**Definition:** The persons present at a delivery for care of the mother.
**Category Values:**
- Accredited specialist non consultant
- Acting obstetric registrar
- Consultant obstetrician
- Experienced obstetric SHO
- General Practitioner
- Healthcare assistant
- Medical student
- Midwife < 2 years experience
- Midwife > 2 years experience
- None
- Other
- Other non specialist doctor
- Paramedic
- SHO (> year 1)
- SHO (Year 1)
- SpR 1/2
- SpR 3/4/5
- Staff grade obstetrician
- Student midwife
- Student nurse

### Item: Place Change Reason
**Definition:** The reason why the actual place of delivery is different from the place originally intended, either in type of place or geographically.
**Category Values:**
- Decision made after onset of labour for clinical reasons.
- Decision made after onset of labour for other reasons.
- Decision made before labour for clinical reasons.
- Decision made before labour for other reasons.
- Decision made during pregnancy because of change of address.
- Occurred unintentionally after onset of labour.

### Item: Position
**Definition:** The position of the mother during delivery of the baby.
**Category Values:**
- All fours
- Birthing chair/stool
- Kneeling
- Left lateral
- Lithotomy
- Right lateral
- Semi-recumbent
- Squatting
- Standing
- Supine (with 15 degree tilt)

### Item: Route
**Definition:** The route of delivery for a baby.
**Category Values:**
- Caesarean
- Other
- Vaginal

### Item: Shoulder Dystocia
**Definition:** Records any delay in delivery of the shoulders of the baby.
**Category Values:**
- Moderate: Delay in shoulders less than two minutes, no assistance called, no fetal damage expected.
- None: No delay in delivery of shoulders.
- Severe: Significant delay or assistance required or fetal damage expected/confirmed
<table>
<thead>
<tr>
<th>Item:</th>
<th>Type of Place of Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The actual place of delivery.</td>
</tr>
</tbody>
</table>
| Category Values: | - DGH or similar hospital with 24 hour on site medical cover  
- Home - planned  
- Home - unplanned  
- In NHS hospital private bed  
- In NHS hospital, ward or unit without delivery facilities  
- In other hospital or institution  
- In private hospital  
- In psychiatric hospital, unit, ward or bed  
- In transit e.g ambulance, private car  
- Maternity unit without 24 hour on site medical cover  
- Not covered by other classifications  
- Not known  
- Tertiary centre hospital with 24 hour on site medical cover |

**Entity: Birth Attendant**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The code of the practitioner conducting the delivery.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Alpha-numeric code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Name of the person conducting the delivery.</td>
</tr>
<tr>
<td>Category Values:</td>
<td>- Text</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item:</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The type of practitioner conducting the delivery.</td>
</tr>
</tbody>
</table>
| Category Values: | - Accredited specialist non consultant  
- Acting obstetric registrar  
- Consultant obstetrician  
- Experienced obstetric SHO  
- General Practitioner  
- Medical Student  
- Midwife < 2 years experience  
- Midwife > 2 years experience  
- None  
- Other  
- Other non specialist doctor  
- Paramedic  
- SHO (> year 1)  
- SHO (Year 1)  
- SpR 1/2  
- SpR 3/4/5  
- Staff grade obstetrician  
- Student midwife |

**Entity: Birth/Neonatal Trauma**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Trauma Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>Trauma to the baby occuring during birth or the neonatal period.</td>
</tr>
</tbody>
</table>
| Category Values: | - Bruising  
- Cephalhaematoma  
- Cuts from surgical procedures  
- Erbs paralysis  
- Fractures  
- Heat effects  
- Klumpkes paralysis  
- Pressure effects  
- Superficial skin trauma  
- Tissued intravenous infusion effects  
- Vascular accidents |

**Entity: Birth: Type of Anaesthesia Active at Birth**

<table>
<thead>
<tr>
<th>Item:</th>
<th>Anaesthesia Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition:</td>
<td>The types of anaesthesia active at delivery. Should be recorded for each birth.</td>
</tr>
</tbody>
</table>
| Category Values: | - Caudal epidural  
- Combined spinal/epidural  
- Conscious sedation  
- Field block abdomen  
- General anaesthesia  
- Local anaesthetic infiltration - abdominal  
- Local anaesthetic infiltration - perineal  
- Lumbar epidural  
- Nerve block - pudendal  
- None  
- Other  
- Spinal  
- Unknown |
**Entity: Blood Characteristics**

**Item:** Abnormal Antibodies  
**Definition:** Records whether abnormal antibodies are present.  
**Category Values:**  
- No  
- Yes

**Item:** ABO  
**Definition:** The ABO blood group of a person.  
**Category Values:**  
- A  
- AB  
- B  
- O

**Item:** Blood Group Subject Type  
**Definition:** The subject of a blood group.  
**Category Values:**  
- Baby  
- Father  
- Fetus  
- Mother

**Item:** Rhesus  
**Definition:** The rhesus blood group of a person.  
**Category Values:**  
- Negative  
- Positive

**Entity: Breech Diagnosed Before/During Labour**

**Item:** When Diagnosed  
**Definition:** Records whether a diagnosis of breech presentation is made before or during labour.  
**Category Values:**  
- Before onset of labour  
- During labour

**Entity: Caesarean Section**

**Item:** Complexity  
**Definition:** Records whether a caesarean section is simple or complex, and if complex, the complications which occur.  
**Category Values:**  
- Extended lower segment incision/tear  
- Gastro-intestinal injury  
- Hysterectomy  
- Lower genital tract injury  
- Simple  
- Upper segment incision  
- Urinary tract injury

**Item:** Decision to Perform Date  
**Definition:** The date when the decision was made to perform a caesarean section.  
**Category Values:**  
- Date

**Item:** Decision to Perform Time  
**Definition:** The time when the decision was made to perform a caesarean section.  
**Category Values:**  
- Time

**Item:** Influence on Decision to Perform  
**Definition:** Identifies any influences on the obstetricians decision to perform a caesarean section.  
**Category Values:**  
- APH/Intrapartum haemorrhage  
- Breech Presentation  
- Chorioamnionitis  
- Cord prolapse  
- Failure to progress (induction/in labour)  
- Malpresentation/Unstable lie  
- Maternal medical disease  
- Maternal request  
- Multiple pregnancy  
- Other fetal  
- Other maternal  
- Placenta praevia, actively bleeding  
- Placenta praevia, not actively bleeding  
- Placental abruption  
- Pre-eclampsia/eclampsia/HELLP  
- Presumed fetal compromise  
- Previous caesarean section  
- Previous infertility  
- Previous physically or emotionally traumatic vaginal delivery  
- Previous poor obstetric outcome  
- UGRI/Abnormal CTG  
- Uterine rupture
Item: Maximum Cervical Dilatation Achieved
Definition: For mothers undergoing caesarean section, the maximum cervical dilatation achieved. Recorded in centimetres. For caesarean sections before labour record as 0
Category Values: Positive integer

Item: Skin Incision Time
Definition: The time of the first skin incision at caesarean section.
Category Values: Time (24 hour clock)

Item: Urgency
Definition: A description of the urgency of a caesarean section.
Category Values: Crash (Grade 1) Immediate threat to life of woman or fetus
- Other
- Planned (Grade 4) at a time to suit the patient and maternity team
- Scheduled (Grade 3) Needing early delivery but no maternal or fetal compromise
- Unknown
- Urgent (Grade 2) Maternal or fetal compromise which is not immediately life threatening

Entity: Chorionic Villus Sampling
Item: Chorionic Villus Sampling Performed or Not
Definition: The process of undertaking a Chorionic Villus Sampling in terms of its successful completion.
Category Values: Not required/not recommended
- Successful
- Test offered but declined
- Unsuccessful - failed diagnosis
- Unsuccessful - technical failure (specimen collection)

Item: Chorionic Villus Sampling: Result
Definition: The result of the Chorionic Villus Sampling as reported by the laboratory.
Category Values: Downs syndrome (Trisomy 21)
- Edwards syndrome (Trisomy 18)
- Klinefelters syndrome (Sex chromosome aneuploidy 47,XXY)
- Normal
- Other
- Pataus syndrome (Trisomy 13)
- Turner syndrome (Sex chromosome aneuploidy 45,X)

Entity: Clinical Investigation
Item: Authorised Result
Definition: The result of an investigation.
Category Values: Abnormal - no treatment or follow up required
- Abnormal - non-urgent treatment or follow up required
- Abnormal - urgent treatment or follow up required
- Normal/NAD

Item: Clinical Investigation Date
Definition: The date on which a clinical investigation is performed.
Category Values: Date

Item: Clinical Investigation Subject Type
Definition: The subject of a clinical investigation.
Category Values: Baby
- Father
- Fetus
- Mother

Item: Clinical Investigation Type
Definition: A type of clinical, laboratory, physiological, radiological or other investigation that leads to the production of one or more results. May be recorded as text or structured.
Category Values: EDIFACT message or text

Item: Date Result Authorised
Definition: The date on which an investigation was concluded, that is, the date the result was authorised.
Category Values: Date

Item: Request Date
Definition: The date on which an investigation or test is requested.
Category Values: Date

Item: Request Time
Definition: The time at which an investigation or test is requested.
Category Values: Time (24 hour clock)

Item: Time Result Authorised
Definition: The time at which an investigation was concluded, that is, the time the result was authorised.
Category Values: Time (24 hour clock)
Entity: Cord Blood
Item: Cord Artery: pH at Delivery
Definition: The pH of the cord artery measured at delivery.
Category Values: -Positive decimal
Item: Cord Vein: pH at Delivery
Definition: The pH of the cord vein measured at delivery.
Category Values: -Positive decimal

Entity: Delivery
Item: Health Authority of Residence
Definition: The Health Authority area in which a baby is born.
Category Values: -Alpha-numeric code
Item: Home Delivery Requested
Definition: Records whether a home delivery is requested by the mother at any time during her pregnancy.
Category Values: -No
-Yes
Item: Number of Infants This Delivery
Definition: The number of infants delivered from the pregnancy including live births and stillbirths.
Category Values: -Positive integer

Entity: Discharge From the Maternity Episode
Item: Destination
Definition: The destination of the patient on discharge.
Category Values: -Local Authority foster care
-NHS hospital provider - mother and baby unit for women with mental health problems
-NHS hospital provider - ward for general patients or the younger physically disabled
-NHS hospital provider - ward for maternity patients or neonates
-NHS hospital provider - ward for patients who are mentally ill or have learning disabilities
-Non-NHS run hospital
-Not applicable - patient died or still birth
-Prison
-Temporary place of residence
-Usual place of residence
Item: Discharge Date
Definition: The date a person is discharged.
Category Values: -Date
Item: Discharge Reason
Definition: A classification of the reason for a professional, or organisation, discharging responsibility for a subject of care.
Category Values: -Other
-Patient died
-Patient discharged him/herself or was discharged by a relative or advocate
-Patient discharged on clinical advice or with clinical consent
-Stillbirth
-Transfer of care
Item: Discharged Home With Mother: Yes or No
Definition: Records whether the baby is being taken home from hospital with the mother at postnatal discharge.
Category Values: -No
-Yes

Entity: Drug Allergies/Sensitivities
Item: Drug Allergy/Sensitivity Type
Definition: Any known allergies or sensitivities to penicillin or other drugs as recorded on medical notes or reported by the mother.
Category Values: -Other drug sensitivity
-Other penicillin reaction (e.g. rash, diarrhoea, thrush)
-Penicillin allergy (collapse, difficulty in breathing, oedema)

Entity: Emergency Contact
Item: Type of Relationship to Woman
Definition: The relationship of the person to be contacted in an emergency, to the person receiving care.
Category Values: -Friend
-Guardian
-Husband
-Neighbour
-Other
-Other family member
-Parent
-Partner
Entity: External Cephalic Version
Item: Attempted or Not
Definition: Records whether external cephalic version is offered and undertaken.
Category Values: - Attempted: successful
- Attempted: unsuccessful
- Not applicable
- Not offered
- Offered: declined

Item: Version Date
Definition: The date on which external cephalic version is performed.
Category Values: - Date

Entity: Feeding - First
Item: Feed Type
Definition: The initial method of feeding recorded within the first six hours of birth.
Category Values: - Breast
- Formula: Special e.g. protein formula
- Formula: Standard
- Mixed
- Other

Item: First Feed Date
Definition: The date of the baby's first feed.
Category Values: - Date

Item: First Feed Time
Definition: The time of the baby's first feed.
Category Values: - Time (24 hour clock)

Entity: Feeding at Discharge
Item: Feeding Type
Definition: The actual method of feeding established at the time of discharge from the maternity episode.
Category Values: - Breast
- Formula: Special e.g. protein formula
- Formula: Standard
- Mixed
- Other

Entity: Fetal Anomaly: Antenatal Diagnosis
Item: Manner and Type of Diagnosis
Definition: Records whether a fetal anomaly has been diagnosed during pregnancy.
Category Values: - Fetal anomaly of unknown progress noted on Ultrasound Scan
- Major structural fetal anomaly noted on Ultrasound Scan
- Minor structural fetal anomaly noted on Ultrasound Scan
- None
- Other pre-natal fetal diagnosis

Entity: Fetal Death
Item: Fetal Death Date
Definition: The date of fetal death as determined by the clinician. This may be estimated.
Category Values: - Date

Item: Fetal Death Time
Definition: The time of fetal death as confirmed by the clinician. This may be estimated.
Category Values: - Time (24 hour clock)

Entity: Fetal Engagement
Item: Degree of Engagement
Definition: The entry of the head of the fetus into the true pelvis. Measured in fifths palpable per abdomen.
Category Values: - 0/5
- 1/5
- 2/5
- 3/5
- 4/5
- 5/5
- Not recorded

Item: Fetal Engagement Date
Definition: The date on which fetal engagement is observed.
Category Values: - Date

Item: Fetal Engagement Time
Definition: The time at which fetal engagement is observed.
Category Values: - Time (24 hour clock)
Entity: Fetal Heart Monitoring - Worst Case
Item: Heart Monitoring Date
Definition: The date on which the worst case fetal heart monitoring is recorded.
Category Values: Date

Item: Heart Monitoring Time
Definition: The time at which the worst case fetal heart monitoring is recorded.
Category Values: Time (24 hour clock)

Item: Heart Rate Type
Definition: Observations of the fetal heart rate via continuous or intermittent cardiotocography, either by ultrasound or fetal scalp electrode.
Category Values: -No fetal heart rate
- Normal
- Suspicious/pathological
- Auscultation (Pinards)
- Continuous cardiotocography via ultrasound
- Continuous cardiotocography with external transducer
- Fetal scalp electrode
- Hand held doppler
- Intermittent cardiotocography
- Intermittent or continuous auscultation via hand held doppler

Entity: Fetal Lie
Item: Date Lie Observed
Definition: The date on which the fetal lie is observed.
Category Values: Date

Item: Time Lie Observed
Definition: The time at which the lie of the fetus is observed.
Category Values: Time (24 hour clock)

Item: Type of Lie
Definition: Relationship of the long axis of the fetus to the long axis of the mother.
Category Values: -Longitudinal
- Not recorded
- Oblique
- Transverse
- Unstable

Entity: Fetal Position at Delivery if Breech
Item: Breech Position Type
Definition: The relationship of the fetal denominator (sacrum) to one of six areas on the mothers pelvis at breech delivery.
Category Values: -Direct sacro-anterior
- Direct sacro-posterior
- Left sacro-anterior
- Left sacro-lateral
- Left sacro-posterior
- Right sacro-anterior
- Right sacro-lateral
- Right sacro-posterior

Entity: Fetal Position at Delivery if Cephalic
Item: Cephalic Position Type
Definition: The relationship of the fetal denominator (occiput or mentum) to one of six areas on the mothers pelvis during cephalic delivery.
Category Values: -Direct mento-anterior
- Direct mento-posterior
- Direct occipito-anterior
- Direct occipito-posterior
- Left mento-anterior
- Left mento-lateral
- Left occipito-anterior
- Left occipito-lateral
- Left occipito-posterior
- Left-mento posterior
- Right mento-anterior
- Right mento-lateral
- Right mento-posterior
- Right occipito-anterior
- Right occipito-lateral
- Right occipito-posterior

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**Entity: Fetal Presentation**

**Item:** Date Presentation Observed  
**Definition:** The date on which the fetal presentation is observed.  
**Category Values:** -Date

**Item:** Time Presentation Observed  
**Definition:** The time at which the presentation of the fetus is observed.  
**Category Values:** -Time (24 hour clock)

**Item:** Type of Presentation  
**Definition:** The part of the fetus lying in the lower pole of the uterus. The classification could be different for each baby born in a multiple birth.  
**Category Values:**  
- Breech - includes frank breech (extended legs), flexed breech and footling breech.  
- Normal cephalic - includes occipito-anterior, occipito-posterior and occipito-transverse positions  
- Other - any presentations not included above.

**Entity: Fetal Presentation Just before Delivery**

**Item:** Type of Fetal Presentation  
**Definition:** The part of the fetus lying in the lower pole of the uterus just before delivery. The classification could be different for each baby born in a multiple birth.  
**Category Values:**  
- Breech includes frank breech (extended legs), flexed breech and footling breech.  
- Cephalic - includes occipito-anterior, occipito-posterior and occipito-transverse positions.  
- Other - any presentations not included above.  
- Transverse or oblique  
- Unknown

**Entity: Fetus: Biparietal Diameter by Ultrasound**

**Item:** Diameter in millimetres  
**Definition:** The biparietal diameter of the fetal skull measured via ultrasound and recorded in millimetres.  
**Category Values:** -Positive decimal

**Item:** Measurement Date  
**Definition:** The date on which the biparietal diameter of the fetus is measured by ultrasound.  
**Category Values:** -Date

**Entity: Fetus: Ultrasound Scan**

**Item:** Part of Baby Scanned  
**Definition:** The part of the baby subject to an ultrasound scan.  
**Category Values:**  
- Abdomen  
- Brain  
- Heart  
- Hip(s)  
- Kidney(s)  
- Other

**Item:** Purpose  
**Definition:** The reason an ultrasound scan is performed during pregnancy.  
**Category Values:**  
- Amniotic fluid assessment  
- Anomaly  
- Biophysical profile  
- Breech assessment  
- Cervical length  
- Confirmation of presentation  
- Dating  
- Fetal growth assessment  
- Fetal intervention e.g. Amniocentesis/CVS, take sample, transfusion, ECV.  
- Fetal viability  
- Following vaginal bleed  
- Localisation of placenta  
- Nuchal translucency  
- Other  
- Placental blood flow

**Entity: General Practice Registered With**

**Item:** General Practice Postcode  
**Definition:** The postcode of a persons registered General Practitioners Practice.  
**Category Values:** -Alpha-numeric code

**Item:** General Practitioner Name Registered With  
**Definition:** The name of a persons registered General Practitioner.  
**Category Values:** -Text

**Item:** Practice Name: Registered  
**Definition:** The name of the Practice of a persons registered General Practitioner.  
**Category Values:** -Text
**Entity: Gestation at Booking**

**Item:** Number of Completed Weeks

**Definition:** The best estimate of gestation of the pregnancy at booking regardless of the basis for the estimate and measured in completed weeks.

**Category Values:** - Positive integer

**Entity: Gestation at Delivery**

**Item:** Basis For Estimate

**Definition:** The basis for the estimation of the baby's gestation at delivery.

**Category Values:** - Best estimate
- LMP
- Paediatric assessment
- Ultrasound scan

**Item:** Best Estimate in Completed Weeks

**Definition:** The best estimate of gestation at the time of delivery in completed weeks. This will normally be based on the postmenstrual age, but may be modified on the basis of antenatal ultrasound scan. Where the gestation at delivery is unknown, this is based on the postnatal estimate of maturity.

**Category Values:** - Positive integer

**Entity: Haemaglobin**

**Item:** Haemaglobin at Booking

**Definition:** The mother's haemaglobin at booking or recorded as early as possible during the pregnancy.

**Category Values:** - Positive decimal

**Entity: Healthcare Professional Attendance**

**Item:** Date Attended

**Definition:** The date on which a Health Care Professional/Practitioner attended a person.

**Category Values:** - Date

**Item:** Date Called

**Definition:** The date on which a Health Care Professional/Practitioner was called to a person.

**Category Values:** - Date

**Item:** Duration Time Called/Time Attended

**Definition:** The actual time, measured in minutes, between the time a Health Care Professional/Practitioner was called to a person and the time they actually attended that person.

**Category Values:** - Positive integer

**Item:** Time Attended

**Definition:** The time at which a Health Care Professional/Practitioner attended a person.

**Category Values:** - Time (24 hour clock)

**Item:** Time Called

**Definition:** The time at which a Health Care Professional/Practitioner is called to a person.

**Category Values:** - Time (24 hour clock)

**Entity: Induction**

**Item:** Induction Date

**Definition:** The date on which induction of labour is commenced.

**Category Values:** - Date

**Item:** Induction Method

**Definition:** The method used for the induction of labour.

**Category Values:** - ARM
- ARM and Syntocinon
- Mechanical
- Mifepristone
- Misoprostol
- Other
- Prostaglandin: E1
- Prostaglandin: E2
- Prostaglandins
- Syntocinon
**Item:** Induction Reason  
**Definition:** The reason why an induction is undertaken.  
**Category Values:**  
- Abnormal blood flow studies  
- Abnormal CTG  
- Abnormal/unstable lie  
- Ante-partum haemorrhage  
- Breech presentation  
- Diabetes  
- Essential hypertension  
- Fetal abnormality  
- Intrauterine death  
- Intrauterine growth retardation  
- Intrauterine infection  
- Macrosomia  
- Maternal request  
- Multiple pregnancy  
- Oligohydramnios  
- Other - fetal reason  
- Other - maternal reason  
- Polyhydramnios  
- Poor obstetric history  
- Post maturity  
- Pre labour rupture of membranes  
- Pregnancy induced hypertension  
- Reduced fetal movements  
- Rhesus disease  
- Social reason

**Item:** Induction Time  
**Definition:** The time at which induction of labour is commenced.  
**Category Values:** - Time (24 hour clock)

**Entity: Intended Place of Delivery**  
**Item:** Intended Place  
**Definition:** The mothers initial intention for place of delivery.  
**Category Values:**  
- DGH or similar hospital with 24 hour on site medical cover  
- Home - planned  
- Home - unplanned  
- In NHS hospital private bed  
- In NHS hospital ward or unit without delivery facilities.  
- In other hospital or institution.  
- In private hospital.  
- In psychiatric hospital, unit, ward or bed.  
- Maternity unit without 24 hour on site medical cover  
- Not covered by other classifications.  
- Tertiary centre hospital with 24 hour on site medical cover

**Entity: Interval From Decision to Conceive to Pregnancy**  
**Item:** Interval in Months  
**Definition:** The time from a womans decision to conceive to actual pregnancy, recorded in months. Unplanned pregnancies will be recorded as 0.  
**Category Values:** - Positive integer

**Entity: Labour Augmentation**  
**Item:** Augmentation: Method  
**Definition:** The method of augmentation used during labour. Action may be taken to augment the contractions when a diagnosis of delay in labour has been made.  
**Category Values:**  
- Artificial Rupture of Membranes  
- Artificial Rupture of Membranes and Syntocinon  
- None  
- Syntocinon

**Entity: Labour: Confirmation by Birth Attendant**  
**Item:** Confirmation Date  
**Definition:** The date on which established labour is confirmed by the birth attendant.  
**Category Values:** - Date

**Item:** Confirmation Time  
**Definition:** The time at which established labour is confirmed by the birth attendant.  
**Category Values:** - Time (24 hour clock)
Entity: Labour: First Stage
Item: First Stage Length
Definition: Duration of the first stage of labour from established labour to full dilatation of the cervix. Recorded in hours and minutes.
Category Values: Hours and minutes.

Item: Onset Date
Definition: The date of the onset of the first stage of labour.
Category Values: Date

Item: Onset Time
Definition: The time of the onset of the first stage of labour.
Category Values: Time

Entity: Labour: First Stage: Highest Maternal Temperature
Item: Degrees Centigrade
Definition: The highest maternal temperature recorded in the 12 hours before delivery. Recorded in degrees centigrade.
Category Values: Positive decimal

Entity: Labour: First Stage: Onset
Item: Type of Onset
Definition: A description of the type of onset of labour.
Category Values: Caesarean before the onset of labour
Labour following induction or ripening
Other
Spontaneous
Unknown

Entity: Labour: Professional Prior Involvement
Item: Prior Involvement or Not
Definition: An indication of whether the professional attending the delivery has attended the patient prior to the onset of labour in the current pregnancy episode. The professional may be a midwife, General Medical Practitioner or obstetrician.
Category Values: No
Yes

Entity: Labour: Second Stage
Item: Second Stage Duration
Definition: Duration of the second stage of labour from full dilatation of the cervix to delivery of the baby. Recorded in hours and minutes.
Category Values: Hours and minutes.

Item: Second Stage Onset Date
Definition: The date of the onset of the second stage of labour.
Category Values: Date

Item: Second Stage Onset Time
Definition: The time of the onset of the second stage of labour.
Category Values: Time (24 hour clock)

Entity: Labour: Third Stage
Item: Delivery Method
Definition: The method of delivering the placenta and membranes during the third stage of labour.
Category Values: Controlled cord traction
- Ergometrine
- Manual removal of retained placenta
- Misoprostol
- Other
- Other oxytocic
- Physiological and maternal effort
- Syntocinon
- Unknown

Item: Placenta: Completeness
Definition: The state of completeness of the placenta on examination following delivery.
Category Values: Apparently complete
Incomplete

Item: Third Stage Duration
Definition: Duration of the third stage of labour from delivery of the baby to delivery of the placenta and membranes. Recorded in minutes.
Category Values: Minutes
Item: Third Stage End Date
Definition: The date when the third stage of labour is complete.
Category Values: -Date

Item: Third Stage End Time
Definition: The time when the third stage of labour is complete.
Category Values: -Time (24 hour clock)

**Entity: Lowest Fetal Blood pH During Labour**
Item: pH Value
Definition: The lowest fetal pH recorded from a blood sample taken during labour. Excludes cordocentesis.
Category Values: -Positive decimal

**Entity: Membrane Rupture/Birth Interval**
Item: Interval in Hours and Minutes
Definition: The interval between rupture of membranes (confirmed or reported by mother) and delivery of the baby. Recorded in hours and minutes.
Category Values: -Hours and minutes

**Entity: Membranes**
Item: Date of Rupture
Definition: The date on which rupture of membranes takes place whether spontaneous or artificial.
Category Values: -Date

Item: Rupture Mechanism
Definition: The mechanism for rupture of membranes.
Category Values: -Artificial (ARM)
- Spontaneous (SROM)

Item: Time of Rupture
Definition: The time at which rupture of membranes takes place whether artificial or spontaneous. This may be the time estimated by the mother.
Category Values: -Time (24 hour clock)

**Entity: Mother: Administrative Category**
Item: Category
Definition: The category of patient as recorded for administrative purposes.
Category Values: -Amenity patient - one who pays for the use of a single room or small ward.
- Category II patient (for diagnostic requests only)
- NHS patient
- Private patient

**Entity: Mother: Admission to Intensive Care Unit**
Item: Source of Admission
Definition: The source of admission for a person admitted to an Intensive Care Unit.
Category Values: -Direct admission
- Transfer from another hospital
- Transfer within this hospital
- Unknown

**Entity: Mother: Alcohol Consumption Before Conception**
Item: Units Consumed Per Week
Definition: Weekly consumption of alcohol 12 months before conception, as reported by the mother at booking. Record in units.
Category Values: -Positive integer

**Entity: Mother: Alcohol Consumption During Pregnancy**
Item: Units Consumed Per Week During Pregnancy
Definition: Weekly current consumption of alcohol during pregnancy measured in units and as reported by the mother at booking.
Category Values: -Positive integer

**Entity: Mother: Antenatal Blood Screening**
Item: Downs syndrome/Trisomy 21
Definition: Records whether screening for Downs syndrome (Trisomy 21) has been offered and whether accepted or declined by the mother.
Category Values: -Not offered
- Not required/not applicable
- Offered - declined
- Offered and accepted
- Offered and accepted but not undertaken
Item: Downs/Trisomy 21 Screening Date
Definition: The date on which Downs/Trisomy 21 screening is performed.
Category Values: -Date

Item: Hepatitis B Screening Date
Definition: The date on which Hepatitis B screening is performed.
Category Values: -Date

Item: HIV Screening Date
Definition: The date on which HIV screening is performed.
Category Values: -Date

Entity: Mother: Blood Pressure
Item: Diastolic
Definition: The diastolic blood pressure of a person measured with the correct sized cuff in the right arm, with the patient sitting comfortably with feet supported. A well maintained mercury sphygmomanometer should be used and Korotkoff phase 5 taken as the diastolic pressure.
Category Values: -Positive integer

Item: Systolic
Definition: The systolic blood pressure of a person measured with the correct sized cuff in the right arm with the patient sitting comfortably with feet supported. A well maintained mercury sphygmomanometer should be used.
Category Values: -Positive integer

Entity: Mother: Blood Pressure - Highest Antenatal
Item: Diastolic Blood Pressure Highest Antenatal
Definition: The highest maternal diastolic blood pressure recorded during the antenatal period.
Category Values: -Positive integer

Item: Systolic Blood Pressure Highest Antenatal
Definition: The highest maternal systolic blood pressure recorded during the antenatal period.
Category Values: -Positive integer

Entity: Mother: Blood Pressure at Booking
Item: Diastolic at Booking
Definition: The mothers diastolic blood pressure at booking.
Category Values: -Positive integer

Item: HIV
Definition: Records whether screening for HIV has been offered and whether accepted or declined by the mother.
Category Values: -Not offered
-Not required/not applicable
-Offered - declined
-Offered and accepted
-Offered and accepted but not undertaken
**Entity: Mother: Blood Transfusion**

**Item:** Date Transfusion Commenced  
**Definition:** The date on which a blood transfusion is commenced.  
**Category Values:** - Date

**Item:** Number of units administered  
**Definition:** Records the total number of units administered during a blood transfusion.  
**Category Values:** - Positive integer

**Entity: Mother: Body Mass Index**

**Item:** Body Mass Index Date  
**Definition:** The date on which a mothers body mass index is recorded.  
**Category Values:** - Date

**Item:** Value  
**Definition:** The mothers weight measured in kilograms, divided by her height in metres squared.  
**Category Values:** - Positive decimal

**Entity: Mother: Booking**

**Item:** Booking Status  
**Definition:** The booking status of the mother identifying whether or not she has been booked for maternity care.  
**Category Values:** - Awaiting/scheduled  
- Booked  
- Booked elsewhere  
- Declined booking  
- Mother undecided  
- Unbooked

**Entity: Mother: Cervical Cytology**

**Item:** Date of Last Cervical Smear  
**Definition:** The date of the mothers last cervical smear. If not known or not performed record as 00-00. If exact date not known, record year only.  
**Category Values:** - Date

**Item:** Result Type of Last Cervical Smear  
**Definition:** The classification, by their results, of cytology samples analysed in Pathology laboratories.  
**Category Values:** - a. Inadequate sample  
- b. Negative  
- c. Borderline changes  
- d. Mild dyskaryosis  
- e. Moderate dyskaryosis  
- f. Severe dyskaryosis  
- g. Severe dyskaryosis/invasive carcinoma  
- h. ?Glandular neoplasia

**Entity: Mother: Congenital Anomalies**

**Item:** Maternal Anomaly Type  
**Definition:** The type of maternal congenital anomaly.  
**Category Values:** - Cardiac  
- Other  
- Renal  
- Spina Bifida

**Entity: Mother: Contraception Intention Post-Birth**

**Item:** Intended Method After Delivery  
**Definition:** The method of contraception which the mother intends to use after delivery.  
**Category Values:** - Cap or diaphragm  
- Female sterilisation  
- Implant  
- Injectable contraceptive  
- Intra-uterine contraceptive device  
- No method  
- Oral contraceptive - combined preparation  
- Oral contraceptive - progestogen only  
- Other chemicals (including sponge)  
- Other method  
- Rhythm method  
- Sheath/condom - female  
- Sheath/condom - male  
- Uncertain/unknown  
- Vasectomy
Entity: Mother: Contraception Prior to Conception
Item: Contraception End Date
Definition: The estimated date when contraception was last used prior to pregnancy, as reported by the woman. If contraception has never been used, enter the value as 00/00
Category Values: -Date

Item: Last Method Before Conception
Definition: The main method of contraception used by the mother before pregnancy regardless of the time when contraception was stopped.
Category Values: -Cap or diaphragm
-Female sterilisation
-Implant
-Injectable contraceptive
-Intra-uterine contraceptive device
-No method provided
-Oral contraceptive - combined preparation
-Oral contraceptive - progestogen only
-Other chemicals (including sponge)
-Other method
-Rhythm method
-Sheath/condom - female
-Sheath/condom - male
-Uncertain/unknown
-Vasectomy

Entity: Mother: Critical Incident
Item: Critical Incident Date
Definition: The date of a critical incident.
Category Values: -Date

Item: Incident Type
Definition: Life-threatening critical incidents arising at any time from before birth until transfer to the community.
Category Values: -Amniotic fluid embolus
-Cardio-pulmonary arrest
-Clotting defect
-Coma
-Elevated liver enzymes
-Epileptiform fit - including eclampsia
-Large volume haemorrhage requiring >2 units blood
-Major surgery (excluding caesarean section) with hysterectomy
-Major surgery (excluding caesarean section) without hysterectomy
-Other
-Other pulmonary embolic phenomenon
-Platelets <50,000/ul
-Psychotic or severe mental health disorder requiring psychotrophic treatment
-Renal failure
-Severe gestational proteinuric hypertension (PET)
-Significant postpartum haemorrhage causing anaemia

Entity: Mother: Date on Which Steroids Given
Item: Date Steroids Given
Definition: The date steroids are administered to the mother for the benefit of the fetus, during pregnancy.
Category Values: -Date

Entity: Mother: Death
Item: Cause on Death Certificate
Definition: The reason for a maternal death as recorded on the death certificate.
Category Values: -Text

Item: Date of Death
Definition: The date on which a mother died, as recorded on the Death certificate.
Category Values: -Date

Item: Time of Death
Definition: The time of a maternal death.
Category Values: -Time (24 hour clock)

Entity: Mother: Delivery
Item: Maternal Age at Delivery
Definition: The mothers age at delivery.
Category Values: -Positive integer

Item: Postcode of Mothers Residence at Time of Delivery
Definition: The post-code of the mothers residence at the time of delivery.
Category Values: -Alpha-numeric code
Entity: Mother: Estimated Blood Loss at Delivery
Item: Amount in millilitres
Definition: Total blood loss associated with delivery of the baby and for up to one hour postpartum. Recorded in millilitres. For multiple births this is the mothers total blood loss per complete delivery, not for each individual birth.
Category Values: - Positive integer

Entity: Mother: Estimated Delivery Date
Item: Expected Date
Definition: The date on which a woman is expected to give birth. It is normally calculated by adding 280 days to the date of the first day of the Last Menstrual Period. Adjustments have to be made for a regular long cycle by adding days in excess of 28 days and in a regular short cycle by subtracting days less than 28.
Category Values: - Date

Entity: Mother: Follow Up Arrangements
Item: Kind of Arrangements Made
Definition: Arrangements made for follow-up of the mother following discharge. This includes any discharge during a maternity episode.
Category Values: - Antenatal clinic appointment
- Gynaecology appointment
- Medical specialty appointment
- Other specialist appointment
- Postnatal care by community midwife
- Postnatal clinic appointment
- Routine care by own GP

Entity: Mother: Glycosuria
Item: Glycosuria Date
Definition: The date on which glycosuria is observed.
Category Values: - Date

Item: Glycosuria Time
Definition: The time at which glycosuria is observed.
Category Values: - Time (24 hour clock)

Item: Level
Definition: The level of glucose found in the urine.
Category Values: - +
- ++
- +++
- ++++
- None
- Trace

Entity: Mother: Height
Item: Value in Centimetres
Definition: The mother's height measured in centimetres.
Category Values: - Positive integer

Entity: Mother: Intravenous Infusion
Item: Intravenous Infusion Date
Definition: The date on which an intravenous infusion is commenced.
Category Values: - Date

Item: Intravenous Infusion Given or Not
Definition: Records whether a mother has an intravenous infusion in situ.
Category Values: - Blood transfusion
- Intravenous cannula sited, not used
- Intravenous infusion - not blood
- No intravenous infusion

Entity: Mother: Last Menstrual Period
Item: Date of First Day of Last Menstrual Period
Definition: The first day of the woman's last menstrual period.
Category Values: - Date
Entity: Mother: Medical Conditions
Item: Medical Condition Type
Definition: Any existing or previous medical conditions which may impact on the health of the mother and her baby either by complicating pregnancy and/or delivery or because the conditions themselves are aggravated by pregnancy.
Category Values: -Cardiac disease - congenital or acquired
- Diabetes - type 1, insulin dependent
- Diabetes - type 2, on diet or tablets
- Diabetes - type 2, on insulin
- Epilepsy - no treatment
- Hypertension - on treatment
- Hypertension - no treatment
- Renal disease

Entity: Mother: Miscarriage
Item: Date of Miscarriage
Definition: The date on which a spontaneous abortion (miscarriage) occurs prior to 24 weeks gestation.
Category Values: -Date

Entity: Mother: Miscarriage Following Invasive Procedure
Item: Miscarriage Yes or No
Definition: Records a miscarriage following an invasive procedure e.g. amniocentesis.
Category Values: -No
- Yes

Entity: Mother: Number of Previous Preganacies
Item: Number
Definition: The number of previous pregnancies resulting in one or more registrable births.
Category Values: -Positive integer

Entity: Mother: Pain During Labour and Delivery
Item: Severity of Pain Experienced
Definition: The mothers retrospective report of pain felt during labour and delivery, recorded within 24 hours of delivery.
Category Values: -A great deal, bearable
- A great deal, unbearable
- No pain at all because of effective pain relief
- No pain at all without any pain relief
- Other/dont know
- Some pain
- Very little pain

Entity: Mother: Parenting Intention
Item: Intention Type
Definition: An indication of the mothers parenting intentions for the pregnancy/child(ren). This is normally recorded at booking but may be amended at any time.
Category Values: -Child Protection
- Father takes legal responsibility
- Fostering/adoption planned
- Intentions not known
- Mother and father take joint legal responsibility
- Mother takes legal responsibility
- Surrogate mother
**Entity: Mother: Perineal and Vaginal Tissues Trauma**

**Item:** Episiotomy Accepted or Refused  
**Definition:** Records a mother's acceptance or refusal of an episiotomy where the procedure is recommended by the clinician providing care.  
**Category Values:**  
- No - refused  
- Not recommended  
- Requested by mother  
- Yes - accepted

**Item:** Kind of Trauma  
**Definition:** An assessment of the perineum and vagina immediately following delivery.  
**Category Values:**  
- Cervical tear - tear to the cervix.  
- Episiotomy - a surgical incision equivalent to a second degree tear.  
- First degree tear - perineal laceration, involving the skin of the fourchette.  
- Fourth degree tear - as third degree plus involving anal mucosa.  
- Graze/bruise - not requiring suturing  
- Labial tear - not requiring suturing  
- Labial tear - requiring suturing  
- None - perineum intact  
- Second degree tear - involving the skin of the fourchette, perineum and perineal body.  
- Third degree tear - involving the skin of the fourchette, perineum, perineal body and anal sphincter  
- Vaginal tear - tear to the vaginal wall.

**Entity: Mother: Perineal Condition**

**Item:** Condition Type  
**Definition:** An assessment of the state of the perineum and perineal healing.  
**Category Values:**  
- Broken down  
- Haematoma  
- Infected  
- Normal - clean, healing

**Entity: Mother: Postnatal Admission**

**Item:** Days Postpartum at Admission  
**Definition:** The number of days postpartum that a mother is admitted as an emergency.  
**Category Values:**  
- Positive integer

**Item:** Postnatal Admission Date  
**Definition:** Records the admission of a mother at any time during the postnatal period. Includes re-admissions following discharge and admissions following planned home deliveries.  
**Category Values:**  
- Date

**Entity: Mother: Postnatal Breast Problem**

**Item:** Problem Type  
**Definition:** Breast problems experienced by the mother during the postnatal period.  
**Category Values:**  
- Breast abscess  
- Cracked nipples  
- Engorgement  
- Inverted nipples  
- Mastitis  
- None  
- Pain  
- Sore nipples

**Entity: Mother: Postnatal Care Contacts**

**Item:** Total Number of Contacts  
**Definition:** The total number of postnatal contacts with the mother following discharge from an NHS facility, for a six week period. This includes contacts in a domiciliary or clinic setting.  
**Category Values:**  
- Positive integer

**Entity: Mother: Postnatal Inpatient Care**

**Item:** Number of In-Patient Days  
**Definition:** The number of postnatal in-patient days.  
**Category Values:**  
- Positive integer
**Entity: Mother: Postnatal Uterus State**

**Item:** Observation of Uterus  
**Definition:** Observation of the return to normal size of the uterus after delivery.  
**Category Values:**  
- Involution reduced - no tenderness  
- Involution reduced - tenderness  
- Involution retained - no tenderness  
- Involution retained - tenderness  
- No longer palpable

**Item:** Uterus Observation Date  
**Definition:** The date on which the state of the mother's uterus is observed postnatally.  
**Category Values:** -Date

**Entity: Mother: Previous Blood Transfusions**

**Item:** Previous Blood Transfusion: Yes or No  
**Definition:** This records whether a mother has previously been given a blood transfusion at any time.  
**Category Values:** -No -Yes

**Entity: Mother: Proteinuria 24 Hour Collection**

**Item:** Result in Grams per Litre  
**Definition:** The level of proteinuria in grams per litre from a 24 hour collection.  
**Category Values:** -Grams per litre

**Entity: Mother: Proteinuria Dipstick Observation**

**Item:** Result  
**Definition:** The level of protein found in the urine.  
**Category Values:** -+ -++ -+++ or greater -None -Trace

**Entity: Mother: Proteinuria Persistence**

**Item:** Persistent Proteinuria  
**Definition:** The presence or absence of persistent proteinuria defined as +2 protein occurring in at least 2 consecutive mid stream specimens, in the absence of infection.  
**Category Values:** -No persistent proteinuria -Persistent significant proteinuria

**Entity: Mother: Rubella**

**Item:** Status  
**Definition:** The mother's rubella antibody status.  
**Category Values:** -Antibodies absent -Antibodies present -Unknown

**Item:** Vaccination Postnatally  
**Definition:** Records whether a mother has received Rubella vaccination in the postnatal period.  
**Category Values:** -Declined by mother -Given -Not given - reason unknown -Not required -Other

**Entity: Mother: Screening**

**Item:** Screening Type  
**Definition:** The type of screening offered to a mother.  
**Category Values:** -Text/code

**Item:** Screening: Offer/Acceptance  
**Definition:** Identifies whether screening is offered to, and accepted by, a person or accepted by a parent/guardian on behalf of a baby.  
**Category Values:** -Not offered -Not required/not applicable -Offered - declined -Offered and accepted -Offered and accepted but not undertaken
**Entity: Mother: Skin to Skin Contact with Baby**

*Item:* Whether Skin to Skin Contact or Not
*Definition:* Whether mother and baby have skin to skin contact within 30 minutes of delivery.
*Category Values:*  
- No - baby admitted to SCBU  
- No - due to babys condition  
- No - due to maternal condition  
- No - maternal choice  
- No - reason unknown  
- Not known  
- Yes

**Entity: Mother: Smoking Habits at Delivery**

*Item:* Number of Cigarettes a Day at Delivery  
*Definition:* The estimated number of cigarettes that a mother was smoking around the time of delivery. It is recognised that it is difficult to record smoking habits accurately.
*Category Values:* -Positive integer

**Entity: Mother: Smoking Habits at First Antenatal Assessment**

*Item:* Number of Cigarettes a Day  
*Definition:* The estimated number of cigarettes that a mother is smoking in a day at the time of the first antenatal assessment. It is recognised that it is difficult to record smoking habits accurately.
*Category Values:* -Positive integer

**Entity: Mother: Steroids**

*Item:* Last Dose Date  
*Definition:* The last date on which steroids are administered to a pregnant woman before delivery of her baby(ies).
*Category Values:* -Date

*Item:* Last Dose Time  
*Definition:* The last time at which steroids are administered to a pregnant woman before delivery of her baby(ies).
*Category Values:* -Time (24 hour clock)

**Entity: Mother: Steroids Course**

*Item:* Pattern of Administration  
*Definition:* The type of steroid course administered to a woman for the benefit of the fetus, during her pregnancy.
*Category Values:* -2 doses started <24 hours before delivery  
- Full course >7 days before delivery  
- Full course 1-7 days before delivery  
- One dose only >6hours before delivery  
- Repeated course

**Entity: Mother: Substance Misuse**

*Item:* Misuse Method  
*Definition:* The method of using drugs as reported by the mother.
*Category Values:* -Intravenous  
- Oral  
- Smoking (inhalational)  
- Sniffing

*Item:* Substance Type  
*Definition:* The type of drug use as reported by the mother.
*Category Values:* -Aerosols  
- Amphetamines  
- Cannabis  
- Cocaine  
- Crack  
- Diazepam  
- Ecstasy  
- Glue  
- Heroin  
- Lighter fuel  
- Methadone  
- None  
- Other  
- Temazepam
**Entity: Mother: Support Status**
- **Item:** Support Status Type
- **Definition:** The level of potential support available to a mother in relation to her living arrangements.
- **Category Values:**
  - Homeless unsupported
  - Homeless with partner
  - In care/fostered
  - Lives alone/unsupported
  - Lives with husband/partner
  - Lives with other friend/relative
  - Lives with parents
  - Mother and baby unit
  - Prisoner
  - Psychiatric Unit
  - Sheltered accommodation/refuge

**Entity: Mother: Surgery**
- **Item:** Surgical Intervention Date
- **Definition:** The date of any surgery undergone by the mother, fetus or baby during the current episode of care.
- **Category Values:** Date

**Entity: Mother: Surgery During Pregnancy**
- **Item:** Surgery During Pregnancy Yes or No
- **Definition:**
- **Category Values:**
- No
- Yes

**Entity: Mother: Transfer Post-Delivery**
- **Item:** Transfer Date
- **Definition:** The date of transfer of a person within a current episode of care e.g. transfer of mother from delivery facilities to a postnatal ward.
- **Category Values:** Date
- **Item:** Transfer Destination
- **Definition:** The type of location to which a mother is transferred following delivery.
- **Category Values:**
  - Died
  - Discharged elsewhere
  - High dependency unit
  - Home
  - Intensive care
  - Maternity unit without 24 hour medical cover
  - Maternity ward
  - Maternity ward - transitional care
  - Not transferred e.g. already at home
  - Other
  - Other hospital - baby in Neonatal Unit
  - Other hospital - convalescence
  - Other hospital - intensive care
  - Psychiatric care - mother and baby unit
- **Item:** Transfer Time
- **Definition:** The time of transfer of a person within a current episode of care e.g. transfer of a mother from delivery facilities to a postnatal ward.
- **Category Values:** Time (24 hour clock)

**Entity: Mother: Vaginal Fluid Loss Postpartum**
- **Item:** Observation Date
- **Definition:** The date on which postpartum vaginal fluid loss is observed.
- **Category Values:** Date
- **Item:** Observation of the Lochia
- **Definition:** Observation of the lochia during the postnatal period.
- **Category Values:**
  - Clots/tissue present
  - Diminishing moderate
  - Diminishing/scanty
  - Offensive
  - Recurrence of fresh red loss after pink/brown loss excessive/sudden profuse

**Entity: Mother: Weight**
- **Item:** Date Recorded
- **Definition:** The date on which a mothers weight is recorded.
- **Category Values:** Positive decimal
- **Item:** Value in Kilograms
- **Definition:** The mothers weight recorded in kilograms to one decimal place.
- **Category Values:** Positive decimal
**Entity: Neonatal Death**

**Item:** Age at Babys Death  
**Definition:** The age of the baby at its death, recorded in days, hours and minutes.  
**Category Values:** - Positive integer

**Item:** Cause  
**Definition:** The cause of death of a baby as recorded on the death certificate.  
**Category Values:** - Text

**Item:** Neonatal Death Date  
**Definition:** The date on which a baby aged up to 28 days died, as recorded on the Death Certificate.  
**Category Values:** - Date

**Item:** Post Mortem Consent  
**Definition:** Records whether consent has been given for a post mortem following a neonatal death.  
**Category Values:** - Consent not given  
- Consent to full post mortem  
- Consent to partial post mortem  
- Not applicable  
- Not asked  
- Undecided

**Item:** Post Mortem Performed or Not  
**Definition:** Whether a post mortem was undertaken on a baby dying before discharge or transfer from the episode of care.  
**Category Values:** - Full post mortem performed  
- No post mortem performed  
- Partial post mortem performed  
- Unknown

**Entity: Neonatal Death**

**Item:** Time of Neonatal Death  
**Definition:** The time at which a baby died. May be estimated.  
**Category Values:** - Hours and minutes

**Item:** Weight of Baby at Death  
**Definition:** The weight of a baby at stillbirth or neonatal death. Recorded in grams.  
**Category Values:** - Positive integer

**Entity: Neonatal Intensive Care Unit: Source of Admission**

**Item:** Source Type  
**Definition:** The source of admission for a baby admitted to the Neonatal Intensive Care Unit.  
**Category Values:** - Another hospital, transferred from another hospital after birth  
- Born before arrival  
- In utero transfer  
- Postnatal retrieval of baby from another hospital after birth by own neonatal retrieval team  
- This hospital  
- Transfer by referring hospital  
- Unknown

**Entity: Number of Previous Neonatal Deaths**

**Item:** Total  
**Definition:** The total number of deaths of infants up to 28 days old.  
**Category Values:** - Positive integer

**Entity: Paramedic/Rapid Response Team Deployment**

**Item:** Reason for Deployment  
**Definition:** The reason for a call out by paramedics or a rapid response team to a domiciliary or other non-hospital location.  
**Category Values:** - Care of the baby.  
- Care of the mother before the onset of labour.  
- Care of the mother in labour.  
- Care of the mother postpartum.
**Entity: Person Identifier**

**Item:** Code Type

**Definition:** The classification of a person identifier.

**Category Values:**
- Code of General Practitioner (GMC code)
- Code of General Practitioner (PPA Code)
- Code of General Practitioner - Organisation codes service
- Code of ophthalmic medical practitioner (GMC)
- Code of ophthalmic optician (GOC)
- Code of ophthalmic practitioner - (OQC)
- Consultant code (GMC)
- General dental practitioner code
- Local patient identifier (PAS number)
- New NHS number
- Nurse/midwife identifier - UKCC
- Old NHS number
- Person identifier (employee)
- Service or personnel number
- Social services client identifier

**Item:** Identifier Code

**Definition:** A unique identification code for a person.

**Category Values:** - Alpha-numeric code

**Entity: Person Notifying Birth**

**Item:** Forename

**Definition:** The forename of the person (usually the midwife) notifying the birth.

**Category Values:** - Text

**Item:** Surname

**Definition:** The surname of the person (usually the midwife), notifying the birth.

**Category Values:** - Text

**Entity: Person: Date of Birth**

**Item:** Date of Birth

**Definition:** The date of birth of a person excluding delivery date of the baby(ies).

**Category Values:** - Date

**Entity: Person: Employment Status**

**Item:** Status Type

**Definition:** The employment status of the person.

**Category Values:**
- Casual employment
- Full time employment
- Full-time mother
- Further/higher education
- Medically unfit
- Other
- Part time employment
- Retired
- School
- Unemployed - not seeking work
- Unemployed - seeking work
- Unknown
- Voluntary work

**Entity: Person: Ethnic Group**

**Item:** Ethnic Group Type

**Definition:** The ethnicity of the person receiving care as defined by the mother. Required for monitoring service delivery.

**Category Values:**
- A White British
- B White Irish
- C White: Any other White background
- D Mixed: White and Black Caribbean
- E Mixed: White and Black African
- F Mixed: White and Asian
- G Mixed: Any other mixed background
- H Asian or Asian British: Indian
- I Asian or Asian British: Pakistani
- K Asian or Asian British: Bangladeshi
- L Asian or Asian British: Any other Asian background
- M Black or Black British: Caribbean
- N Black or Black British: African
- P Black or Black British: Any other Black background
- R Chinese
- S Any other ethnic group
- Z Not stated
Entity: Person: Language Ability
Item: Language Ability
Definition: The ability of a person to understand and communicate in English
Category Values:
- Fluent in English
- Limited understanding of English
- No significant understanding of English
- Signer
- Unknown

Entity: Person: Marital Status
Item: Marital Status
Definition: The marital status of the mother.
Category Values:
- Divorced
- Married
- Not known
- Separated
- Single
- Widowed

Entity: Person: Name
Item: Sequence
Definition: The sequence number allocated to a Person Name to distinguish between different names applying to a Person.
Category Values: - Positive integer

Item: Text
Definition: An unstructured name for a Person.
Category Values: - Text

Item: Word Position
Definition: The position of a Person Name Word within a Persons name (e.g. "1").
Category Values: - Positive integer

Item: Word Text
Definition: The character or string of characters comprising an element of a Persons name which has been recorded for at least one Person (e.g. "Dr", "John", "Smith").
Category Values: - Text

Item: Word Type
Definition: The classification of the information conveyed by a part of a Persons name, as requested by the Person.
Category Values:
- a. Title
- b. Family Name or Surname
- c. Forename or Personal Name
- d. Suffix

Entity: Person: Religion
Item: Religion
Definition: The religion of a person.
Category Values:
- Agnostic
- Atheist
- Bahai
- Buddhist
- Chinese religions - other
- Christian -other
- Church of England
- Eastern Orthodox
- Greek Orthodox
- Hindu
- Jain
- Jehovahs Witness
- Jewish
- Mormon
- Muslim
- No religion
- Not known/not stated
- Other -specify
- Person declined information
- Rastafarian
- Religious beliefs - religion not specified
- Roman Catholic
- Sects
- Shintoism
- Sikh
- Taoism
- Zoroastrian
Entity: Person: Telephone Number
Item: Telephone Number
Definition: The telephone number of an individual.
Category Values: - Telephone number

Entity: Post-operative Analgesia - Quality
Item: Maternal Satisfaction
Definition: The mothers reported satisfaction with post-operative analgesia
Category Values: - Dissatisfied
- Satisfied
- Unknown
- Very satisfied

Entity: Prescribed Pharmaceutical Product
Item: Date Prescribed
Definition: The date on which the Prescription was signed by the Health Care Practitioner.
Category Values: - Date

Item: Form
Definition: The physical form used to administer or apply a medicinal product.
Category Values: - Capsule
- Gel
- Infusion solution
- Inhaler
- Injectable solution
- Nasal drops
- Nebuliser
- Oral solution
- Patch
- Pessary
- Spray
- Suppository
- Tablet
- Topical solution

Item: Frequency of Administration
Definition: The number of times per hour, day, week or month that a pharmaceutical product should be administered.
Category Values: - Text/Integer

Item: Identifier
Definition: The unique identifier for a Prescribed Item within a Prescription.
Category Values: - Numeric code

Entity: Prescribed Pharmaceutical Product
Item: Prescribed Dose
Definition: The dose of a prescribed pharmaceutical product.
Category Values: - Positive decimal

Item: Route of Administration
Definition: A classification of the route of administration for a pharmaceutical product.
Category Values: - Epidural
- Infusion
- Inhalational
- Intramuscular
- Intrathecal
- Intravenous injection
- Nasal
- Oral
- Patch
- Per rectum
- Per vaginum
- Sub-lingual
- Subcutaneous
- Suppository
- Topical

Item: Strength
Definition: The strength of a prescribed pharmaceutical product.
Category Values: - Text and numerals

Item: Subject Type
Definition: The subject of a prescribed pharmaceutical product.
Category Values: - Baby
- Mother
**Entity: Previous Delivery**

**Item:** Baby Gestation at Delivery  
**Definition:** The gestation of previous babies born to the mother, measured in completed weeks.  
**Category Values:** - Positive integer

**Item:** Baby Weight at Delivery  
**Definition:** The weight of previous babies born to the mother, measured in grams.  
**Category Values:** - Positive decimal

**Item:** Current Status of Child  
**Definition:** The status of a child born from a previous pregnancy.  
**Category Values:** - Alive and well  
- Died  
- Other e.g. congenital/terminal illness

**Item:** Dead-born Fetus: Gestation  
**Definition:** The gestation, at the assumed time of death, of a dead-born fetus from a previous pregnancy. Record in completed weeks.  
**Category Values:** - Positive integer

**Item:** Month and Year of Delivery  
**Definition:** The month and year of delivery for any previous pregnancy.  
**Category Values:** - Month and year

**Item:** Order  
**Definition:** A sequential number denoting the order of previous pregnancies.  
**Category Values:** - Positive integer

**Entity: Previous Delivery**

**Item:** Outcome  
**Definition:** The outcome of each previous pregnancy.  
**Category Values:** - Live birth  
- Miscarriage at 12 weeks or more gestation  
- Miscarriage before 12 weeks gestation  
- Still birth  
- Termination at 24 weeks gestation or later  
- Termination prior to 24 weeks gestation

**Item:** Sex of Baby  
**Definition:** The sex of the baby born from a previous pregnancy.  
**Category Values:** - Female  
- Male  
- Not known - information not available or not offered  
- Not specified - ambiguous or indeterminate

**Entity: Previous Neonatal Death**

**Item:** Age at Death  
**Definition:** The age at death of a previous neonatal death. Record in days.  
**Category Values:** - Positive integer

**Item:** Death Cause  
**Definition:** The cause of death of a previous neonatal death as recorded on the death certificate.  
**Category Values:** - Text

**Entity: Provision of Anaesthesia**

**Item:** Grade of First Anaesthetist Present (Locum)  
**Definition:** The grade of the attending anaesthetist  
**Category Values:** - Associate specialist  
- Consultant  
- Other  
- SHO (> year 1)  
- SHO (Year 1)  
- SpR 1/2  
- SpR 3/4/5  
- Staff grade  
- Trust doctor  
- Unknown
**Item:** Grade of First Anaesthetist Present (Permanent)

**Definition:** The grade of the attending anaesthetist.

**Category Values:**
- Associate specialist
- Consultant
- Other
- SHO (> year 1)
- SHO (Year 1)
- SpR 1/2
- SpR 3/4/5
- Staff grade
- Trust doctor
- Unknown

**Item:** Grade of Second Anaesthetist Present

**Definition:** The grade of the second anaesthetist present.

**Category Values:**
- Associate specialist
- Consultant
- Not present
- Other
- SHO (> year 1)
- SHO (Year 1)
- SpR 1/2
- SpR 3/4/5
- Staff Grade
- Trust doctor
- Unknown

**Item:** Grade of Third Anaesthetist Present

**Definition:** The grade of the third anaesthetist present.

**Category Values:**
- Associate specialist
- Consultant
- Not present
- Other
- SHO (> year 1)
- SHO (Year 1)
- SpR 1/2
- SpR 3/4/5
- Staff grade
- Trust doctor
- Unknown

**Item:** Presence of More Than One Anaesthetist: Reason

**Definition:** The reason why more than one anaesthetist may be present with a patient.

**Category Values:**
- Clinical need
- Failed, unsatisfactory or repeat procedures.
- Supervision and training

**Entity: Referring General Practitioner**

**Item:** General Practitioner Name

**Definition:** The name of the womans General Practitioner who refers her for maternity care.

**Category Values:**
- Text

**Item:** Practice Name

**Definition:** The name of the Practice of the womans General Practitioner that refers her for maternity care.

**Category Values:**
- Text

**Entity: Second Opinion**

**Item:** Second Opinion Date

**Definition:** The date on which a second opinion is given.

**Category Values:**
- Date

**Item:** Second Opinion Time

**Definition:** The time at which a second opinion is given.

**Category Values:**
- Time (24 hour clock)
### Entity: Stillbirth

**Item:** Cause of Death on Certificate  
**Definition:** Cause of death in stillbirth as recorded on medical certificate of stillbirth.  
**Category Values:** -Text

**Item:** Certificate Identifier  
**Definition:** A unique identifier for the medical certificate of still birth.  
**Category Values:** -Alpha-numeric code

**Item:** Date of Delivery  
**Definition:** The date on which a stillborn baby is delivered.  
**Category Values:** -Date

**Item:** Time of Delivery  
**Definition:** The time at which a stillborn baby is delivered.  
**Category Values:** -Time (24 hour clock)

### Entity: Termination

**Item:** Termination Date  
**Definition:** The date on which a pregnancy is terminated, prior to 24 weeks gestation.  
**Category Values:** -Date

**Item:** Termination Gestation  
**Definition:** The gestation of pregnancy at termination. Measured in completed weeks.  
**Category Values:** -Positive integer

**Item:** Termination Method  
**Definition:** The primary method of termination of a pregnancy.  
**Category Values:** -Drugs  
-Extra amniotic  
-Intra amniotic  
-Suction

### Entity: Ultrasound Scans Performed

**Item:** Total Number During Pregnancy  
**Definition:** The total number of ultrasound scans performed during pregnancy including those in early pregnancy, and regardless of the purpose of the scan.  
**Category Values:** -Positive integer

### Entity: Uterine Scar

**Item:** Scar Present or Not  
**Definition:** Records the presence of one or more uterine scars. Used to derive the Robson groups for comparison of caesarean section rates.  
**Category Values:** -Dont know  
-No  
-Yes