British Columbia Perinatal Data Registry Reference Manual Version 6.01 – Addendum June 2017

The following hyperlinked documents contain details of the amendments and clarifications to the Perinatal Data Registry Reference Manual – Version 6.01(April 2014). Please utilize these reference documents in addition to the reference manual. These changes will be incorporated into the next revision of the manual.

Period End Procedure – CIHI Transfer & Data Quality
This revision replaces section 8.2.3 Period End Procedure – CIHI Transfer and Data Quality in the BCPDR Reference Manual – April 2014 (pages 153-179). This revised section has been updated to incorporate additional information on importing, data quality, and exporting procedures.

PDR Data Quality Reference Guide for Coders
This document provides general instructions for correcting data quality errors generated by the PDR Data Quality Tool and Supplemental DQ Reports distributed by Perinatal Services BC (PSBC).
The document is searchable by Error ID, provides the suites and fields to check and general instructions on how to correct errors.

PDR Changes
This document presents the data collection amendments and clarifications to the Perinatal Data Registry Reference Manual for Fiscal 2016/17.

Updated PDR Scope
This revision was developed in response to questions regarding the existing scope contained in the manual and to reflect the changes to homebirth data collection for designated facilities effective April 1, 2016.

Neonatal Daily Classification
The following links are to the Neonatal Daily Classification reference materials from the education sessions offered to coders in January 2015.
Training Video
FAQs
Abstraction Rules
Case Examples (without answers)
Case Examples with Answers

All the above documents are also available on the PSBC website Resources for Coders page.

Perinatal Services BC
West Tower, Suite 350
555 West12th Avenue
Vancouver, BC V5Z 3X7

BRITISH COLUMBIA PERINATAL DATA REGISTRY REFERENCE MANUAL

VERSION 6.01

Revised: April 2014

TABLE OF CONTENTS

1. INTRODUCTION . . . 1

1.1 Overview . . . 1

1.1.1 Background . . . 1

1.1.2 The BC Perinatal Data Registry Goals . . . 1

1.1.3 Collection of Data . . . 2

1.2 Scope of Hospital Data Collection . . . 3

1.3 Registry Support . . . 5

2. GENERAL INSTRUCTIONS . . . 7

2.1 Using the Login Screen / Main Screen . . . 7

2.2 Windows Menu Commands . . . 9

2.2.1 Toolbar Command Buttons . . . 10

2.3 Use of the Keyboard . . . 11

2.4 Explanation of Colour Coding . . . 12

3. MOTHER SUITE . . . 13

3.1 Mother Screen Command Buttons . . . 13

3.2 Mother Sub-Screen Command Buttons . . . 14

3.3 Mother Screen . . . 15

3.4 Antenatal Screen . . . 17

3.5 Birth Summary Screen . . . 22

3.6 Chart Data Screen . . . 34

3.7 Pregnancy / PP Screen . . . 38

3.8 Risks Screen . . . 42

3.9 CIHI Data Screen (Mother) . . . 49

3.10 Supplementary Screen (Mother) . . . 54

4. POSTPARTUM SUITE . . . 55

4.1 Postpartum Screen Command Buttons . . . 55

4.2 Postpartum Mother Sub-Screen Command Buttons . . . 56

4.3 Postpartum Screen 57
4.4 Pregnancy/PP Screen 59
4.5 CIHI Data Screen (Postpartum Mother) 63
4.6 Supplementary Screen (Postpartum Mother) 68

5. BABY NEWBORN SUITE 69
5.1 Baby Newborn Screen Command Buttons 69
5.2 Baby Newborn Sub-Screen Command Buttons 70
5.3 Baby Newborn Screen 71
5.4 Newborn Record Screen 74
5.5 Baby Chart Screen 80
5.6 CIHI Data Screen (Baby Newborn) 84
5.7 Supplementary Screen (Baby Newborn) 89

6. BABY TRANSFER/READMISSION SUITE 91
6.1 Baby Transfer/Readmission Screen Command Buttons 91
6.2 Baby Transfer/Readmission Sub-Screen Command Buttons 92
6.3 Baby Transfer/Readmission Screen 93
6.4 Baby Chart Screen (Baby Transfer/Readmission) 97
6.5 CIHI Data Screen (Baby Transfer/Readmission) 101
6.6 Supplementary Screen (Baby Transfer/Readmission) 106

7. FUNCTIONS 107
7.1 Finding Existing Records 107
7.1.1 Searching for a Range of Records 107
7.2 Linking and Unlinking Suites 108
7.2.1 Linking Previously Entered Mother Suite to Baby Newborn Suite 108
7.2.2 Linking Previously Entered Mother Suite to Baby Transfer/Readmission Suite 113
7.2.3 Linking Previously Entered Baby Newborn Suite to Mother Suite 118

7.2.4 Linking Previously Entered Baby Transfer / Readmission Suite to Mother Suite . . . 122
7.2.5 Unlinking Suites . . . 126
7.3 Deleting a Record . . . 129
7.3.1 Deleting Records Before Exporting . . . 129
7.3.2 Deleting Records After Exporting . . . 135
7.3.3 Deleting a Record After Exporting . . . 144

8. DATA TRANSFER . . . 145
8.1 Overview . . . 145
8.1.1 Hospital ADT System . . . 145
8.1.2 CIHI Import – Period End Procedure . . . 145
8.2 Performing Data Transfers . . . 146
8.2.1 Signing into Transfer Programs . . . 146
8.2.2 Data Transfer – Hospital ADT System . . . 147
8.2.3 Period End Procedure – CIHI Transfer & Data Quality . . . 153

9. REPORTS . . . 181
9.1 Provincial Reports . . . 181
9.1.1 Annual Indicators for BC Residents and for Place of Delivery . . . 181
9.1.2 Core Surveillance Quarterly Report . . . 181
9.1.3 PSBC Perinatal Health Report . . . 181
9.1.4 Special Reports . . . 181
9.1.5 Facility-level maternity and neonatal indicators . . . 181
9.2 Hospital Reports . . . 182
9.2.1 Standard Hospital Reports . . . 182
9.2.2 Change Fiscal Year For Hospital Reports . . . 186
9.3 Ad Hoc Reports . . . 189
9.3.1 Ad Hoc Reporting . . . 189
9.4 Database Structure . . . 190
9.4.1 Table Relationship Diagram . . . 190
9.4.2 Alphabetic List of Fields . . . 191
9.4.3 Sorted by Entry Screen . . . 202

9.5 Field Values . . . 213
9.5.1 Coded Field Values . . . 213
9.5.2 Non-coded Field Values . . . 221
9.6 Supplementary Screens . . . 222
9.6.1 Institution Fields . . . 222
9.6.2 BCPDR Fields . . . 222

10. APPENDICES . . . 223
10.1 PSBC Provincial Perinatal Forms Documentation Hierarchy . . . 223
10.2 Height Conversion Table . . . 240
10.3 Weight Conversion Table – Pounds to Kilograms . . . 241
10.4 Weight Conversion Table – Pounds / Ounces to Grams . . . 242
10.5 Gestational Age Calculation . . . 243
10.5.1 Gestational Age Calculation Used by BCPDR Application . . . 243
10.5.2 Gestational Age Calculation Used by PSBC Surveillance . . . 244
10.6 Labour and Delivery Presentation and Position . . . 246
10.6.1 Table . . . 246
10.6.2 Diagrams . . . 248
10.6.3 Flowcharts . . . 249
10.7 Adapted Case Scenarios for Registration of Births and Stillbirths in British Columbia . . . 251
10.8 Newborn Resuscitation and Ventilation . . . 252
10.8.1 Definitions . . . 252
10.8.2 Scenario Table . . . 253
10.8.3 Calculation of Start Age and Stop Age for Resuscitation – Examples . . . 254
10.9 Supplementary Institution Fields . . . 255

1. INTRODUCTION

1.1 Overview

1.1.1 Background

The British Columbia Reproductive Care Program (BCRCP) was initiated in June 1988 by the Ministry of Health (Hospital Programs) and the British Columbia Medical Association (BCMA) through the Continuing Advisory Subcommittee on Perinatal Care (CASC). This body has representation from health care providers, health authorities and academic organizations. The BCRCP became part of the Provincial Health Services Authority (PHSA) in 2001 when the BC Health Authority structure was introduced by the Ministry of Health. In 2007, a new organizational structure – the BC Perinatal Health Program (BCPHP) – was created to coordinate both the BCRCP and the Provincial Specialized Perinatal Services (PSPS). In 2010, Perinatal Services British Columbia (PSBC) was created to replace the BCPHP and to provide strategic leadership on the full continuum of perinatal care across the province, focusing on perinatal system planning, service delivery, and quality improvement.

One of the mandates of PSBC is the collection and analysis of provincial perinatal data for the purpose of monitoring and improving perinatal care and outcomes through the BC Perinatal Data Registry (BCPDR). Rollout of the Registry began in 1994, with full provincial participation since April 1, 2000.

1.1.2 The BC Perinatal Data Registry Goals

a) To aggregate and report on perinatal events, care processes, and outcomes at the provincial, regional and community levels, enabling:

- Individual hospitals and staff to perform comparisons. Comparative aggregate data will permit:
  - Providers to examine their practice in relation to outcome.
  - Program/service managers/administrators to monitor aspects of practices, performance and results.
  - Policy developers/decision makers to analyze outcome/practice.
- Care provider reviews of clinical processes, practices and outcomes in order to improve the quality of perinatal care in the province and to minimize perinatal morbidity and mortality. This can result in the development of practice guidelines or educational program initiatives (under PSBC).
- Support the development of effective program/clinical resource management of providing data that may be analyzed to optimize the use of clinical resources to improve utilization, resource allocation and quality of care/outcomes and/or reduce cost.
- Support the development of effective program planning by providing aggregate data that may be analyzed to optimize resource allocation, to improve quality of care/outcomes and/or reduce costs.

b) To support perinatal health services research aimed at improving the delivery of patient care by providing authorized researchers with access to information from a very extensive perinatal database.

1.1.3 Collection of Data

PSBC houses the provincial perinatal database, which consists of data collected from obstetrical facilities as well as births occurring at home attended by BC Registered Midwives. Perinatal data is collected from facilities throughout the province and imported into the central BCPDR. Installation hospitals have the same software as the central system, and send data on a periodic basis to the provincial database. The non-installation hospitals have their databases maintained at the central office. Data from the Canadian Institute for Health Information (CIHI) and matched files from the British Columbia Vital Statistics Agency complement the data elements. Participation in the registry is not mandatory.

When the BCPDR application is started, four command buttons become available:

Data Collection:	for data input
Hospital Reports:	for data output
Adhoc Reports:	for data output
Transfer Programs:	for importing and exporting data

Recommended and alternative sources for data collection can be found in *Appendix 10.1 PSBC Provincial Perinatal Forms Documentation Hierarchy on page 223*.

PSBC makes every effort to utilize privacy expert advice as a guide in establishing strict policies to ensure that privacy concerns are addressed at both the provider (hospital) and provincial level.

Sources for the privacy expert advice come from:

- The BC Freedom of Information and Protection of Privacy Act (FOIPPA)
- The Canadian Organization for the Advancement of Computers in Health (COACH)
- The Provincial Health Services Authority (PHSA) data access / release policies and procedures
- Federal / Provincial acts and regulations

The collection, use, and disclosure of PSBC data is governed by the conditions outlined in the Memorandum of Agreement & Partnership Accord established between PSBC and each facility partnering with PSBC. The information in the BCPDR is used only for the purposes for which it was collected.

1.2 Scope of Hospital Data Collection

There are four suites available in the BCPDR: Mother Suite, Postpartum Suite, Baby Newborn Suite and Baby Transfer/Readmission Suite. The following tables indicate when data should be collected for each suite.

- **ONE MOTHER SUITE TO BE COMPLETED PER PREGNANCY**
- The initiating event for data collection is the delivery episode.

SUITE	CRITERIA	SPECIAL RULES/TIME PERIOD
MOTHER	**Delivers newborn or stillborn in BC hospital**	**See Baby Newborn Suite Scope for Special Rules/Time Period of Stillborns**
	Delivers newborn or stillborn en route to BC hospital	Mother admitted to hospital
	Delivers newborn or stillborn at home in BC (*with* the attendance of a registered midwife)	These midwifery cases are currently abstracted at Victoria General Hospital (for those midwives who practise in the Victoria region) and at PSBC (for those midwives who practise in the rest of the province)
	Delivers newborn or stillborn at home in BC (*without* the attendance of a registered midwife)	**Mother admitted to hospital ≤24 hours of delivery**

- **ONE POSTPARTUM SUITE FOR EACH SURGICAL DAY CARE OR INPATIENT ADMISSION**

SUITE	CRITERIA	SPECIAL RULES/TIME PERIOD
POSTPARTUM	**Mother is admitted as either an inpatient or Surgical Day Care patient**	**Mother admitted to hospital ≤ 42 days post delivery**
	Mother who delivered newborn or stillborn at home in BC (*with* the attendance of a registered midwife) is admitted as either an inpatient or Surgical Day Care patient	Mother admitted to hospital ≤ 42 days post delivery
	Companion well mothers	Mother admitted to hospital ≤ 42 days post delivery

- **ONE NEWBORN SUITE FOR EACH NEWBORN / STILLBORN**
- The Registry classifies Newborn / Stillborns using the same definition as ***BC Vital Statistics***.

SUITE	CRITERIA	SPECIAL RULES / TIME PERIOD
Baby Newborn	**Newborn born in BC hospital**	
	Newborn born en route to BC hospital	Newborn admitted to hospital
	Newborn born at home in BC (*with* the attendance of a registered midwife)	These midwifery cases are currently abstracted at Victoria General Hospital (for those midwives who practise in the Victoria region) and at PSBC (for those midwives who practise in the rest of the province)
	Newborn born at home in BC (*without* the attendance of a registered midwife)	**Newborn admitted to hospital ≤24 hours** of delivery. This is the **first** hospital admission for newborn.
	Stillborn born in BC (delivered ≥20 weeks gestation or ≥500 g)	All stillbirths should be collected regardless of location of birth, (Eg: in hospital, en route, or at home) and regardless if mother is admitted to hospital. For the precise legal definition please see the ***BC Vital Statistics***.

ONE BABY TRANSFER / READMISSION SUITE FOR EACH ADMISSION

- Include companion well babies.

SUITE	CRITERIA	SPECIAL RULES / TIME PERIOD
Baby Transfer / Readmission	**Baby transferred to BC hospital from another hospital and where baby has not been discharged home yet**	Collect until one of the following occurs: • discharged home • transferred to a long term care institution • reaches one year of age (baby may still be in hospital but would be a forced discharge from the PDR)
	Baby (re)admitted to hospital	Baby (re)admitted to BC hospital ≤**28 days** days of age
	Baby born at home in BC (*with* the attendance of a registered midwife) and is admitted as an inpatient	Baby admitted to hospital ≤**28 days** of age
	Companion well babies	Baby (re)admitted to hospital ≤**28 days** of age

1.3 Registry Support

PSBC's Product Support team will provide database application support for problems encountered with definitions, data entry, error messages, data import/export, and simple report generation.

Call the Helpline at **604-877-2121 ext 223753** or email your inquiries to ***psbc@phsa.ca***. The Helpline will provide a 24-hour response time, excluding weekends and holidays.

The BCPDR can be reached through Perinatal Services BC at the following address:

West Tower, Suite 350
555 West 12th Avenue
Vancouver, BC V5Z 3X7
Ph: 604-877-2121
Fax: 604-877-1987

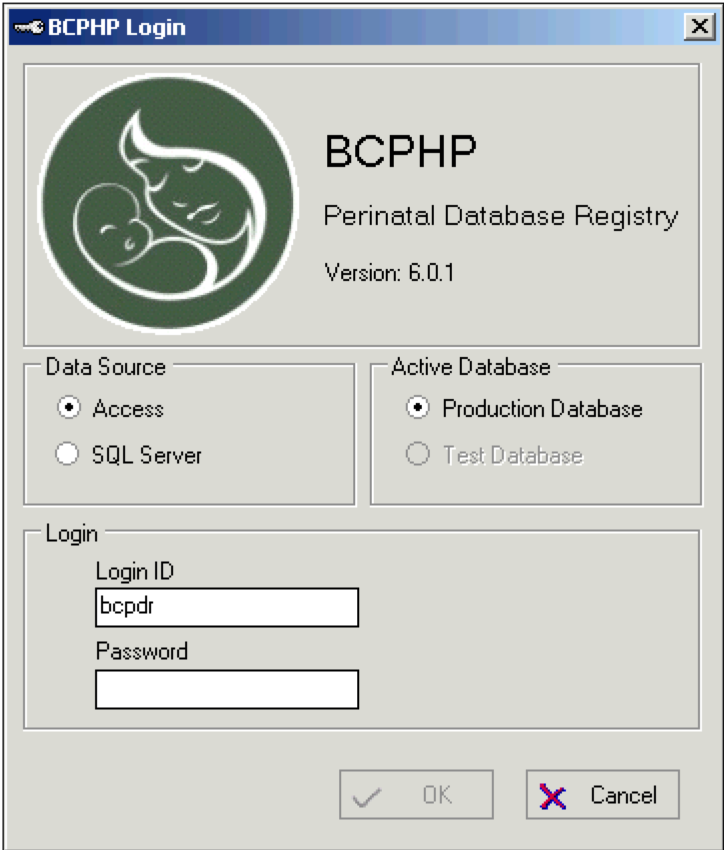
PSBC's website is: ***www.perinatalservicesbc.ca***

THIS PAGE INTENTIONALLY LEFT BLANK

2. GENERAL INSTRUCTIONS

2.1 Using the Login Screen / Main Screen

When the user starts the application the following Login Screen will appear.



This screen is partitioned into three functional areas.

Data Source

This is used to select the data source to utilize. Depending on the installation specific for your institution, you will select either 'Access' or 'SQL Server'. The default will be set for each hospital.

Active Database

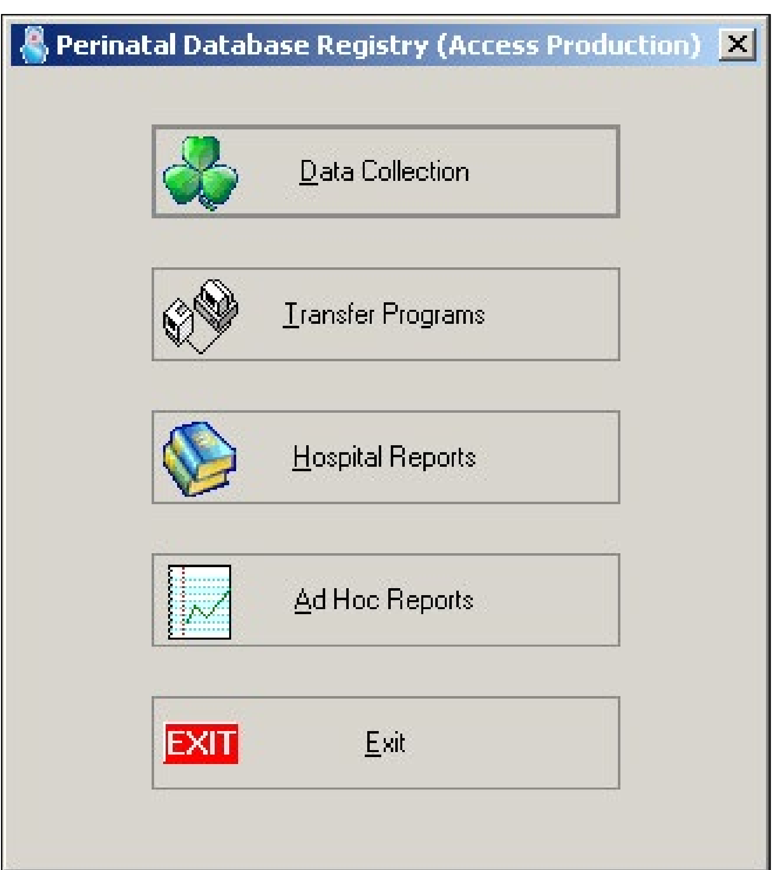
This is used to select either the 'Production Database' or the 'Test Database'. The default is 'Production Database'.

Login

This is used to enter the user's **Login ID** and **Password**. The default will be the login ID of the last user.

Note: After entering the password, select ***OK*** *or* <Tab> *to* ***OK*** *and press* <Enter>.

If the user successfully logs in by entering a valid **Login ID** and **Password**, the Main Screen will display.



Data Collection	Data Collection Screens
Transfer Programs	Transfer Programs
Hospital Reports	Standard Hospital Reports
Ad Hoc Reports	Ad Hoc Reporting Database
Exit	Exits the program

Depending on the security setup of the system, a specific user may or may not have access to all the available applications.

2.2 Windows Menu Commands

When Data Collection is selected, the following Main Menu Bar and Suite Toolbar will display at the top of the screen:

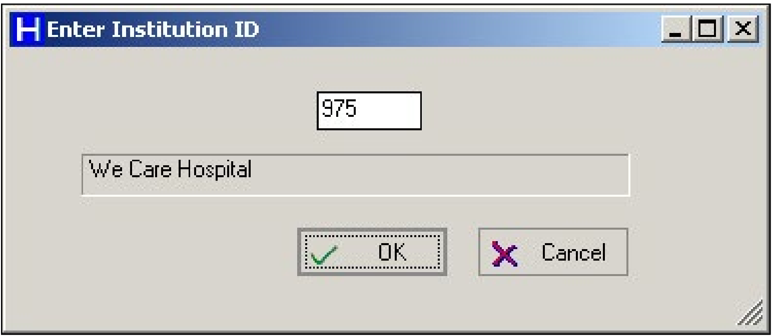
Main Menu commands can be activated by using either the mouse or the keyboard shortcut keys – <Alt> and the underlined letter on the command (Eg: to activate File, use <Alt> + <F>). Once a command is activated, a drop-down list will display.

Menu Command	Drop down list from Menu Command	Action
File	Exit	Will exit the program and return to the Main Screen
Help	Help	Disabled – Do Not Use
	About	Will display the information dialog box called BCPHP Perinatal Database Registry, which will display the version number of the application that is installed on the computer

2.2.1 Toolbar Command Buttons

Hospital

This button is used to enter the Institution ID to identify the hospital for data entry. The Enter Institution ID screen will display.



Enter the three-digit institution number. The hospital name will appear below the institution number. To accept this institution, select **OK** or <Tab> to **OK** and press <Enter>. The hospital name will now appear on the status bar on the lower left corner of the screen.

2.3 Use of the Keyboard

The BCPDR database is a Windows based program and is generally navigated with the mouse. However, many functions can be performed using the keyboard. The following are examples of how data entry can be performed using the keyboard.

Examples:

GENERAL ENTRY

To activate a command that has any letter underlined, eg Mother	<Alt> + underlined letter in the command (eg to activate Mother command, press <Alt> <M>).
To move from one field to the next or previous field	<Tab> / <Enter> or <Shift> <Tab> / <Shift> <Enter>
To activate command button that is highlighted	<Enter>

COMBO BOX ENTRY (as in Labour Presentation on Birth Summary screen)

To open a combo box	<F4> or <Alt> <Down Arrow>
To move down one line in combo box	<Down Arrow>
To move up one line in combo box	<Up Arrow>
To move to the top in combo box	<Home>
To move to the bottom in combo box	<End>
To exit the combo box or list box	<Tab>

OPTION GROUP ENTRY (as in Blood Type on the Antenatal Screen)

To move to the right in option group	<Right Arrow> or <Up Arrow>
To move to the left in option group	<Left Arrow> or <Down Arrow>

CHECK BOX ENTRY (as in Anesthetic/Analgesia on the Birth Summary screen)

To switch between the values in a check box – to put a check in a box or to delete a check in a box	<Spacebar>

GENERAL MICROSOFT SHORTCUT KEYS

To highlight to the left	<Shift> <Left Arrow> or <Shift> <Up Arrow>
To highlight to the right	<Shift> <Right Arrow> or <Shift> <Down Arrow>
To undo last action	<Ctrl> <Z>
To undo typing	<Alt> <Backspace>
To delete the selection or the character to the left of the insertion point	<Backspace>
To delete the selection or the character to the right of the insertion point	<Del>

2.4 Explanation of Colour Coding

Throughout the Reference Manual different colours are used to designate whether a change is new, [highlighted in green], or a change is a revision, [highlighted in yellow]. These colours may not be able to be differentiated from one another if the Reference Manual is printed in black and white.

3. MOTHER SUITE

3.1 Mother Screen Command Buttons

The Mother suite consists of the Mother screen and sub-screens: Antenatal, Birth Summary, Chart Data, Pregnancy/PP, Risks, CIHI, and Supplementary.

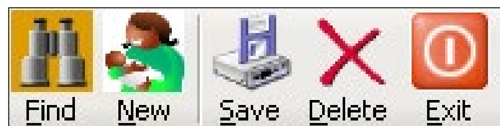
When the Mother Suite Mother is selected, the following screen appears:

Sub-screen icons

Command Buttons

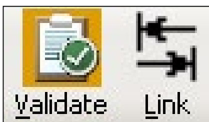
The sub-screen icons (Antenatal, Birth Summary, Chart Data, Pregnancy/PP, Risks, CIHI and Supplementary) activate the Mother sub-screens.

The command buttons are displayed across the top of the screen:



Find	Searches the database for a Mother record.
New	Clears the screen for entry of a new Mother record.
Save	Saves the Mother record if all errors are cleared.
Delete	Removes the current Mother record from the database.
Exit	Closes the Mother screen.
Help	Disabled – Do Not Use

Once a Mother record has been saved, two additional commands become available:

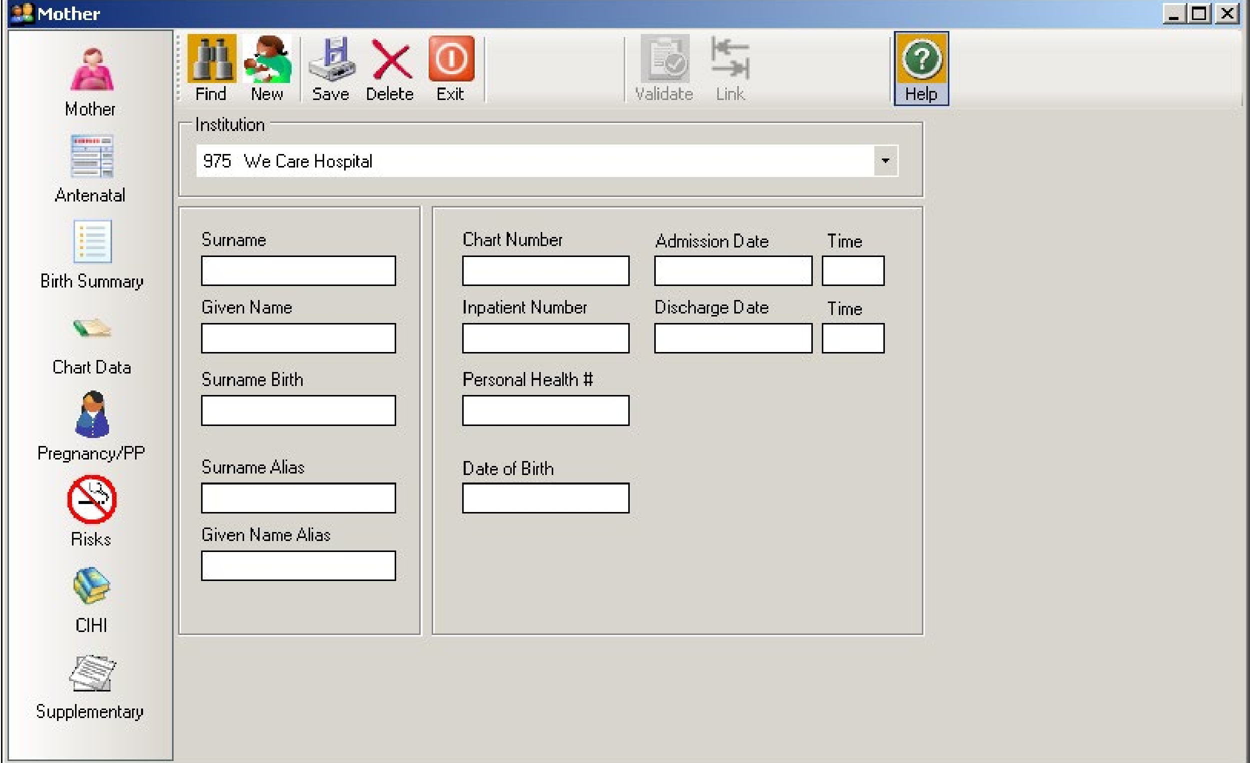


Validate	Identifies specific errors or omissions, if any, in the Mother record. When validation is successful, the CTS (clear to send) flag populates the mother_admission table. The CTS flag is one of the identifiers that indicate a record is ready for exporting.
Link	Allows the current Mother record to be linked to a previously entered Newborn or Baby Transfer/Readmission record.

3.2 Mother Sub-Screen Command Buttons

Check	Checks for field completion for the screen.
Cancel	Cancels abstracted information for the screen.
Help	Disabled - Do Not Use

3.3 Mother Screen



Surname

The currently used last name of the mother. The surname is the family name associated with the mother and is usually, but not always, shared by family members. All parts of a hyphenated or multi-part surname are included.

Given Name

The mother's first given name. May be an ethnic name.

Surname Birth

The mother's last name at birth (ie: maiden name).

Surname Alias

Other last name used, or other name under which previous medical data may be documented. May be a previous married name or common law spouse's name. If both are available, abstract previous married name over the common law spouse's surname.

Used to link all deliveries for this mother within the Provincial Database.

Given Name Alias

Other given names used, or given name under which previous medical data may be documented. May be a middle name, nickname, or English translation of an ethnic name.

Chart Number

The mother's unique unit number assigned by the facility. This number is used by the facility, to track all services provided, for the current and subsequent admissions.

***Chart Number** must match the CIHI chart number exactly as it appears in the hospital abstracting system, including leading zeros*

Eg: 0123456, H0123456.

Inpatient Number

The admitting number assigned by the facility to identify the specific mother admission.

Used by the facility (hospital) for mother identification and linkage. Optional use. May be left blank.

Personal Health

The 10-digit British Columbia Personal Health Number (PHN) is a unique numerical lifetime identifier used to specifically identify an individual having any interaction with the BC Health System. It is assigned to and used by one person and will not be assigned to any other person at any time.

Abstract 0 if the PHN is not available or if the PHN is an out of province number.

Date of Birth

The date (day, month, year) the mother was born.

Admission Date

The date (day, month, year) the mother was admitted/transferred to the hospital as an inpatient.

Admission Time

The time the mother was admitted/transferred to the hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

Eg: If the mother is admitted midnight, New Year's Day, abstract as January 1 at 0000 hours.

Discharge Date

The date (day, month, year) the mother was discharged from, died at, or transferred from, the hospital.

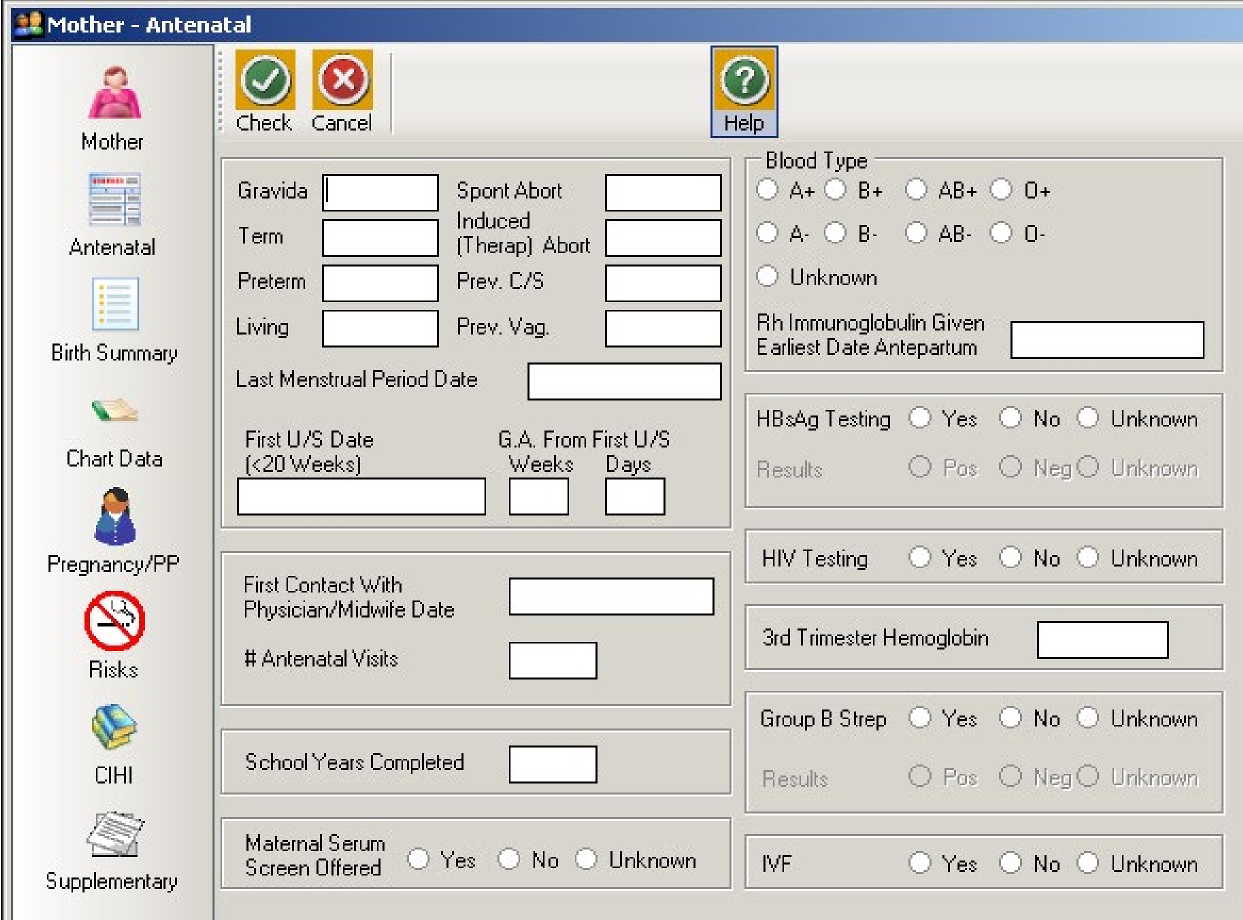
Discharge Time

The time the mother was discharged from hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359. If the discharge time is not available, abstract 1200 hours.

Eg: If the mother is discharged midnight, New Year's Day, abstract as January 1 at 0000 hours.

3.4 Antenatal Screen



Gravida

The total number of prior pregnancies, including current pregnancy, regardless of gestational age, type, time or method of termination/outcome. A multiple birth is considered one pregnancy.

Includes ectopic pregnancies, missed abortions, blighted ova, and hydatiform moles.

Term

The total number of previous pregnancies delivered at ≥37 completed weeks gestation (≥259 days), counting from the first day of the last menstrual period.

Eg: 37 weeks 2 days gestation is 37 completed weeks.

For previous delivery of a multiple birth at term, abstract 1 ***Term****.*

Term *should not be greater than or equal to* ***Gravida****.*

Exception: ***Term*** *may be greater than or equal to* ***Gravida*** *if the mother had a previous multiple birth resulting in one term and one preterm baby. In this case, abstract 1* ***Term*** *and 1* ***Preterm****.*

Preterm

The total number of previous pregnancies delivered between 20 to 36 completed weeks gestation (140 days to 258 days), counting from the first day of the last menstrual period.

Include late terminations.

Eg: 36 weeks 5 days gestation is 36 completed weeks gestation.

For a previous multiple pregnancy at preterm, abstract 1 ***Preterm****.*

Preterm *should not be greater than* ***Gravida****.*

Exception: ***Preterm*** *may be greater than or equal to* ***Gravida*** *if the mother had a previous multiple birth resulting in one preterm baby and one term baby (ie: the second baby is delivered at term). In this case, abstract 1* ***Preterm*** *and 1* ***Term****.*

Living

The total number of children the mother has given birth to, who are currently living.

Does not include the current pregnancy.

A multiple pregnancy is counted per living child. Eg: twins=2, triplets=3, etc.

Spont Abort

The total number of previous natural or spontaneous losses in pregnancy <20 completed weeks gestation (≤139 days) and less than 500 grams.

Ectopic pregnancies, missed abortions, blighted ova, and hydatiform moles are abstracted as spontaneous abortions.

If previous abortion type is not documented, leave both abortion fields blank.

Induced (Therap) Abort

The total number of previous intentional or induced (surgical/medical) losses in pregnancy <20 completed weeks gestation (≤139 days) and less than 500 grams.

If previous abortion type is not documented, leave both abortion fields blank.

Prev. C/S

The total number of previous pregnancies resulting in a Cesarean section (C/S) delivery, ≥20 completed weeks gestation (≥140 days).

For previous multiple births delivered by C/S, abstract 1 ***Prev. C/S****.*

For previous multiple births with the first baby delivered vaginally and the second baby delivered by C/S, abstract 1 ***Prev. Vag*** *and 1* ***Prev. C/S****.*

Prev. Vag.

The total number of previous pregnancies resulting in a vaginal delivery, ≥20 completed weeks gestation (≥140 days).

For previous multiple births delivered vaginally, abstract 1 ***Prev. Vag****.*

For previous multiple births with the first baby delivered vaginally and the second baby delivered by C/S, abstract 1 ***Prev. Vag.*** *and 1* ***Prev. C/S****.*

Last Menstrual Period Date

The date (day, month, year) of the first day of last normal menstrual period.

Abstract only if menstrual cycle is regular (Eg: approximately every 28 days) and information is reliable.

Do not abstract if menstrual cycle is irregular or if last menstrual period date is uncertain.

The use of a Gestational Age Wheel may be helpful in determining accuracy of this date.

This field is used to calculate the Final Gestational Age.

See Appendix 10.5 Gestational Age Calculation on page 243.

First U/S Date (< 20 Weeks)

The date (day, month, year) of the earliest ultrasound (U/S) performed between 4 and 19 completed weeks (28 to 139 days) for the current pregnancy.

***First U/S Date** may be abstracted even if **Weeks** and **Days** are unknown.*

*If **First U/S Date** is uncertain, leave blank.*

G.A. From First U/S – Weeks & Days

The gestational age determined at the first ultrasound (U/S) performed <20 weeks gestation (<139 days) documented in completed weeks and days.

*Eg: 14 **Weeks** and 4 **Days***

*If **Days** is not available, or is not precise, abstract the number of **Weeks** and leave the **Days** blank.*

*Eg: Just over 5 weeks is documented in the chart. Abstract 5 **Weeks** blank **Days**.*

*Eg: If a **GA From First U/S** is given as a range, (Eg: 5-6 weeks) abstract 5 **Weeks** blank **Days**.*

***GA From First U/S** – **Weeks** and **Days** may be abstracted without a **First U/S Date**.*

First Contact With Physician/Midwife Date

The date (day, month, year) of the mother's first contact with a physician/midwife for the current pregnancy.

*Leave blank if **First Contact With Physician/Midwife Date** is uncertain or if **First Contact With Physician/Midwife Date** is after the **First U/S Date**.*

Antenatal Visits

The total number of antenatal visits with the Primary Care provider that is available in the chart. These will be documented on the Antenatal Record 1 and 2.

Includes family physicians, obstetricians and/or midwives, but excludes consultations and clinic visits (Eg: Diabetic Clinic).

If the mother had more than one Antenatal Record or saw more than one Primary Care provider, abstract the total number of visits from all Antenatal Records. Includes visit documented on Antenatal Record 1 if not on Antenatal Record 2.

If the mother had no antenatal care, abstract 0.

If the number of visits is uncertain, leave blank. Count actual visits (ie: do not include no-shows).

School Years Completed

The total number of school years completed by the mother.

Includes elementary, high school, college, university and post secondary (excluding kindergarten).

Eg: If mother completed grade 12 plus 2 years of college, abstract 14.

*Eg: If **School Years Completed** is blank and mother works as a high school teacher, she probably had grade 12 plus 5 years post secondary education; abstract 17.*

If information is not available, may abstract best guess. This information is used as a socio-economic indicator.

Maternal Serum Screen Offered

Maternal serum screening was offered to the mother during the antenatal period, regardless of the outcome.

Maternal serum screening is a prenatal blood test used to determine a possible risk of having a baby with Down syndrome, neural tube defect, or Trisomy 18. This blood test is usually performed between 15 to 20 weeks gestation.

Abstract 'Yes', 'No', *or* 'Unknown'.

Abstract 'No' *if the mother presented to the care provider too late in pregnancy to be offered the **Maternal Serum Screen.***

Abstract 'Unknown' *if blank or if there is no documentation in the chart (Eg: test results) that indicates the test was offered.*

Other names for this test include Prentatal Genetic Screening, Maternal Triple Screen (MTS), Maternal Serum Screen (MSS), Triple Marker Screen (TMS) and Alphafetoprotein (AFP), Serum Integrated Pregnancy Screening (SIPS), Integrated Prenatal Screening (IPS), First Trimester Screening (FTS), and Quad Screen.

Blood Type

The classification of the mother's blood type.

Abstract one of:	'A+'	'B+'	'AB+'	'O+'
	'A-'	'B-'	'AB-'	'O-'
	'Unknown'			

Rh Immunoglobulin Given Earliest Date Antepartum

The date (day, month, year) of the first antepartum injection of Rh immunoglobulin administered to an Rh-negative mother during the current pregnancy. This is usually administered at approximately 28 weeks gestation.

Etiology of Rh Isoimmunization: When an Rh D (-) mother has a baby that is Rh D (+) and if the Rh D (+) fetal red cells enter the maternal circulation, an antibody against the Rh D fetal red cells may be formed. The most common method by which fetal cells enter the maternal circulation is by disruption of the fetal placental vessels during the third stage of labour.

If date is not documented, leave blank.

Note: In rare instances, an Rh(+) mother will have low anti D antibodies requiring treatment with Rh Immunoglobulin. In these cases, it is acceptable for an Rh(+) mother to receive Rh Immunoglobulin.

HBsAg Testing

Hepatitis B testing was performed at any time during the current pregnancy, prior to delivery.

Testing for the Hepatitis B surface antigen (HBsAg) is a screening test performed at the first prenatal visit.

Abstract 'Unknown' *if blank or cannot find in chart if test was done.*

HBsAg Testing – Results

If **HBsAg Testing** is abstracted as 'Yes', the **Results** of 'Pos', 'Neg', or 'Unknown' must be abstracted

HIV Testing

HIV testing was performed during this pregnancy.

HIV screening is a test to determine if the mother is infected with the human immunodeficiency virus with the possibility of transmitting the disease to her baby.

Abstract 'Unknown' *if blank or cannot find in chart if test was done.*

3rd Trimester Hemoglobin

The lowest hemoglobin level taken during the third trimester (≥27 completed weeks gestation – ≥189 days), in Standard International Units, or the lowest in-hospital hemoglobin level prior to delivery.

Group B Strep

Group B Strep (GBS) testing was performed prior to delivery. If the test was performed due to a postpartum infection with a specific diagnosis, this is abstracted in the Postpartum Screen.

If a Group B Strep positive mother is not given antibiotics before delivery, the baby will come into contact with the bacteria as it passes through the vagina with a high probability of the baby contracting Group B Strep. Babies surviving the infection can be left with speech, hearing and vision problems, as well as mental retardation. Group B Strep are common bacteria found in the vagina, rectum, and bladder.

Abstract 'Unknown' *if blank or cannot find in chart if test was done.*

Group B Strep – Results

If **Group B Strep** is abstracted as 'Yes', the **Results** of 'Pos', 'Neg', or 'Unknown' must be abstracted.

IVF

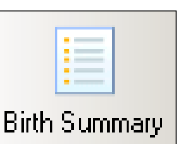
Mother had in-vitro fertilization for the current pregnancy.

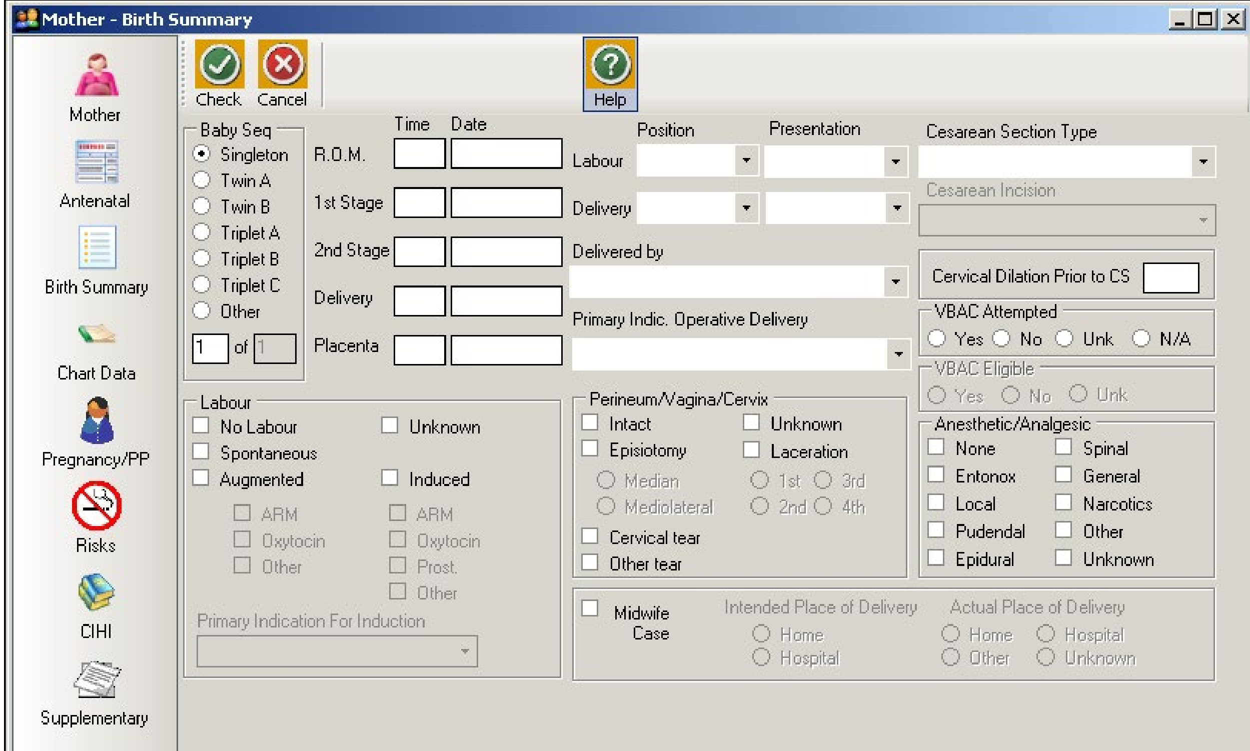
A technique used in which egg cells are fertilized by sperm outside the woman's uterus. Includes Intracytoplasmic Sperm Injection (ICSI); does not include intrauterine (or artificial) insemination (IUI).

Abstract 'Yes'*,* 'No'*, or* 'Unknown'.

Abstract 'Unknown' *if blank or cannot find in chart if this procedure was done.*

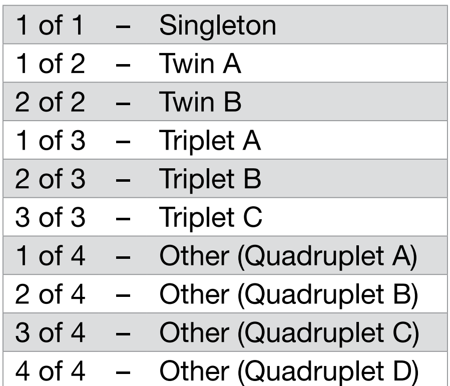
3.5 Birth Summary Screen





Baby Seq

Incremental sequence number for each baby born from the current pregnancy.



1 of 1	–	Singleton
1 of 2	–	Twin A
2 of 2	–	Twin B
1 of 3	–	Triplet A
2 of 3	–	Triplet B
3 of 3	–	Triplet C
1 of 4	–	Other (Quadruplet A)
2 of 4	–	Other (Quadruplet B)
3 of 4	–	Other (Quadruplet C)
4 of 4	–	Other (Quadruplet D)

How to complete twin births:

- *Click on 'Twin A' under **Baby Seq** and complete Birth Summary for Twin A.*
- *Then click on 'Twin B' under **Baby Seq.** This will open a second Birth Summary. Complete Birth Summary for Twin B.*
- *Data elements specific to the mother (Eg: **Anesthetic/Analgesic**) will remain the same for both babies.*
- *Data elements specific to the baby (Eg: **1st Stage Date/Time, Delivery Position**) will be different for each baby.*

R.O.M. (Rupture of Membranes) Time

The time, using the 24-hour clock, that artificial/spontaneous rupture of the amniotic sac occurred.

If more than one time is documented, abstract the earliest.

***R.O.M Time** may be different for multiple babies.*

Time must be between 0000 and 2359 hours.

R.O.M. (Rupture of Membranes) Date

The date (day, month, and year) that artificial/spontaneous rupture of the amniotic sac occurred.

*May abstract **R.O.M. Date** even if **R.O.M. Time** is not available.*

1st Stage Time

The time, using the 24-hour clock, when there was onset of regular uterine contractions and cervical dilation (first stage of labour).

Time must be between 0000 and 2359 hours.

1st Stage Date

The date (day, month, year) when there was onset of regular uterine contractions and cervical dilation.

*May abstract **1st Stage Date** even if **1st Stage Time** is not available.*

2nd Stage Time

The time, using the 24-hour clock, when there was full cervical dilation and delivery of the newborn commences.

Time must be between 0000 and 2359 hours.

2nd Stage Date

The date (day, month, year) when there was full cervical dilation and delivery of the newborn commences.

*May abstract **2nd Stage Date** even if **2nd Stage Time** is not available.*

Delivery Time

The time, using the 24-hour clock, when delivery of the newborn was complete.

Time must be between 0000 and 2359 hours.

Delivery Date

The date (day, month, year) when delivery of the newborn was complete.

Mandatory field. Should be the same as baby's date of birth in the Baby Newborn Suite.

Placenta Time

The time, using the 24-hour clock, when the placenta was delivered.

Time must be between 0000 and 2359 hours.

If there is a booked C/S and the time is not available, may abstract 1 minute after delivery time.

Placenta Date

The date (day, month, year) when the placenta was delivered.

*May abstract **Placenta Date** even if **Placenta Time** is not available.*

Labour and Delivery Position

Position, both at Labour and Delivery, refers to the baby's head position.

Position Terms:

- Anterior
- Posterior
- Transverse

If the patient was not in labour use 'Not Applicable'.

See Appendix 10.6 Labour and Delivery Presentation and Position on page 246.

Labour and Delivery Presentation

Presentation, both at Labour and Delivery, refers to the part of the fetus's body that is presenting in reference to the birth canal:

Presentation Terms

- Occiput (head)
- Cephalic (head)
- Vertex (head)
- Breech (buttocks)
- Sacral (buttocks)
- Transverse (body lying perpendicular)

See Appendix 10.6 Labour and Delivery Presentation and Position on page 246.

Delivered by

The health care provider who physically delivers the baby.

- 'Family Physician'
- 'Obstetrician (or Fellow)'
- 'Midwife'
- 'Nurse'
- 'Medical Student Intern'
- 'Obstetrical Resident'
- 'Midwife Trainee'
- 'Family Practice Resident'
- 'Other' (Eg: family member, ambulance attendant)
- 'No Attendant' (if the mother delivers by herself and no one is in attendance.)
- 'Unknown' (use if there is no documentation)
- 'Surgeon'

The person who delivers the baby may be different from the CIHI Abstract.

Eg: If a nurse delivers the baby and family physician does the repair of tear, abstract 'Nurse' *as the person who delivers the baby, not* 'Family Physician'*.*

Primary Indic. Operative Delivery

The one diagnosis which best describes the principal or primary reason (indication) for C/S delivery. The primary indication for the C/S is usually independent of any other complicating maternal/fetal factors. *Note: This data element is abstracted for every baby delivered.*

If there is more than one reason documented for operative delivery, clarify the primary indication with the physician. The following method may be useful in deciding which of two or more reasons is the primary reason for the C/S. The indication, if it stood alone, (if the mother had no other complicating factors) leading to the C/S is likely the primary indication for the C/S delivery.

- 'Not Applicable'
  C/S was not performed.
- 'Repeat C-Section'
  Mother had previous C/S and is not a candidate for vaginal birth after C/S (VBAC), usually a medical decision.

  Eg: If mother had previous C/S and is not eligible for a VBAC as stated by the physician.
- 'Dystocia / CPD'
  An abnormal or difficult childbirth or labour.

  Includes failure to progress, incoordinate uterine activity, and cephalopelvic disproportion (CPD)
- 'Nonreassuring Fetal Heart Rate'
  Increased or decreased fetal heart rate (tachycardia and bradycardia), especially during and after a contraction. Decreased variability in the fetal heart rate.
- 'Breech'
  The position of the baby in the uterus such that it will be delivered buttocks first as opposed to the normal head first position.
- 'Abruptio Placenta'
  The premature separation of the placenta from the uterus.
- 'Malposition / Malpresentation'
  All positions/presentations of the fetus other than vertex, making normal delivery difficult.

  Includes persistent occipitoposterior, persistent occipitotransverse, brow presentation, transverse lie, or transverse arrest of fetal head.

  Excludes breech.
- 'Placenta Previa'
  The placenta lies low in the uterus and partially or completely covers the cervix.
- 'Active Herpes'
  A common, highly infectious disease that is transmitted from one person to another during sexual activity.
- 'VBAC Declined / Maternal Request'
  VBAC Declined: Mother had previous C/S and is eligible for a vaginal birth after C/S (VBAC) but declines the VBAC. If the mother had a previous C/S and is not eligible for a VBAC, refer to Repeat C/S.
  Maternal Request: Mother is either a nullipara or has had a previous vaginal delivery and has requested a C/S.

  Eg: Mother requests an elective C/S. May be a primary elective or repeat elective C/S.

- ‘Other’
  Other reason not indicated above.

  Eg: Mother is induced but never goes into established labour.

  Eg: Abstract for second twin if first twin is delivered due to breech presentation but the second twin is vertex.

- ‘Unknown’
  Reason for C/S is unclear/unknown.

Cesarean Section Type

Types of C/S include:

- ‘Not Applicable’
  If the mother had a vaginal delivery, abstract ‘Not Applicable’.
- ‘Primary Elective’
  The mother has not had a prior C/S and method of delivery for this pregnancy is C/S. The mother may be booked for an elective C/S. The mother is not in labour and the decision for C/S is made prior to labour.
- ‘Primary Emergency’
  The mother has not had a previous C/S and the method of delivery for this pregnancy is C/S. The C/S is carried out on an urgent or emergency basis (due to a threat to the maternal or fetal health).
- ‘Repeat Elective’
  The mother has had at least one prior C/S and method of delivery for this pregnancy is C/S. The mother may be booked for an elective C/S. The mother is not in labour and the decision for the C/S is made prior to labour.
- ‘Repeat Emergency’
  The mother has had at least one prior C/S and method of delivery for this pregnancy is C/S. The C/S is carried out on an urgent or emergency basis (due to a threat or risk to the maternal or fetal health).

  Eg: Mother was booked for a Repeat C/S but rupture of membranes results in the C/S being performed ahead of schedule. Abstract ‘Repeat Emergency’ *not* ‘Repeat Elective’.

  Eg: VBAC was planned but mother or fetal condition warrants an urgent or emergency C/S. Abstract ‘Repeat Emergency’.

Note: The type of C/S documented in the BCPDR may not always match the type of C/S that is coded in CIHI.

Eg: A mother booked for an elective C/S who goes into labour prior to her C/S date would be considered an Emergency C/S in the BCPDR.

Eg: A mother booked for a C/S because of placenta previa who delivers on the scheduled date would be considered an Elective C/S in the BCPDR.

Cesarean Incision

The type of incision created for C/S deliveries:

- 'Not Applicable'
  If the mother had a vaginal delivery, abstract 'Not Applicable'.
- 'Low Segment Transverse Incision'
  A transverse uterine incision in the lower, non-contracting portion of the uterus.
  This is the most common type of incision performed. If another type of C/S is not mentioned, you can make an educated guess that the type of incision performed is a 'Low Segment Transverse Incision'*.*
- 'Low Segment Vertical Incision'
  A vertical uterine incision in the lower, non-contracting portion of the uterus.
- 'Classical Incision'
  A vertical midline uterine incision in the upper segment of the uterus.
- 'Other Incision'
  The uterine incision is known but is not classifiable into one of the above.

  Eg: Inverted T incision, not known if the incision extended into contracting segment of uterus.
- 'Unknown'
  The mother did receive a C/S but the type of incision is not stated.

Cervical Dilation Prior to CS

The last documented measurement of cervical dilation during labour, in centimeters, prior to C/S. Only abstract if mother was in labour before proceeding to C/S. Leave blank if mother had an elective C/S and was never in labour.

Eg: Mother arrives at 1107 with a cervical dilation of 5 cm. Goes to Operating Room at 1302 with no further documentation of cervical dilation; abstract 5 cm.

Eg: Mother arrives in labour with a booked C/S. Abstract dilation if available because mother is in labour.

Eg: Mother has a failed VBAC. Abstract dilation if available because mother is in labour.

VBAC Attempted

The mother had a previous C/S, and for the current pregnancy a vaginal delivery was attempted. This field indicates the intent, not the outcome of the attempted vaginal birth after C/S (VBAC).

Abstract 'Yes' *if the mother had a previous C/S and a VBAC was attempted.*

Eg: If mother was induced but the labour was never established. The intent was for mother to have a vaginal delivery, so attempt was made.

Eg: If the mother was booked for a repeat C/S, spontaneous labour occurs, and a C/S is done after the 2nd stage of labour is established. Attempt was made.

Abstract 'No' *if the mother had a previous C/S and a VBAC was not attempted.*

Eg: If the mother is booked for a repeat C/S but comes into hospital with rupture of membranes, there is no trial of labour, and mother has an emergency C/S. No attempt was made.

Eg: if the mother has a planned VBAC, changes her mind, asks for a C/S, and C/S done prior to the 1st stage of labour. No attempt was made.

Abstract 'Unknown' *if the mother had a previous C/S and it is not known whether or not a VBAC was attempted.*

Abstract 'N/A' *(not applicable) if the mother has not had a previous C/S.*

VBAC Eligible

The mother had a previous C/S and documentation indicates that she is a candidate to attempt a vaginal delivery in this pregnancy.

Abstract 'Yes' *if mother has a successful VBAC even if there is no documentation to state that she was eligible for a VBAC.*

A consult by an obstetrician does not indicate whether or not a woman is eligible for a VBAC. A booked section is not necessarily an indication that a woman is ineligible for VBAC.

Labour

Labour – No Labour

The mother did not go into labour.

Eg: Booked elective C/S and mother did not go into labour.

Eg: Mother was diagnosed with abruptio placenta and did not go into labour prior to delivery by emergency C/S.

Note: A non stress test does not constitute labour.

Note: If date and time of first stage is not documented and there is no documentation of all three criteria of labour (painful contractions, cervical dilation and effacement), , abstract ***No Labour.***

Labour – Unknown

It is unknown how labour commenced (onset of regular uterine contractions or effacement and progressive dilation of the cervix).

Eg: Mother is admitted for a C/S and there is no documentation of labour.

Labour – Spontaneous

Onset of regular contractions and progressive dilation of the cervix occurred without instrumental or medicinal assistance.

Labour = Painful contractions, cervical dilation and effacement.

Prodromal labour is not the beginning of 1st stage as there is no change in dilation

Labour – Augmented

Stimulating the uterus to increase the frequency, duration and strength of contractions, generally following the onset of the first stage of labour.

If ***Labour – Augmented*** *is selected, then* ***Labour – Spontaneous*** *or* ***Labour – Induced*** *should be abstracted.*

When abstracting induction/augmentation, use the same logic as when determining induction/augmentation for CIHI purposes. See ***Canadian Coding Standards***.

If **Labour – Augmented** is abstracted, one (or more) of the following types of augmentation must be abstracted:

ARM

The mother received instrumental assistance to rupture the membranes in order to aid in the progression of labour (following the onset of first stage of labour).

Oxytocin

The mother received oxytocin, pitocin, syntocinon or any other medicinal assistance to aid in the progression of labour (following the onset of first stage of labour).

Other

Any other method used to aid in the progression of labour (following the onset of first stage of labour).

Labour – Induced

Instrumental or medicinal assistance to initiate labour (prior to the onset of first stage of labour).

*Even if medical induction failed, abstract **Labour – Induced**. Do not abstract **Labour – No Labour**. This field does not refer to the outcome of pregnancy.*

Eg: Mother is induced but labour is never established and subsequently C/S is performed.

*If induction was performed prior to the delivery admission (Eg: as antepartum admission or outpatient visit), resulting in labour and subsequent admission for delivery, abstract **Labour – Induced**. Do not abstract **Labour – Spontaneous**.*

*Do not abstract methods used for ripening the cervix such as membrane stripping, castor oil, herbs, nipple stimulation, or black cohash as methods of labour induction. See example under **Prost** for exceptions.*

When abstracting induction/augmentation, use the same logic as when determining induction/augmentation for CIHI purposes. See ***Canadian Coding Standards***.

If **Labour – Induced** is abstracted, one (or more) of the following types of induction must be abstracted:

ARM

The mother received instrumental assistance to rupture the membranes to start labour (prior to the onset of first stage of labour).

Oxytocin

The mother received oxytocin, pitocin, syntocinon to start labour (prior to the onset of first stage of labour).

Prost

The mother received prostaglandin to start labour (prior to the onset of first stage of labour).

Cervidil [prostaglandin E2 (PGE-2)] provides a slow release of prostaglandin E2 in a tampon type formulation so that it can be directly administered to the posterior fornix and easily removed in the event of hyperstimulation or allergic response.

*Prepidil and cervidil may be classified to **Prost**.*

If prostaglandin/cervidil is used for ripening of the cervix, abstract as a form of induction.

Other

Any other method used to start labour (prior to the onset of first stage of labour).

Eg: misoprostol, which is also called PGE1 or Cytotec, is a synthetic prostaglandin E1 analogue.

Eg: foley catheter

- *If foley catheter is used and no other instrumental or medicinal induction is used, then foley catheter is the method of induction.*
- *If foley catheter is used and there is another instrumental or medicinal induction, then foley catheter was used for ripening. Do not abstract.*

Primary Indication for Induction

The diagnosis which best describes the principal or primary reason that an external agent was used to stimulate delivery before onset of spontaneous labour.

If there is more than one reason documented for induction, clarify the primary indication with the care provider. The following method may be useful in deciding which of two or more reasons is the primary reason for induction. The indication, if it stood alone, (if the mother had no other complicating factors) leading to an induction is likely the primary indication for induction.

- 'Not Applicable'
  The mother was not induced.
- 'Post Dates'
  ≥41 completed weeks (≥287 days). The pregnancy has gone beyond the due date and/or care provider specifies the reason for induction is post dates.
- 'Prelabour ROM'
  Rupture of membranes occurred before the onset of uterine contractions at term.
- 'Fetal Compromise'
  There is medical concern about the newborn's condition.

  Eg: abnormal non-stress test, IUGR, oligohydramnios, or decreased fetal movement
- 'Other Maternal Condition'
  There is medical concern about the mother's condition, severe enough to compromise mother's health.

  Eg: abruptio placenta, drug addiction, prodromal labour, cardiac, psychiatric
- 'Logistics'
  Inability for mother to access supportive healthcare in reasonable time.

  Eg: past rapid labour, geographical barriers
- 'Fetal Demise'
  Fetal death in utero.
- 'Hypertension in Pregnancy'
  The woman has high blood pressure (increase in systolic >30 mmHg, increase in diastolic >15 mmHg) on at least 2 occasions, 6 hours apart, including pre-existing hypertension and gestational hypertension.

- ‘APH’
  The mother had bleeding during her pregnancy.
- ‘Chorioamnionitis’
  The mother has a cervicovaginal infection, possibly due to intra-uterine infection or inflammation.
- ‘Diabetes’
  The mother has any type of diabetes (Type I, Type II, Gestational).
- ‘Other’
  Other reason for induction.

  Eg: anxiety, abdominal pain, breech, large for dates, late termination
- Unknown
  Reason for induction is unclear/unknown.

Perineum / Vagina / Cervix

Intact

There was no trauma to the perineum/vagina/cervix during delivery.

Unknown

The type or degree of trauma to the perineum/vagina/cervix is unknown or there is no documentation regarding the condition of the perineum, vagina or cervix.

Episiotomy

A surgical incision (median/midline or mediolateral) was made through the perineum to enlarge the vagina and assist delivery.

*Abstract **Episiotomy** if episiotomy was done.*

*If **Episiotomy** is abstracted, either* ‘Median’ *or* ‘Mediolateral’ *should be abstracted.*

Laceration

A tear and/or rupture occurred to the vagina or perineum during delivery, excluding abrasions.

*Abstract **Laceration** regardless of whether a repair was done.*

A labial tear or periurethral tear is a 1st degree laceration

An abrasion is not a laceration.

*If **Laceration** is abstracted, the degree of laceration (*‘1st’, ‘2nd,’ ‘3rd’, or ‘4th’*)* *should* *be abstracted. Abstract the most severe tear only.*

Cervical Tear

There was injury to the cervix during delivery.

Other Tear

Another type of tear or laceration.

Eg: high vaginal laceration to the perineum/vagina/cervix during delivery

Eg: gutter tear

Anesthetic / Analgesic

Drugs administered during medical or surgical procedures which induce partial or total loss of sensation. Abstract ALL **Anesthetics/Analgesics** given during first, second, or third stage of labour, and/or during operative procedure(s) where a C/S is performed with or without labour.

Not specific to the facility where the mother delivers. If a mother is transferred in labour from another hospital abstract the ***Anesthetic/Analgesic*** *given at the initial hospital.*

Abstract ***Anesthetic/Analgesic*** *given during manual removal of placenta (third stage of labour) or given during repair of tear (if repair is performed during or shortly after third stage).*

None

No anesthetic or analgesic was administered to the mother during labour (first, second, or third stage).

Entonox

Entonox was administered to the mother during labour (first, second, or third stage).

Eg: Entonox is also known as Nitronox (50% nitrous oxide, 50% oxygen).

Local

A local anesthetic was administered to the mother during labour (first, second, or third stage).

Local given for tear repair during or shortly after third stage of labour.

Eg: marcaine, xylocaine, lidocaine

Pudendal

A pudendal block was administered to the mother during labour (first, second, or third stage).

Epidural

An epidural anesthetic was administered to the mother during labour (first, second, or third stage).

For combined spinal epidural (CSE), abstract both ***Spinal*** *and* ***Epidural****.*

Spinal

A spinal anesthetic was administered to the mother during labour (first, second, or third stage).

General

A general anesthetic was administered to the mother during labour (first, second, or third stage).

Eg: Abstract ***General*** *given for removal of retained placenta (third stage is complete after the placenta is expelled).*

Narcotics

Narcotics were administered to the mother during labour (first, second, or third stage).

Excludes epidural narcotics.

Eg: fentanyl (I.V. or injections), Demerol (meperidine), Tylenol with codeine (Tylenol # 1, 2, 3, or 4).

Other

Other anesthetics/analgesics were administered to the mother during labour (first, second, or third stage).

Eg: TENS, sterile water injections, Tylenol, talwin, or intrathecal injections (which is an injection into the subarachnoid space of the spinal cord).

Unknown

The type of anesthetic/analgesic administered to the mother during labour (first, second, or third stage) is unknown.

Midwife Case

A BC College Registered Midwife is involved in the care of the mother.

This section is applicable to cases where a registered midwife has provided care at any time during the antenatal period, labour or delivery.

A complete list of BC College of Registered Midwives is regularly updated and available at: ***www.cmbc.bc.ca/pdf.shtml?List-of-Registrants***

Intended Place of Delivery

Where the mother plans to deliver.

Abstract 'Hospital' *or* 'Home'*.*

Abstract the last documented decision for the place of delivery (ie: mother can change her mind during the course of her antenatal care).

Abstract 'Hospital' *if mother delivered in hospital and no further documentation.*

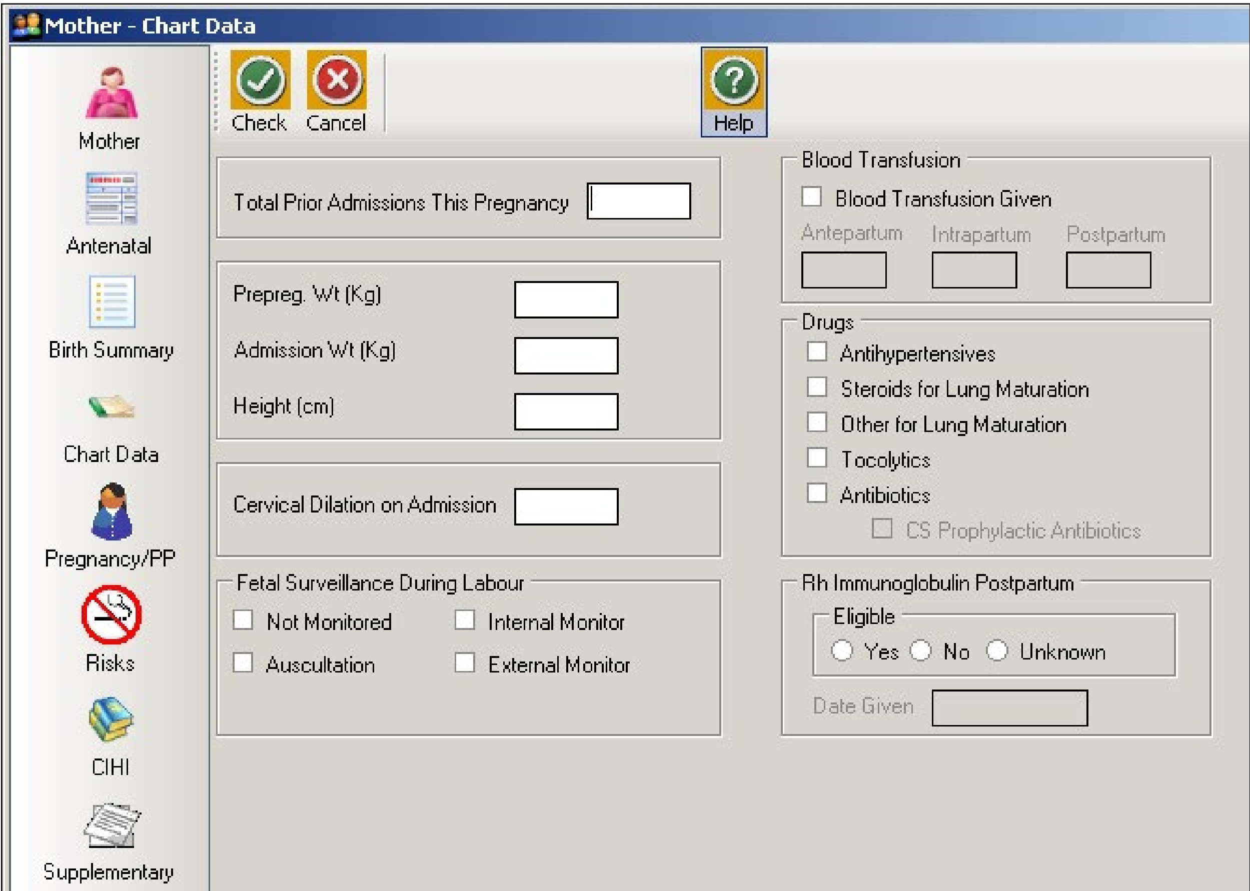
Actual Place of Delivery

Where the mother actually delivered.

Abstract 'Hospital', 'Home', 'Other' *or* 'Unknown'.

Parking lot or sidewalk cases are abstracted as 'Other'*.*

3.6 Chart Data Screen



Total Prior Admissions This Pregnancy

The total number of prior inpatient hospital admissions, to any facility, for any reason, during the current pregnancy (does not include current delivery admission).

If no visits are documented, abstract 0.

Prepreg Wt. (Kg)

The mother's weight (in kilograms) before pregnancy or ≤ 11 weeks completed gestation (≤ 84 days). Abstract to a maximum of one decimal place. *Eg: 54.6 kg.*

To convert pounds to kilograms, See *Appendix 10.3 Weight Conversion Table – Pounds to Kilograms on page 241*.

Admission Wt. (Kg)

The mother's weight (in kilograms) at the time of admission for her delivery episode or the last weight documented ≤ 7 days prior to delivery, measured in kilograms. Abstract to a maximum of one decimal place. *Eg: 72.1 kg*

To convert pounds to kilograms, See *Appendix 10.3 Weight Conversion Table – Pounds to Kilograms on page 241*.

Height (cm)

The mother's height (in centimeters).

To convert feet/inches into centimeters, See *Appendix 10.2 Height Conversion Table on page 240**.*

Cervical Dilation on Admission

The measurement of cervical dilation, in centimeters, taken within the first hour of admission for the delivery episode. Valid values are 0 – 10 centimeters or leave blank if unknown.

For 1 – 2 cm, abstract 2; for fingertip (FT) abstract 1; for effacement abstract 1.

If mother is admitted then sent home and is readmitted the same day, abstract the cervical dilation from the most recent admission.

If mother is admitted to one hospital in labour then transferred to a second hospital where she delivers, abstract the cervical dilation from the second hospital.

If mother does not deliver in a hospital but is admitted to hospital ≤24 hours of delivery, leave blank.

Fetal Surveillance During Labour

Not Monitored

No monitoring of the fetal heart rate (internal or external) during the 1st and/or 2nd stage of labour.

*If **Labour – No Labour** is abstracted, **Not Monitored** must be abstracted.*

*Eg: If fetal distress is suspected and mother had auscultation, external, or internal fetal monitoring performed but she was not in labour, abstract **Not Monitored**.*

Auscultation

Monitoring of the fetal heart during the 1st and/or 2nd stage of labour with an acoustical device (fetoscope) or hand held ultrasound (doptone), done intermittently.

Internal Monitor

Monitoring of the fetal heart during 1st and/or 2nd stage of labour using an internal monitoring device.

External Monitor

Monitoring of the fetal heart during the 1st and/or 2nd stage of labour using an external monitoring device.

Blood Transfusion

Blood Transfusion Given

The mother received whole or packed red blood cells during this admission.

Includes autologous blood transfusion.

Excludes platelets, plasma or cryoprecipitate transfusion.

If **Blood Transfusion Given** is abstracted, one (or more) of the following should be abstracted.

Antepartum

The total number of units of whole or packed red blood cells the mother received during the antepartum period of this pregnancy.

Antepartum *includes any time (both prior to and during the current hospital admission) prior to the onset of first stage of labour.*

Intrapartum

The total number of units of whole or packed red blood cells the mother received during labour and delivery.

Intrapartum *includes any time after first stage of labour to the delivery of the placenta.*

Postpartum

The total number of units of whole or packed red blood cells the mother received during the postpartum period of this pregnancy, including autologous blood transfusions.

Postpartum *includes any time after the end of the delivery of the placenta until discharge from the current hospital admission.*

Drugs

Antihypertensives

The mother received antihypertensive medication during the delivery episode of care (the inpatient admission during which she delivers).

Eg: Aldomet, labetalol, Adalat (nifedipine), Apresoline (hydralazine)

Steroids for Lung Maturation

Mother received steroid medication during the inpatient delivery episode of care, or for transport (ie: mother is usually in preterm labour).

Eg: dexamethasone or betamethasone

Other for Lung Maturation

Other medications were administered to mother for fetal lung maturation during the inpatient delivery episode of care, or for transport (ie: mother is usually in preterm labour).

Tocolytics

The mother received medication to suppress premature labour during the inpatient delivery episode of care or transport.

Eg: indomethacin, magnesium sulphate, nifedipine, nitroglycerine patch

Antibiotics

The mother received antibiotics during the inpatient delivery episode of care.

Eg: Indications for which antibiotics are administered include: mother is Group B Strep positive, has prolonged labour, has prolonged rupture of membranes, or as a prophylaxis after a C/S.

Eg: GBS antibiotics – penicillin, clindamycin and Vancomycin

CS Prophylactic Antibiotics

The mother was administered prophylactic antibiotics one hour before or after C/S to reduce the risk of infectious morbidity. This is inclusive of intra-operative antibiotics.

The time period includes from one hour before mother enters the Operating Room through one hour after mother leaves the Operating Room.

*Eg: **CS Prophylactic Antibiotics –** Ancef (cefazolin) and other broad-spectrum antibiotics (Eg: ampicillin).*

Rh Immunoglobulin Postpartum

Eligible

The mother is Rh negative and has delivered an Rh positive baby and therefore is eligible for a postpartum Rh immunoglobulin injection.

Abstract 'Yes', 'No' or 'Unknown'.

Note: Rh positive mothers should always be abstracted as 'No'.

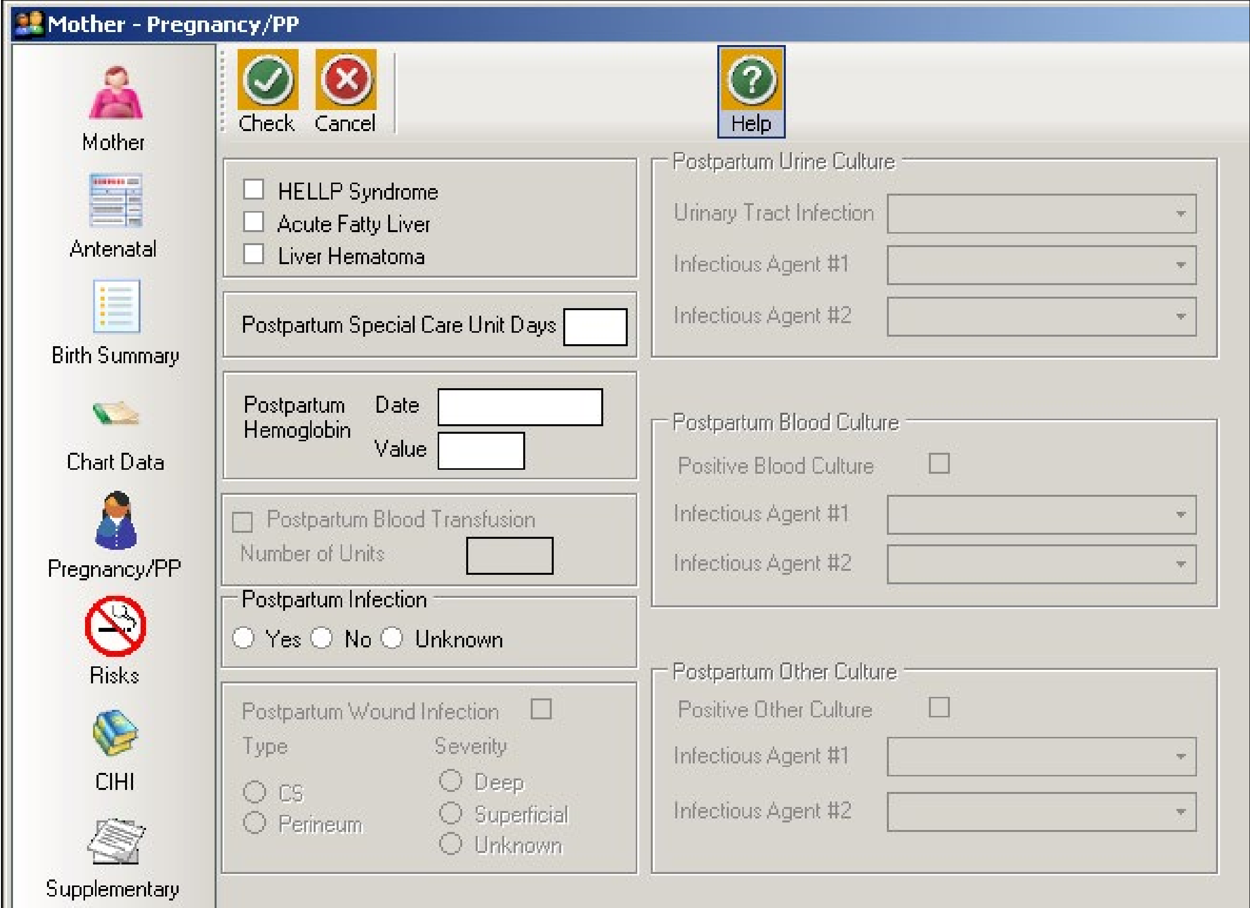
*Note: In rare instances an Rh(+) mother will have low Anti D antibodies requiring treatment with Rh Immunoglobulin. In these cases, it is acceptable for an Rh(+) mother to be eligible for **Rh Immunoglobulin Postpartum**.*

Date Given

The date (day, month, year) of the postpartum injection of Rh immunoglobulin administered to the mother during the current (delivery) episode of care.

If date is not documented, leave blank.

3.7 Pregnancy/PP Screen



Overview: *Co-morbid conditions that may affect the postpartum period for the current delivery episode only.*

Includes admissions ≤24 hours of delivery. For all other postpartum admissions use the Postpartum Suite.

HELLP Syndrome

The mother was diagnosed with HELLP Syndrome (H – hemolysis; EL – elevated liver enzymes; LP – low platelet count) during current pregnancy or postpartum period.

Do not abstract if HELLP is a query diagnosis.

Acute Fatty Liver

The mother was diagnosed with acute fatty liver during current pregnancy or postpartum period.

Do not abstract if acute fatty liver is a query diagnosis.

Liver Hematoma

The mother was diagnosed with liver hematoma during current pregnancy or postpartum period.

Do not abstract if liver hematoma is a query diagnosis.

Postpartum Special Care Unit Days

Number of days the mother spent in any Special Care Unit (ICU, CCU, etc) postpartum.

The purpose of this field is to obtain information on bed utilization in a specified SCU, not level of care.

Eg: Mother goes to ICU for 3 hrs post C/S because the PAR is closed; abstract 1 day.

Leave blank if the mother was never admitted into any Special Care Unit.

Postpartum Hemoglobin

Date

The date of mother's lowest postpartum hemoglobin result during delivery episode of care. Test is performed after delivery, but prior to discharge.

Value

Value of the postpartum hemoglobin test result during the postpartum period.

Postpartum Infection

The mother had an infection during the postpartum period.

Must abstract 'Yes', 'No' *or* 'Unknown'.

Example of Postpartum Infection - Yes:

- *Postpartum endometritis*

Examples of Postpartum Infection - No:

- *Nothing documented in the chart to indicate an infection*
- *Cystitis during intra & postpartum periods (just a continuation of intrapartum infection)*
- *Postpartum fever NOS*
- *MRSA (or any other bacterial) colonization only*

Examples of Postpartum Infection - Unknown:

- *Positive culture with no further documentation*
- *Postpartum fever with antibiotics only*
- *Query Postpartum infection*
- *Red & tender wound with antibiotics only*

Postpartum Wound Infection

The mother had a postpartum wound infection.

Type

Specific location of the mother's postpartum wound infection.

Eg: Abstract 'C/S' *or* 'Perineum'

Severity

The degree of the mother's postpartum wound infection.

Eg: Abstract 'Deep', 'Superficial' *or* 'Unknown'

Postpartum Urine Culture

Urinary Tract Infection

Abstract type of urinary tract infection during the postpartum period.

- 'Cystitis'
- 'Pyelonephritis'
- 'Both Cystitis and Pyelonephritis'
- 'Other Urinary Tract Infection'
- 'Unknown Urinary Tract Infection'

Infectious Agent #1

The most significant infectious agent causing positive maternal urine culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive maternal urine culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Postpartum Blood Culture

Positive Blood Culture

Abstract if the mother's blood culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive maternal blood culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2:

Other infectious agent causing positive maternal blood culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Postpartum Other Culture

Positive Other Culture

Abstract if lab culture results were positive (other than urine or blood) during the postpartum period.

If **Postpartum Wound Infection** is abstracted, **Postpartum Other Culture** should also be abstracted. Abstract infectious organism if documented.

Eg: sputum, stool, or wound infection

Infectious Agent #1

The most significant infectious agent from other maternal positive culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2:

Other infectious agent from other positive maternal culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

3.8 Risks Screen

Mother - Risks

Mother
Antenatal
Birth Summary
Chart Data
Pregnancy/PP
Risks
CIHI
Supplementary

Check Cancel Help

Past Obstetrical History
- Prior Neonatal Death
- Prior Stillbirth
- Prior Low Birth Weight
- Prior Macrosomic Baby
- Prior Rh Isoimmunization
- Major Congenital Anomalies

History of Mental Illness
- Anxiety
- PP Depression
- Depression
- Other
- Bipolar
- Unknown

Current Pregnancy
- Bleeding [<20weeks]
- APH [>=20weeks]
- Gestational Hypertension (PIH)
- Proteinuria (>+1)
- Rh Antibodies
- Other Antibodies
- IUGR Identified

Substance Use
- Heroin/Opioids
- Cocaine
- Methadone
- Solvents
- Prescription
- Marijuana
- Other
- Unknown

TWEAK Score

Alcohol Average Number of Drinks/WK

Binge Drinking Yes No Unknown

Cigarettes Current #/Day

Never Former Current

Exposure to Second Hand Smoke

Medical History
- Diabetes & Other Abnormal Glucose Factor
  - Diabetes Mellitus in Pregnancy, Insulin Required
  - Diabetes Mellitus in Pregnancy, Non-insulin Required
  - Pre-existing Diabetes Mellitus Type 1 or 2, Insulin Dependent
  - Pre-existing Diabetes Mellitus Type 1 or 2, Non-insulin Dependent
  - Other Abnormal Glucose Factor
- Hypertension >= 140/90
- Antihypertensive Drugs
- Hypertensive Chronic Renal Disease
- Other Cause Of Hypertension

No Selected Risks

Overview: *Risks to the pregnancy that were identified (generally) prior to hospital admission.*

Note: Query diagnoses are not captured in the Risk Screen

Eg: Query diabetes, query hypertension, query mental illness, query substance abuse

Past Obstetrical History

Prior Neonatal Death

Mother had at least one prior live born infant, who died within the first 28 days of life.

Prior Stillbirth

Mother had at least one prior stillbirth or intrauterine death documented.

Prior Low Birth Weight

Mother had at least one prior low birth weight baby (< 2,500 grams or 5 lbs. 8 oz), with a pregnancy ≥20 weeks gestation.

Prior Macrosomic Baby

Mother had at least one prior macrosomic baby (birth weight >4,000 grams or 8 lbs. 13 oz).

Prior Rh Isoimmunization

The mother had a previous pregnancy in which isoimmunization occurred.

Etiology of Rh Isoimmunization: When an Rh D (-) mother has a baby that is Rh D (+) and if the Rh D (+) fetal red cells enter the maternal circulation, an antibody against the Rh D (+) fetal red cells may be formed. The most common method by which fetal cells enter the maternal circulation is by disruption of the fetal placental vessels during the third stage of labour.

In subsequent pregnancies the maternal antibody crosses the placenta and enters the fetal circulation.

Major Congenital Anomalies

The mother had at least one previous pregnancy in which the baby or fetus displayed a major congenital anomaly.

A major congenital anomaly has serious medical, surgical, or cosmetic consequences and may have required intervention.

Eg: cleft palate, Down syndrome, Tetralogy of Fallot, hypoplastic lung

Excludes minor anomalies such as accessory digit, tongue-tie, or dislocatable hips.

History of Mental Illness

The specific type of mental illness(es) that the mother has suffered from prior to, or during current pregnancy.

Abstract if prior to or during current pregnancy.

Abstract if indicated by care provider.

Anxiety

A feeling of apprehension and fear, characterized by physical symptoms such as palpitations, sweating and feelings of distress.

Depression

Major depression or dysthymia, characterized by a combination of symptoms including sad mood that interferes with daily life.

Bipolar

Formerly known as manic-depressive disorder. Characterized by cycles of depression and mania.

PP Depression

Mother experienced postpartum depression after a previous delivery.

Other

Mental illness not specified above.

Eg: Schizophrenia

Unknown

Mental illness mentioned but the specific type is not documented.

Current Pregnancy

Bleeding (<20 weeks)

The mother had any antepartum bleeding in pregnancy <20 weeks gestation.

Excludes spotting.

APH (≥20 weeks)

The mother had any antepartum hemorrhage or bleeding in pregnancy at ≥20 weeks gestation, including bleeding from cervical polyps.

Do not abstract if there was spotting or intrapartum bleeding.

Gestational Hypertension (PIH)

The care provider diagnosed mother with gestational hypertension during the current pregnancy (antepartum, intrapartum, and/or postpartum).

Use of the term Pregnancy Induced Hypertension was discouraged after 2008.

Proteinuria (> +1)

Care provider diagnosed proteinuria.

Rh Antibodies

The mother developed or showed signs of Rh (anti-D) antibodies in her blood, in the current pregnancy.

Note: Rh positive women have D antigen while Rh negative mothers do not.

Note: All Rh negative mothers do not have Rh blood antibodies.

Rh blood antibodies may be called anti-D antibodies.

Do not abstract if mother received Rhogam (she will have passive antibodies).

Other Antibodies

The mother developed or showed signs of antibodies in her blood, other than Rh antibodies, in the current pregnancy.

Eg: anti-K antibodies, antiphospholipid antibodies, anticardiolipin antibodies, lupus anticoagulant, ANA, anti-A, anti-B, c and Kell antibodies.

IUGR Identified

The health care provider identifies intrauterine growth restriction (IUGR) during the antenatal period (ultrasound estimated fetal weight is <10th percentile and/or abdominal circumference is <10th percentile for gestational age). The baby may or may not be appropriately grown at birth.

Substance Use

The mother used substances, including illicit drugs, at any time during the current pregnancy regardless of whether the mother was aware she was pregnant.

Heroin / Opioids

Heroin, morphine, fentanyl, Oxycodone, Hydromorphone

Methadone

Methadone hydrochloride

Note: Abstract regardless of the reason the mother was receiving methadone.

Prescription

Care provider documents mother's use of a prescription drug as a risk in this pregnancy.

Eg: Benzodiazepines (Lorazepam, Ativan, Diazepam, Oxazepam, Serax)

Other

Other non-prescription drugs including hallucinogens (lysergic acid diethylamide-LSD, magic mushrooms), stimulants (amphetamines, ephedrine, methamphetamine-ice, crystal-meth, methyldioxyamphetamine (MDA)), methylphenidate (Ritalin), designer drugs (Ketamine-dissociative anesthetic, ecstasy-serotonergic effects, Gamma-Hydroxybutyrate-GHB)).

Cocaine

Cocaine, blow, C, coke, snow, crack-rock

Solvents

Glue sniffing, inhaling gas, paint thinner, aerosol paints

Marijuana

Hashish (hard chunks of dried cannabis resin and compressed flowers), tetrahydrocannabol (THC).

Unknown

Physician/midwife lists mother's use of an unspecified drug as a risk in this pregnancy.

TWEAK Score

The TWEAK (Tolerance, Weak, Eye-Opener, Amnesia, Cut Down) score (0 – 7) assesses the risk of alcohol use in the current pregnancy.

If not documented, leave blank. Abstract 0 only if 0 is documented in source documentation.

Alcohol

The care provider indicates the mother's use of alcohol as a risk factor in the current pregnancy.

Do not abstract if mother had one or two drinks prior to knowing she was pregnant.

Average Number of Drinks/Wk

The average number of alcoholic drinks consumed per week during the current pregnancy.

If not documented, leave blank.

Binge Drinking

The mother consumed ≥ 4 alcoholic drinks at one time during the current pregnancy.

Cigarettes

The mother smoked tobacco products.

If not documented, leave blank.

Never

There is documentation that the mother has never smoked.

Former

There is documentation that the mother quit smoking prior to the current pregnancy and did not smoke during the pregnancy.

Current

There is documentation that the mother smoked throughout the current pregnancy or part of the pregnancy.

Include if the mother smoked when she became pregnant and quit any time during the pregnancy.

If **Current** *is abstracted, the* **Current #/Day** *may be completed.*

Current # / Day

The current number of cigarettes smoked per day.

One pack is equal to 20 cigarettes.

If number of cigarettes is documented as 5-10 per day, abstract 10.

If not documented, leave blank.

Exposure to Second Hand Smoke

The mother was regularly exposed to indoor second hand smoke any time during her pregnancy either at home or work.

Medical History

Diabetes & Other Abnormal Glucose Factor

Care provider diagnosed diabetes mellitus in pregnancy (gestational diabetes)

If **Diabetes & Other Abnormal Glucose Factor** is abstracted, one of the following must be abstracted:

Diabetes Mellitus in Pregnancy, Insulin Required

Diabetes mellitus in pregnancy, insulin is used. It was not pre-existing.

Mother has diabetes mellitus in pregnancy and used insulin at any time during the antenatal period.

Diabetes Mellitus in Pregnancy, Non-insulin Required

Diabetes mellitus in pregnancy, insulin is not used. It was not pre-existing.

Mother has diabetes mellitus in pregnancy and has not used insulin at any time during the antenatal period; diabetes was controlled by diet.

Mother had diabetes in pregnancy controlled by diet, did not receive insulin any time during the antenatal period, but only received insulin during labour.

Pre-existing Diabetes Mellitus Type 1 or 2, Insulin Dependant

Pre-existing diabetes mellitus Type 1 or Type 2, insulin used.

Mother has pre-existing diabetes mellitus (Type 1 or 2) and insulin was used at any time during the antenatal period.

Pre-existing Diabetes Mellitus Type 1 or 2, Non-insulin Dependant

Pre-existing diabetes mellitus Type 1 or Type 2, insulin not used.

Mother has pre-existing diabetes mellitus (Type 1 or 2) and insulin was not used at any time during the antenatal period but diabetes was controlled by diet.

Mother had pre-existing diabetes mellitus (Type 1 or 2) controlled by diet, did not receive insulin at any time during the antenatal period and only received insulin during labour.

Other Abnormal Glucose Factor

Care provider diagnosed Abnormal Glucose Factor in pregnancy.

It is no longer necessary to analyze lab data to determine abnormal glucose factor.

Hypertension (≥140 / 90)

Mother had a diastolic blood pressure reading of ≥90 mmHg, based on the average of at least two measurements, prior to labour.

Antihypertensive Drugs

The mother received antihypertensive drugs during her current pregnancy (antepartum period only).

Eg: aldomet, labetalol, hydralazine, adalat, nifedipine (adalat), apresoline

Hypertensive Chronic Renal Disease

The mother had hypertension associated with chronic renal disease in the current pregnancy.

Other Cause of Hypertension

The mother had hypertension as a result of another cause during pregnancy, labour, or the postpartum period, and has not been diagnosed as having pregnancy induced hypertension.

Includes pre-existing essential (benign or malignant) hypertension.

Excludes hypertensive renal disease.

No Selected Risks

The mother did not have any of the risk factors identified above in the current pregnancy, past pregnancies or in the mother's medical history.

Abstract **No Selected Risks** if:

- No risk factors are identified
- **TWEAK Score** is abstracted as 0 with no other risk factors
- **Cigarettes** is abstracted as 'Never' with no other risk factors
- **TWEAK Score** is abstracted as 0 and **Cigarettes** is abstracted as 'Never' with no other risk factors

3.9 CIHI Data Screen (Mother)

Mother - CIHI

Mother
Antenatal
Birth Summary
Chart Data
Pregnancy/PP
Risks
CIHI
Supplementary

Check Cancel Help

Admission Weight
Main Patient Service
Institution Number From To
975
Demographics Codes Prov Postal Residence
Coder #
Death Codes In OR Suite Death
Doctors Service Type
Diagnoses Prefix Code Seq Type
Procedures Code Stat Loc Ext Date Dr. Serv Anaes. Agent Seq
NICU Days Level II Level III
1/1 1/1 1/1

CIHI data is imported into the CIHI Data Screen when the Period End Procedure is performed.

On occasion, manual entry of the data may be necessary.

For assistance with DAD Code Tables and Definitions, please consult the DAD Manual ***https://secure.cihi.ca/estore/productSeries.htm?pc=PCC78***

Main Patient Service

The main patient service categorizes patients according to related diseases, conditions and treatments. *Abstract patient service 51 (Obstetrics delivered) if the patient delivered during this admission.*

See DAD manual.

Institution

Number

An identification number assigned to the facility (hospital) by a province or territory Ministry of Health.

From

The four-digit CIHI institution number referring to the hospital from which the patient was transferred.

To

The four-digit CIHI institution number referring to the hospital to which the patient was transferred.

Demographics Codes

Prov

The one digit code that indicates the province of the hospital where the episode of care occurred.

Eg: British Columbia is 9

See DAD manual.

Postal

The full postal code as assigned by Canada Post to identify the patient's place of residence. Valid postal code format is: ANANAN. If postal code is unknown, leave blank and abstract a **Residence** code.

Residence

Use only when the postal code is unknown; in which case, abstract the two-digit alpha **Residence** code (per CIHI's mini postal code) to identify the province, state, or territory of the patient's residence.

See DAD manual.

Coder

The one or two digit coder number identifying the individual responsible for entering the CIHI data, also the last person editing the record.

Death Codes

In OR Suite

The patient died in the operating room or in the post intervention recovery room.

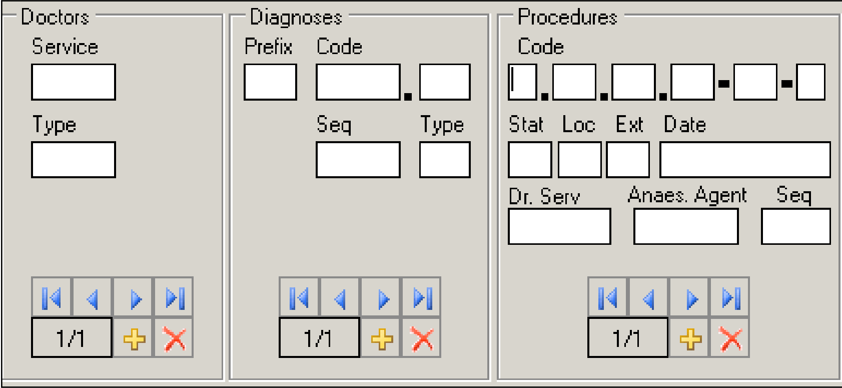
Death

The patient is pronounced dead.

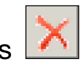
During the Period End Procedure, this field is captured (downloaded) from the Discharge Disposition of the hospital's Health Record Abstracting system.

How to enter Doctors / Diagnoses / Procedures

The CIHI Sub-form is used to enter the data.

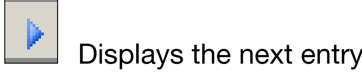


To enter data, press . The sequential number of the entry will automatically display in the box.

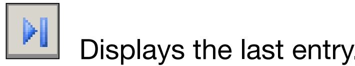
To delete data, press .

Displays the first entry.

Displays the previous entry.



Displays the next entry.



Displays the last entry.

Doctors

Service

The five-digit number identifying the doctor (provider) specialty service (per CIHI).

See DAD manual.

Type

A one digit number or letter describing the doctor (provider) role in the care of the patient during hospitaization. A total of eight different doctors (providers) may be abstracted per patient.

See DAD manual.

Diagnoses

Prefix

A hospital-assigned alpha or numeric character to further define a diagnosis code.

The following prefixes have been assigned a standard definition by CIHI and are only used for the defined purpose as described below:

Prefix	Standard Definition
C	Cause of death codes
Q	Questionable or query diagnoses

Code

The ICD-10-CA (International Statistical Classification of Diseases and Related Health Problems, 10th revision, Canadian edition) medical diagnostic code reflecting the diagnosis or condition of patient, while in hospital. The code may be up to seven characters in length.

A total of twenty-five different diagnoses may be abstracted per patient.

Seq

The hierarchical order of diagnoses within this admission.

Type

A Diagnosis Type (as per CIHI) is abstracted for each diagnostic code.

See DAD manual.

Procedures

Code

The medical classification of health interventions (procedures) performed during admission is coded using the Canadian Classification of Health Interventions (CCI).

Principal procedure (intervention) is the intervention considered to be the most significant during the patient's hospital stay.

Abstract other relevant procedural information (date, doctor service, anesthetic agent).

Abstract only one anesthetic technique per procedure regardless of the number of anesthetics given. Abstract the highest anesthetic technique.

A total of twenty procedures may be abstracted per patient.

Stat Loc Ext

Status, Location, and Extent are attributes (per CIHI) that provide extra useful detail that does not impact on the essence of the intervention.

Stat: details such as revision, abandoned procedure, delayed, staged, etc.

See DAD manual.

Loc: details such as specific anatomical location of the procedure

Eg: left, right, bilateral, superficial, deep, etc.

See DAD manual.

Ext: details of quantitative measure

Eg: length of laceration performed, number of anatomical structures involved

See DAD manual.

Date

The date (day, month, year) of procedure. When manually entering data, each procedure should have a procedure date.

Dr. Serv

The five-digit number identifying the procedure provider service (per CIHI).

See DAD manual.

Anaes. Agent

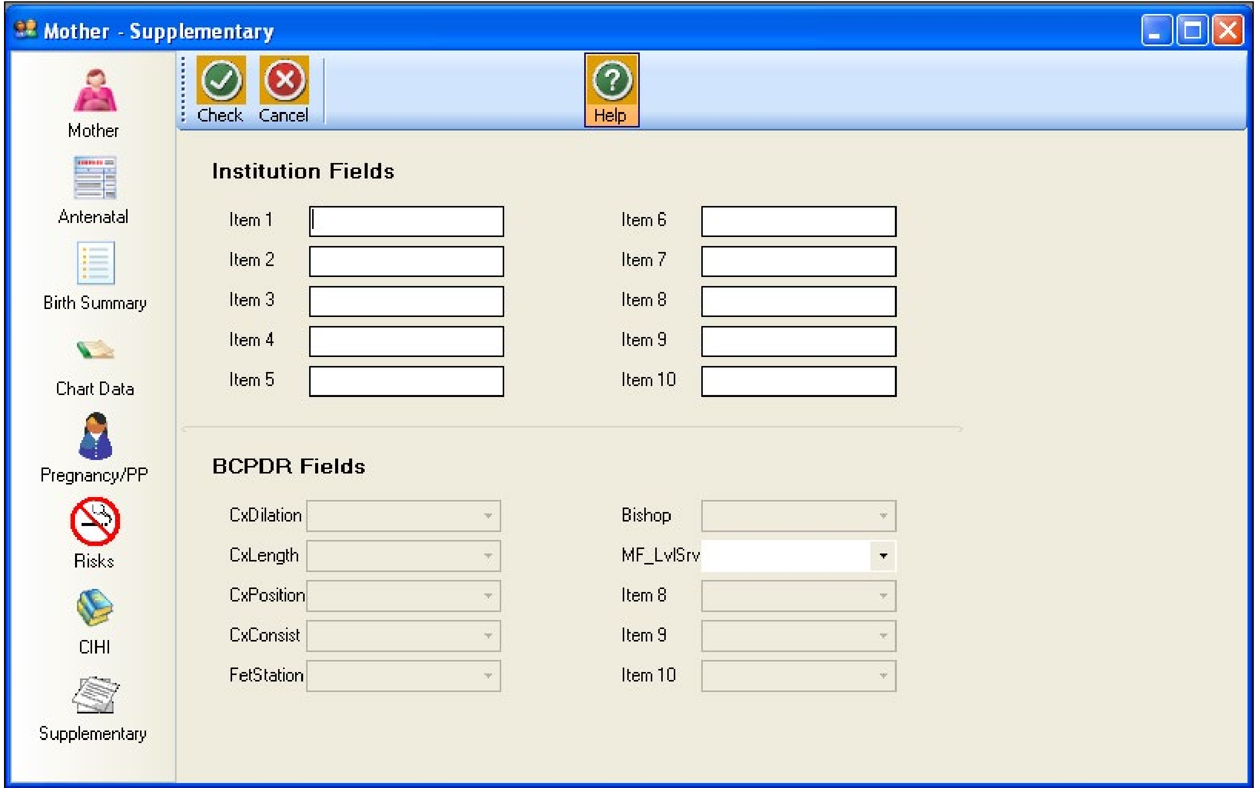
The one-digit number that identifies the anesthetic agent technique. Drug administered for medical or surgical procedures (interventions) that induces partial or total loss of sensation.

See DAD manual.

Seq

The hierarchical order of procedures performed during admission.

3.10 Supplementary Screen (Mother)



Institution Fields (Item 1 to 10)

These fields are for Health Authority/Hospital use to capture additional information outside of the current fields within the database. Maintenance and management of these fields will be the responsibility of the Health Authority/Hospital.

See Section 9.6.1 Institution Fields on page 222.

To view the relevant descriptions, policy and procedure, forms and definitions:

See Appendix 10.9 Supplementary Institution Fields on page 255.

BCPDR Fields (Item 1 to 10)

These fields will be assigned and activated by the BCPDR as necessary. The BCPDR will only implement the activation and use of the new fields after approval from the PSBC Executive.

The first six fields have been deactivated.

The seventh field is the Maternal/Fetal LOS field ***http://www.perinatalservicesbc.ca/Guidelines/Guidelines/perinatal-level-care/default.htm***.

MF_LvlSrv

See Section 9.6.2 BCPDR Fields on page 222.

4. POSTPARTUM SUITE

4.1 Postpartum Screen Command Buttons

The Postpartum Suite consists of the Postpartum Mother screen and sub-screens: Pregnancy/PP, CIHI, and Supplementary.

When the Postpartum Suite [PostPartum] is selected, the following screen appears:

Sub-screen icons

Command Buttons

Mother Postpartum - Postpartum Mother

Find | New | Save | Delete | Exit | Validate | Link | Help

Postpartum Mot...
Pregnancy/PP
CIHI
Supplementary

Institution: 975 We Care Hospital

Surname
Given Name
Surname Birth
Surname Alias
Given Name Alias

Chart Number | Admission Date | Time
Inpatient Number | Discharge Date | Time
Personal Health # | Delivery Date
Date of Birth | Place of Delivery

The sub-screen icons activate the Postpartum sub-screens (Pregnancy/PP, CIHI, and Supplementary).

The command buttons below are displayed across the top of the screen:

Find	Searches the database for a Postpartum Mother record.
New	Clears the screen for entry of a new Postpartum Mother record.
Save	Saves the Postpartum Mother record into the database if all errors are cleared.
Delete	Removes the current Postpartum Mother record from the database.
Exit	Closes the Postpartum Mother screen
Help	Disabled – Do Not Use

Once a Postpartum Mother record has been saved, one additional command becomes available:

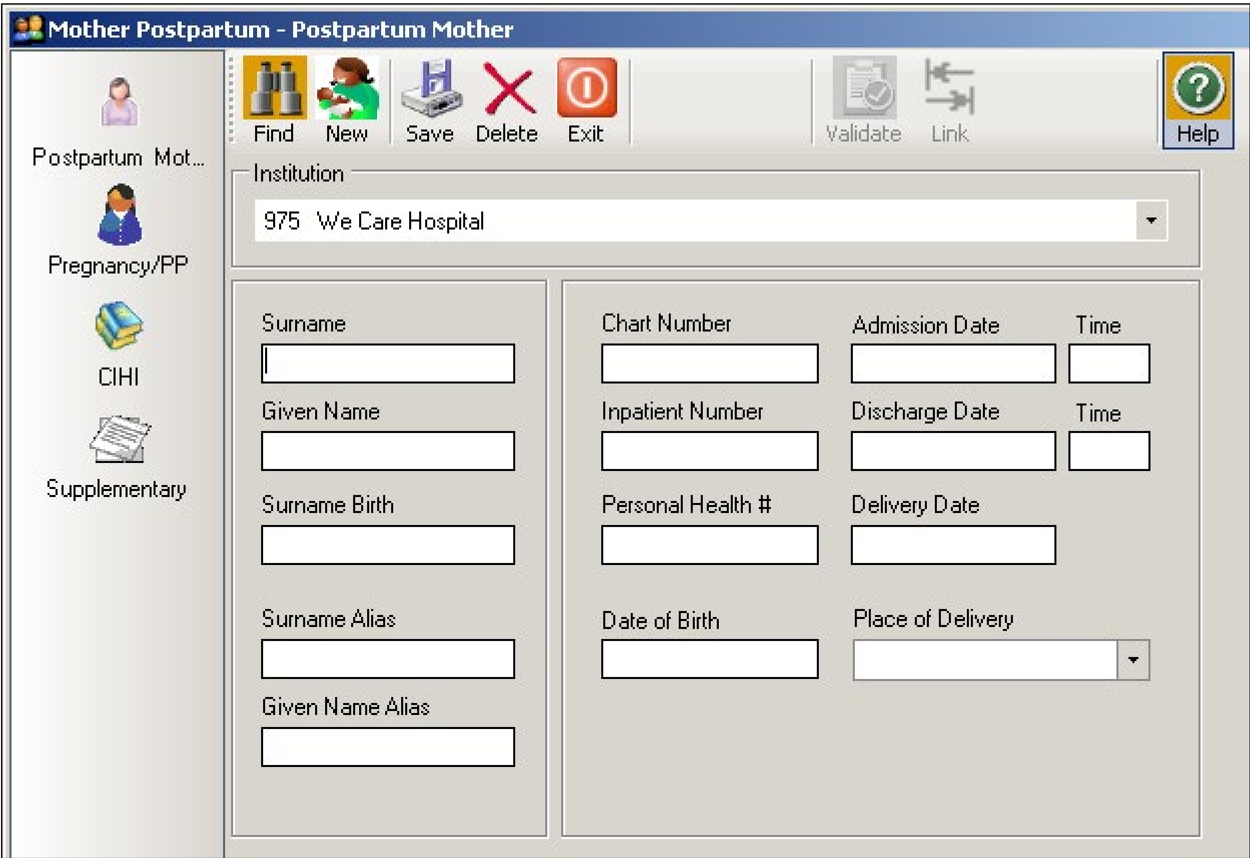
Validate	Identifies specific errors or omissions, if any, in the Postpartum Mother record. When validation is successful, the CTS (clear to send) flag populates the mother_ admission table. The CTS flag is one of the identifiers that indicates a record is ready for exporting.

Note: There is no ADT download for Postpartum Mothers. There is no CIHI download for Postpartum Mothers except for patient service 59 and specified postpartum 'O' codes. See Step 2 *Section 8.2.3.1 Performing a CIHI Import on page 154.*

4.2 Postpartum Mother Sub-Screen Command Buttons

Check	Checks for field completion for the screen.
Cancel	Cancels abstracted information for the screen.
Help	Disabled – Do Not Use

4.3 Postpartum Screen



Surname

The currently used last name of the mother. The surname is the family name associated with the mother and is usually, but not always, shared by family members. All parts of a hyphenated or multi-part surname are included.

Given Name

The mother's first given name. May be an ethnic name.

Surname Birth

The mother's last name at birth (ie: maiden name).

Surname Alias

Other last name used, or other name under which previous medical data may be documented. May be a previous married name or common law spouse's name. If both are available, abstract previous married name over the common law spouse's surname.

Used to link all deliveries for this mother within the Provincial Database.

Given Name Alias

Other given names used, or given name under which previous medical data may be documented. May be a middle name, nickname, or English translation of an ethnic name.

Chart Number

The mother's unique unit number assigned by the facility. This number is used by the facility, to track all services provided, for the current and subsequent admissions.

Chart Number *must match the CIHI chart number exactly as it appears in the hospital abstracting system, including leading zeros.*

Eg: 0123456, H0123456

Inpatient Number

The admitting number assigned by the facility to identify the specific mother admission.

Used by the facility (hospital) for mother identification and linkage. Optional use. May be left blank.

Personal Health #

The 10-digit British Columbia Personal Health Number (PHN) is a unique numerical lifetime identifier used to specifically identify an individual having any interaction with the BC Health System. It is assigned to and used by one person and will not be assigned to any other person at any time.

Abstract 0 if the PHN is not available or if the PHN is an out of province number.

Date of Birth

The date (day, month, year) the mother was born.

Admission Date

The date (day, month, year) the mother was admitted/transferred to the hospital as an inpatient.

Admission Time:

The time the mother was admitted/transferred to the hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

Eg: If the mother is admitted midnight, New Year's Day, abstract as January 1 at 0000 hours.

Discharge Date

The date (day, month, year) the mother was discharged from, died at, or transferred from, the hospital.

Discharge Time

The time the mother was discharged from hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359. If the discharge time is not available, abstract 1200 hours.

Eg: If the mother is discharged midnight, New Year's Day, abstract as January 1 at 0000 hours.

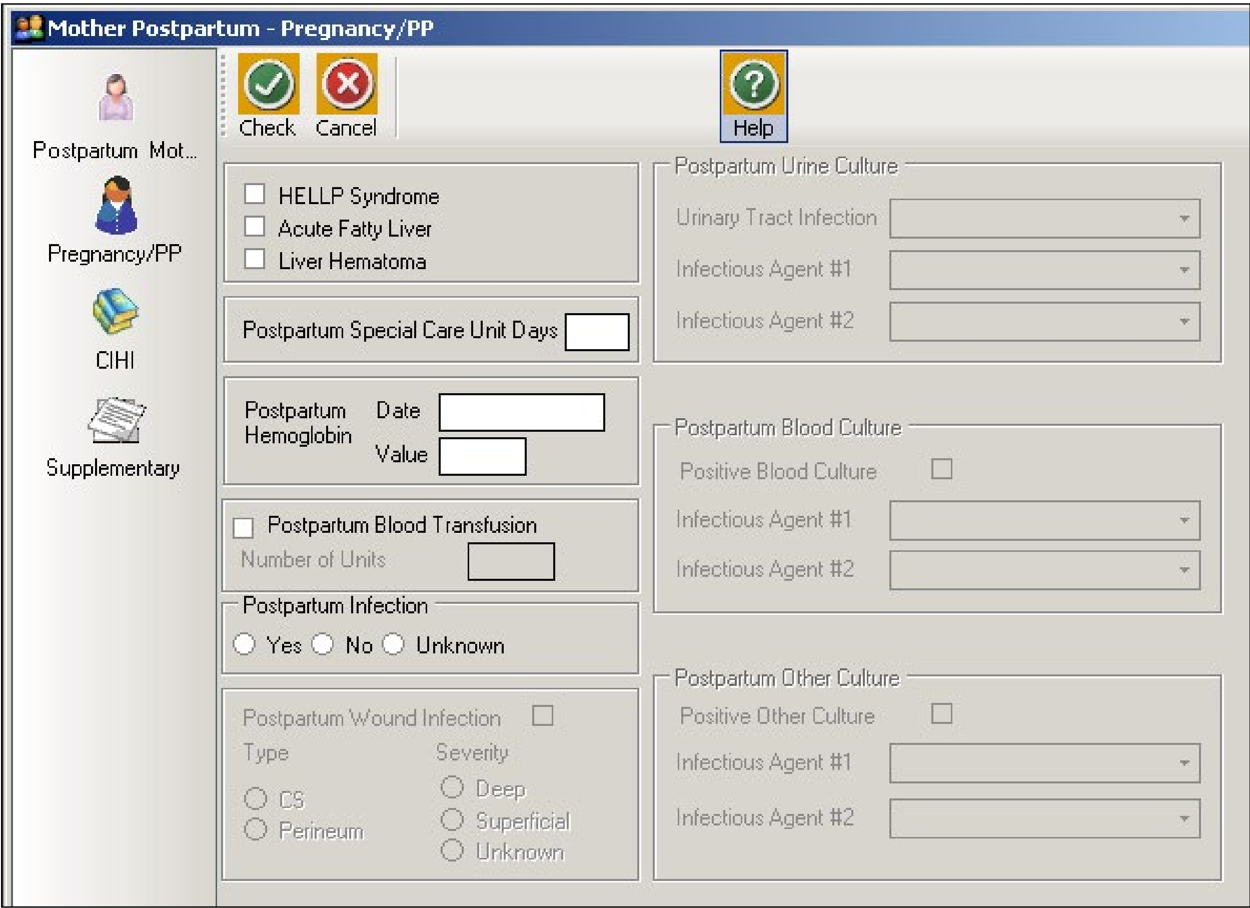
Delivery Date

The date (day, month, year) that the baby was delivered. For multiple births, the delivery date for the last baby delivered is used.

Place of Delivery

The facility (hospital) where the delivery occurred.

4.4 Pregnancy/PP Screen



<u>Overview:</u> Co-morbid conditions that may affect the postpartum period

HELLP Syndrome

The mother was diagnosed with HELLP Syndrome (H – hemolysis; EL – elevated liver enzymes; LP – low platelet count) during current pregnancy or postpartum period.

Do not abstract if HELLP is a query diagnosis.

Acute Fatty Liver

The mother was diagnosed with acute fatty liver during current pregnancy or postpartum period.

Do not abstract if acute fatty liver is a query diagnosis.

Liver Hematoma

The mother was diagnosed with liver hematoma during current pregnancy or postpartum period.

Do not abstract if liver hematoma is a query diagnosis.

Postpartum Special Care Unit Days

Number of days the mother spent in any Special Care Unit (ICU, CCU, etc) postpartum.

The purpose of this field is to obtain information on bed utilization in a specified SCU, not level of care.

Leave blank if the mother was never admitted into any Special Care Unit

Postpartum Hemoglobin

Date

The date of the lowest postpartum hemoglobin result during the postpartum admission.

Value

Value of the postpartum hemoglobin test result done during the postpartum admission.

Postpartum Blood Transfusion

The mother received whole or packed red blood cells during the postpartum period of the current admission.

Includes autologous blood transfusions.

Number of Units

The total number of units of whole or packed red blood cells the mother received during the postpartum period.

Postpartum Infection

Mother admitted ≤ 42 days post delivery with any infection (not necessarily documented as a postpartum infection).

Must abstract 'Yes', 'No' *or* 'Unknown'*.*

Example of Postpartum Infection - Yes:

- *Postpartum endometritis*

Examples of Postpartum Infection - No:

- *Nothing documented in the chart to indicate an infection*
- *Cystitis during intra & postpartum periods (just a continuation of intrapartum infection)*
- *Postpartum fever NOS*
- *MRSA (or any other bacterial) colonization only*

Examples of Postpartum Infection - Unknown:

- *Positive culture with no further documentation*
- *Postpartum fever with antibiotics only*
- *Query Postpartum infection*
- *Red & tender wound with antibiotics only*

Postpartum Wound Infection

The mother had a postpartum wound infection.

Type

Specific location of the mother's postpartum wound infection.

Eg: Abstract 'C/S' *or* 'Perineum'

Severity

The degree of the mother's postpartum wound infection.

Eg: Abstract 'Deep', 'Superficial' *or* 'Unknown'

Postpartum Urine Culture

Urinary Tract Infection

Abstract type of urinary tract infection during the postpartum period.

- 'Cystitis'
- 'Pyelonephritis'
- 'Both Cystitis and Pyelonephritis'
- 'Other Urinary Tract Infection'
- 'Unknown Urinary Tract Infection'

Infectious Agent #1

The most significant infectious agent causing positive maternal urine culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive urine culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Postpartum Blood Culture

Positive Blood Culture

Abstract if the mother's blood culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive maternal blood culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive blood culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Postpartum Other Culture

Positive Other Culture

Abstract if other lab culture results were positive (other than urine or blood) during the postpartum period.

If **Postpartum Wound Infection** is abstracted, **Postpartum Other Culture** should also be abstracted. Abstract infectious organism if documented.

Eg: sputum, stool, wound infection

Infectious Agent #1

The most significant infectious agent from other maternal positive culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent from other positive maternal culture results during the postpartum period.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

4.5 CIHI Data Screen (Postpartum Mother)

Mother - CIHI

Mother
Antenatal
Birth Summary
Chart Data
Pregnancy/PP
Risks
CIHI
Supplementary

Check Cancel Help

Admission Weight
Main Patient Service
Institution Number From To
975
Demographics Codes Prov Postal Residence
Coder #
Death Codes In OR Suite Death
Doctors Service Type
Diagnoses Prefix Code Seq Type
Procedures Code Stat Loc Ext Date Dr. Serv Anaes. Agent Seq
NICU Days Level II Level III
1/1 1/1 1/1

CIHI data is imported into the CIHI Data Screen when the Period End Procedure is performed.

On occasion, manual entry of the data may be necessary.

For assistance with DAD Code Tables and Definitions, please consult the ***DAD Manual****.*

Main Patient Service

The main patient service categorizes patients according to related diseases, conditions and treatments.

See DAD manual.

Institution

Number

An identification number assigned to the facility (hospital) by a province or territory Ministry of Health.

From

The four-digit CIHI institution number referring to the hospital from which the patient was transferred.

To

The four-digit CIHI institution number referring to the hospital to which the patient was transferred.

Demographics Codes

Prov

The one digit code that indicates the province of the hospital where the episode of care occurred.

Eg: British Columbia is 9

See DAD manual.

Postal

The full postal code as assigned by Canada Post to identify the patient's place of residence. Valid postal code format is: ANANAN. If postal code is unknown, leave blank and abstract a **Residence** code.

Residence

Use only when the postal code is unknown; in which case, abstract the two-digit alpha **Residence** code (per CIHI's mini postal code) to identify the province, state, or territory of the patient's residence.

See DAD manual.

Coder

The one or two digit coder number identifying the individual responsible for entering the CIHI data, also the last person editing the record.

Death Codes

In OR Suite

The patient died in the operating room or in the post intervention recovery room.

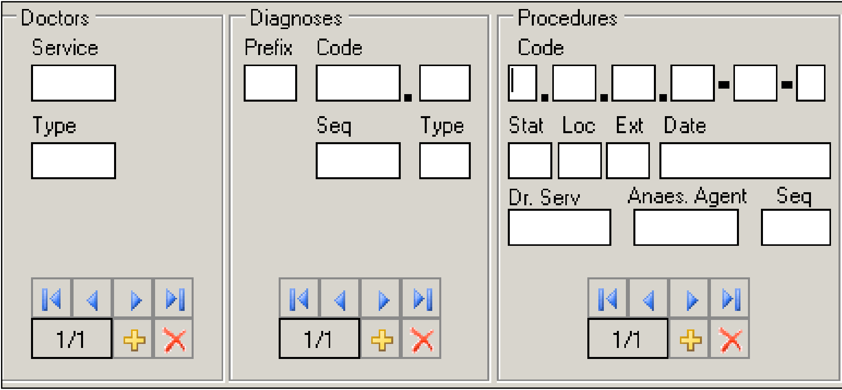
Death

The patient is pronounced dead.

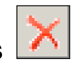
During the Period End Procedure, this field is captured (downloaded) from the Discharge Disposition of the hospital's Health Record Abstracting system.

How to enter Doctors / Diagnoses / Procedures

The CIHI Sub-form is used to enter the data.

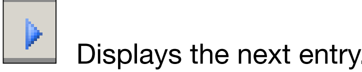


To enter data, press . The sequential number of the entry will automatically display in the box.

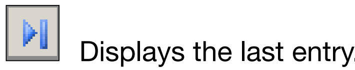
To delete data, press .

Displays the first entry.

Displays the previous entry.



Displays the next entry.



Displays the last entry.

Doctors

Service

The five-digit number identifying the doctor (provider) specialty service (per CIHI).

See DAD manual.

Type

A one digit number or letter describing the doctor (provider) role in the care of the patient during hospitaization. A total of eight different doctors (providers) may be abstracted per patient.

See DAD manual.

Diagnoses

Prefix

A hospital-assigned alpha or numeric character to further define a diagnosis code.

The following prefixes have been assigned a standard definition by CIHI and are only used for the defined purpose as described below:

Prefix	Standard Definition
C	Cause of death codes
Q	Questionable or query diagnoses

Code

The ICD-10-CA (International Statistical Classification of Diseases and Related Health Problems, 10th revision, Canadian edition) medical diagnostic code reflecting the diagnosis or condition of patient, while in hospital. The code may be up to seven characters in length.

A total of twenty-five different diagnoses may be abstracted per patient.

Seq

The hierarchical order of diagnoses within this admission.

Type

A Diagnosis Type (as per CIHI) is abstracted for each diagnostic code.

See DAD manual.

Procedures

Code

The medical classification of health interventions (procedures) performed during admission is coded using the Canadian Classification of Health Interventions (CCI).

Principal procedure (intervention) is the intervention considered to be the most significant during the patient's hospital stay.

Abstract other relevant procedural information (date, doctor service, anesthetic agent).

Abstract only one anesthetic technique per procedure regardless of the number of anesthetics given. Abstract the highest anesthetic technique.

A total of twenty procedures may be abstracted per patient.

Stat Loc Ext

Status, Location, and Extent are attributes (per CIHI) that provide extra useful detail that does not impact on the essence of the intervention.

Stat: details such as revision, abandoned procedure, delayed, staged, etc.

See DAD manual.

Loc: details such as specific anatomical location of the procedure

Eg: left, right, bilateral, superficial, deep, etc.

See DAD manual.

Ext: details of quantitative measure

Eg: length of laceration performed, number of anatomical structures involved

See DAD manual.

Date

The date (day, month, year) of procedure. When manually entering data, each procedure should have a procedure date.

Dr. Serv

The five-digit number identifying the procedure provider service (per CIHI).

See DAD manual.

Anaes. Agent

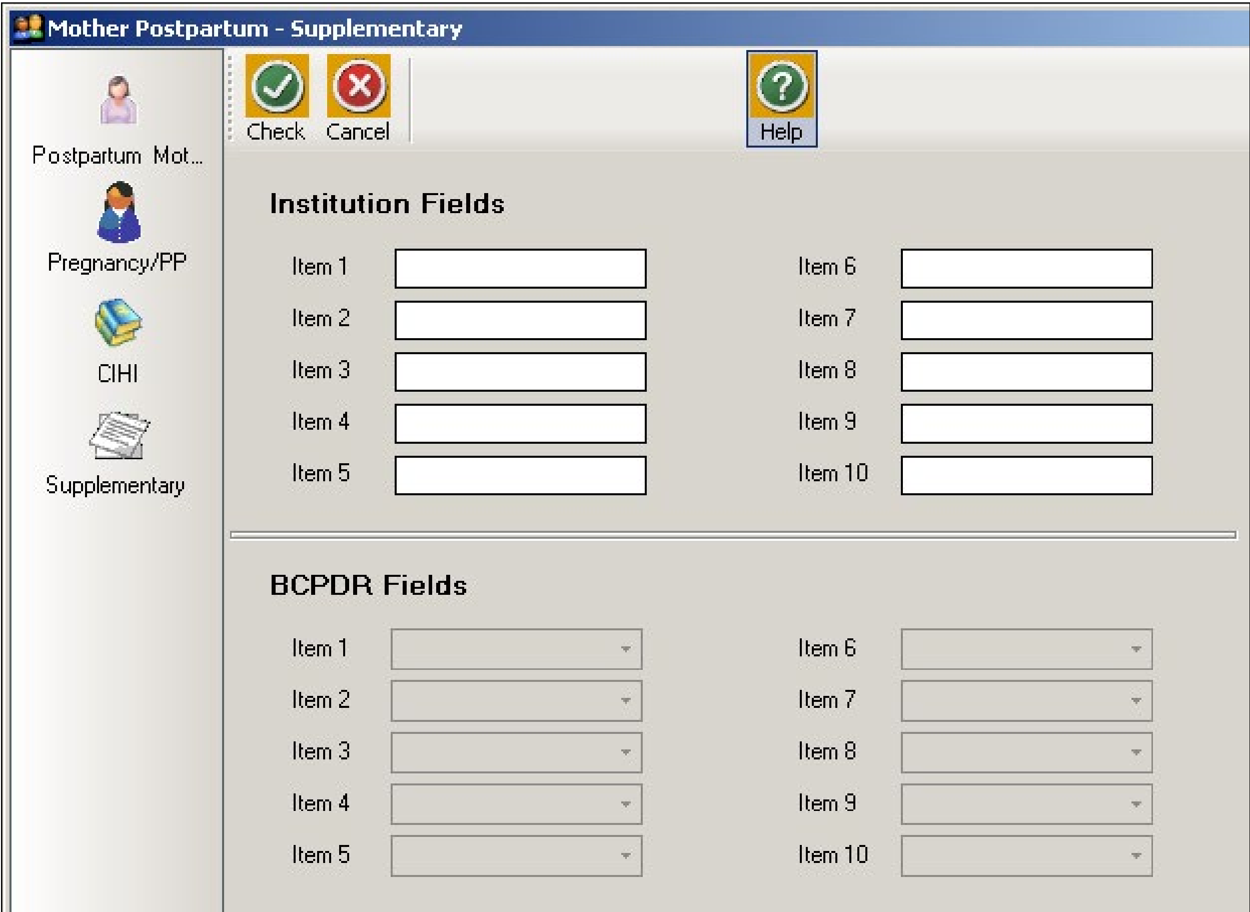
The one-digit number that identifies the anesthetic agent technique. Drug administered for medical or surgical procedures (interventions) that induces partial or total loss of sensation.

See DAD manual.

Seq

The hierarchical order of procedures performed during admission.

4.6 Supplementary Screen (Postpartum Mother)



Institution Fields (Item 1 to 10)

These fields are for Health Authority/Hospital use to capture additional information outside of the current fields within the database. Maintenance and management of these fields will be the responsibility of the Health Authority/Hospital.

See Section 9.6.1 Institution Fields on page 222.

To view the relevant descriptions, policy and procedure, forms and definitions:

See Appendix 10.9 Supplementary Institution Fields on page 255.

BCPDR Fields (Item 1 to 10)

These fields will be assigned and activated by the BCPDR as necessary. The BCPDR will only implement the activation and use of the new fields after approval from the PSBC Executive.

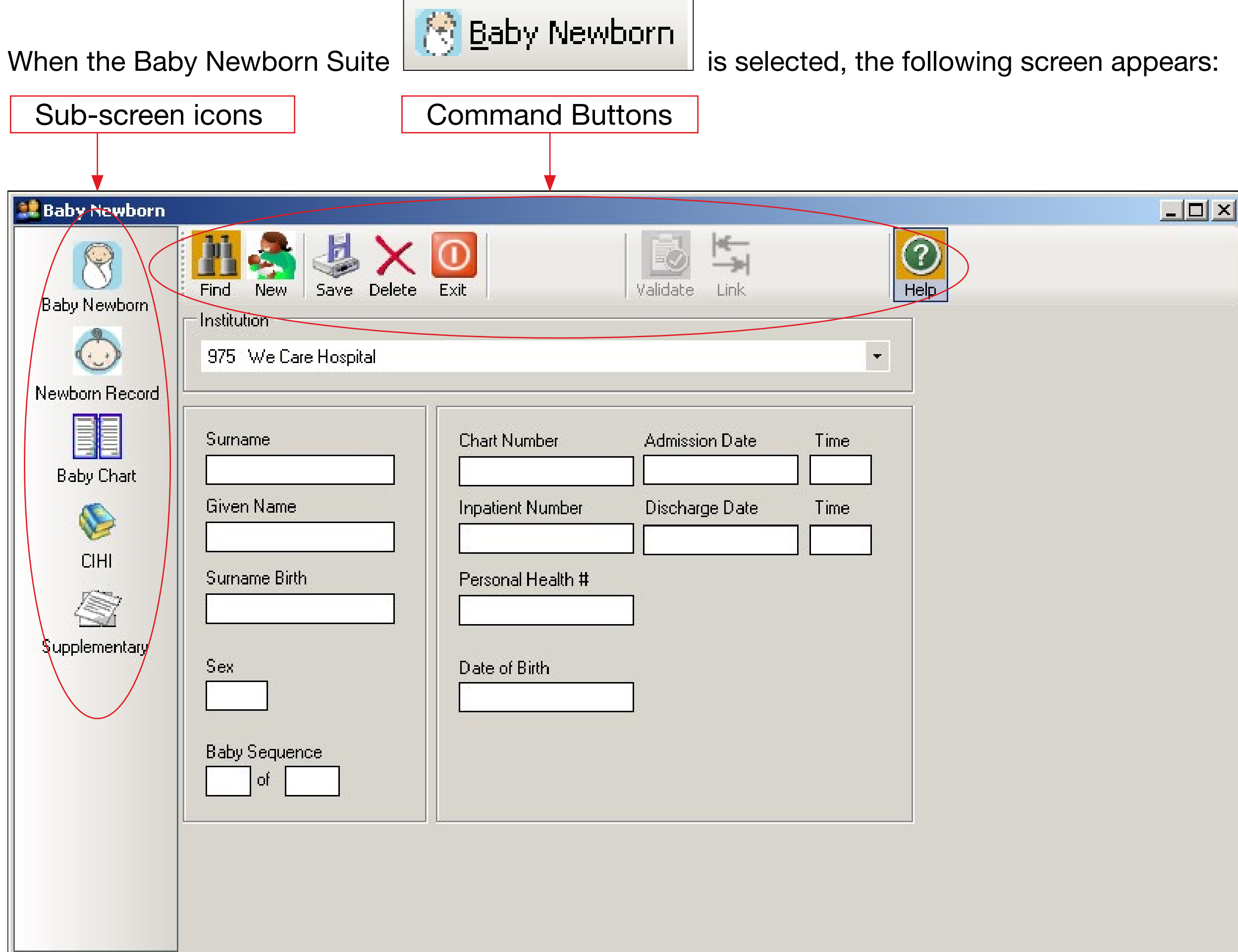
See Section 9.6.2 BCPDR Fields on page 222.

5. BABY NEWBORN SUITE

5.1 Baby Newborn Screen Command Buttons

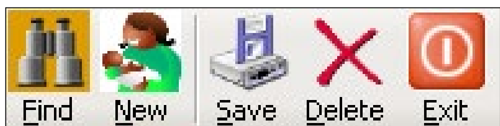
The Baby Newborn Suite consists of the Baby Newborn screen and sub-screens: Newborn Record, Baby Chart, CIHI, and Supplementary.

When the Baby Newborn Suite Baby Newborn is selected, the following screen appears:



The sub-screen icons activate the Baby Newborn sub-screens (Newborn Record, Baby Chart, CIHI, and Supplementary).

The command buttons below are displayed across the top of the screen:

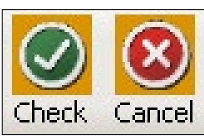


Find	Searches the database for a Baby Newborn record.
New	Clears the screen for entry of a new Baby Newborn record.
Save	Saves the Baby Newborn record into the database if all errors are cleared.
Delete	Removes the current Baby Newborn record from the database.
Exit	Closes the Baby Newborn screen.
Help	Disabled – Do Not Use

Once a Baby Newborn record has been saved, two additional commands become available:

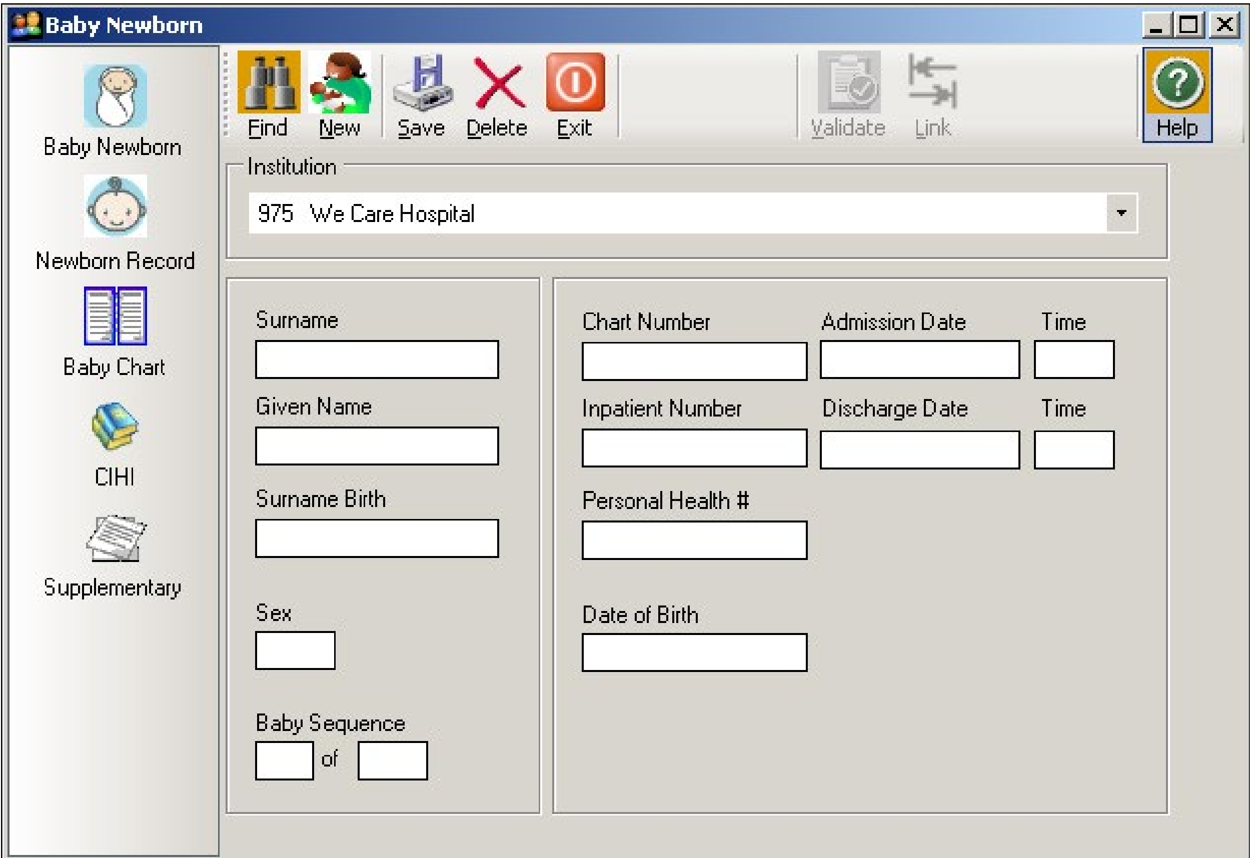
Validate	Identifies specific errors or omissions, if any, in the Baby Newborn record. When validation is successful, the CTS (clear to send) flag populates the baby_ admission table. The CTS flag is one of the identifiers that indicates a record is ready for exporting.
Link	Allows the current Baby Newborn record to be linked to a previously entered Mother record.

5.2 Baby Newborn Sub-Screen Command Buttons



Check	Checks for field completion for the screen.
Cancel	Cancels abstracted information for the screen.
Help	Disabled - Do Not Use

5.3 Baby Newborn Screen



Surname

The currently used last name of the baby at time of discharge. The surname is the family name associated with the baby and is usually, but not always, shared by family members. All parts of a hyphenated or multi-part surname are included.

Given Name

The baby's first given name or NBF, NBM, SBF, SBM, Twin A or Twin B. If left blank, system will default to N.B. when the Baby Newborn screen is saved.

Surname Birth

The baby's surname at birth. Do not abstract common law father's surname. Mother's surname is preferred.

Sex

Biological and physiological characteristics defining the baby.

'M' = Male
'F' = Female
'U' = Undifferentiated (for stillbirths only)
'O' = Other (Eg. Hermaphrodite)

Baby Sequence

First Number

Incremental sequence number for each baby born during the current pregnancy. This sequencing is irrespective of live birth or stillbirth.

Eg: Twin A = sequence 1, Twin B = sequence 2

Second Number

The total number of babies born during the current pregnancy.

Eg: Singleton = '1'. Twins = '2'.

Chart Number

The baby's unique unit number assigned by the facility. This number is used by the facility, to track all services provided, for the current and subsequent admissions.

***Chart Number** must match the CIHI chart number exactly as it appears in the hospital abstracting system, including leading zeros.*

Eg: 0123456, H0123456

Inpatient Number

The admitting number assigned by the facility to identify the specific baby admission.

Used by the facility (hospital) for baby identification and linkage. Optional use. May be left blank.

Personal Health

The 10-digit British Columbia Personal Health Number (PHN) is a unique numerical lifetime identifier used to specifically identify an individual having any interaction with the BC Health System. It is assigned to and used by one person and will not be assigned to any other person at any time.

Suffix 66 is used for a singleton newborn with the same Personal Health Number as the mother (ie: the newborn was not assigned a unique PHN).

Suffix of 66 – 61 (descending order for multiple births)

Eg:

66 = first born during this delivery

65 = second born during this delivery

64 = third born during this delivery

Suffix 54 is used for newborns assigned a unique Personal Health Number at birth (includes singletons as well as multiple births).

Abstract 0 if the PHN is not available, is an out of province number, or if the newborn is a stillbirth.

Date of Birth

The date (day, month, year) the baby was born.

Admission Date

The date (day, month, year) the baby was admitted to/born at the hospital.

Admission Time

The time the baby was admitted to / born at the hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

Eg: If the baby is admitted at midnight, New Year's Day, abstract as January 1 at 0000 hours.

Discharge Date

The date (day, month, year) the baby was discharged from, died at, or transferred from, the hospital.

Discharge Time

The time the baby was discharged from hospital, using the 24-hour clock.

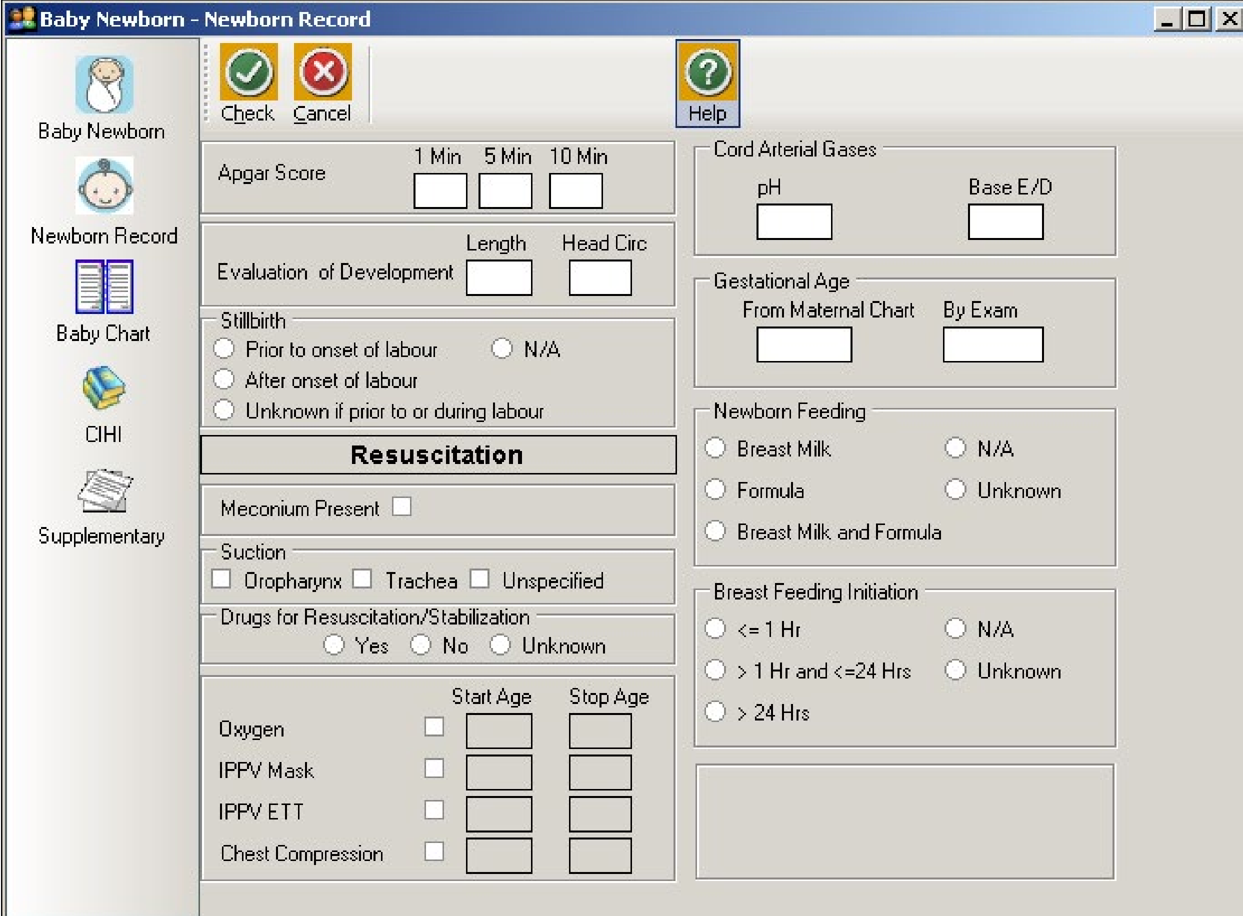
Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

If discharge time is not available, abstract 1200 hours.

Stillbirth discharge time should be the same as the admission time.

Eg: If the baby is discharged at midnight, New Year's Day, abstract as January 1 at 0000 hours.

5.4 Newborn Record Screen



Apgar Score

1 Min

The total score, between 0 to 10, based on five criteria (skin colour, heart rate, reflex irritability, muscle tone, respiration) on a scale of 0 to 2, abstracted at 1 minute of birth.

5 Min

The total score, between 0 to 10, based on five criteria (skin colour, heart rate, reflex irritability, muscle tone, respiration) on a scale of 0 to 2, abstracted at 5 minutes of birth.

10 Min

The total score, between 0 to 10, based on five criteria (skin colour, heart rate, reflex irritability, muscle tone, respiration) on a scale of 0 to 2, abstracted at 10 minutes of birth.

Evaluation of Development

Length

The length of the newborn at birth (in centimeters expressed as a whole number).

Eg: 54.2 cm = 54, 54.5 cm = 55

Head Circ

The head circumference of the newborn at birth (in centimeters expressed as a whole number).

Eg: 35.2 cm = 35, 36.5 cm = 37

Do not abstract head circumference taken at discharge.

Stillbirth

The stage in labour when the stillbirth occurred. Includes all stillbirths born in BC, regardless of location of birth.

Includes in hospital, en route or at home.

Vital Statistics Legal Definition of Stillbirth: The complete expulsion or extraction from its mother after at least 20 weeks pregnancy or after attaining a weight of ≥500 grams, of a product of conception in which, after the expulsion or extraction, there is no breathing, beating of heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle.
www.vs.gov.bc.ca/stats/pdf/physicians-and-midwives-handbook.pdf

Note: This is different from the CIHI definition: Any intrauterine fetal demise or termination occurring at or after 20 completed weeks of gestation in which the fetus shows no signs of life.

The BCPDR may therefore not always match with CIHI.

See Appendix 10.7 Adapted Case Scenarios for Registration of Births and Stillbirths in British Columbia on page 251.

Prior to onset of labour

Stillbirth or intrauterine death documented prior to onset of first stage of labour.

After onset of labour

Stillbirth or intrauterine death documented after onset of first stage of labour.

Unknown if prior to or during labour

Stillbirth or intrauterine death documented, but unknown if prior to or after onset of first stage of labour.

N/A

Not Applicable. Baby is a live birth.

Resuscitation

Applies to the initial resuscitation for first hour after birth, or immediately prior to transfer to the NICU, whichever comes first.

See *Appendix 10.8 Newborn Resuscitation and Ventilation on page 252*.

Meconium Present

The presence of thick or thin meconium at any time during the intrapartum period, including delivery.

Do not abstract if the newborn passed meconium only.

Suction

Suctioning during the birth episode.

Oropharynx

Clearing of the newborn's airway at the level of the oropharynx.

Trachea

Clearing of the newborn's airway at level of the trachea.

Suctioning below cords indicates suctioning of the trachea.

Unspecified

Clearing the newborn's airway at a level not specified.

Suctioning of the stomach may sometimes be done to remove meconium from the stomach, but technically this is a post-resuscitation procedure and actually does not count as suctioning per se. Therefore, do not abstract suctioning of the stomach in this section.

Drugs for Resuscitation / Stabilization

Administration of medication to the newborn for resuscitative/stabilization purposes during the birth episode only.

Drugs are usually administered by an umbilical venous catheter (UVC).

Eg: of Drugs:

- *Narcan / naloxene – usually given if mother has narcotics such as demerol or morphine within 4 hours prior to delivery and baby has respiratory problems.*
- *Adrenaline / epinephrine, sodium bicarbonate – usually given if there is prolonged cardiac arrest with no response to other therapies.*
- *Volume expanders (albumin, normal saline, blood products, and cord blood) – usually given for acute blood loss.*

See *Appendix 10.8.3 Calculation of Start Age and Stop Age for Resuscitation – Examples on page 254.*

Oxygen

Administration of oxygen to the newborn for resuscitative purposes during the birth episode.

Includes Continuous Positive Airway Pressure (CPAP) without intubation as long as oxygen is given with the CPAP. CPAP given on its own (on room air or without simultaneous oxygen administration) during the resuscitation period is not captured by the BCPDR.

Includes oxygen given to pink up.

*If oxygen administration and IPPV are consecutive, abstract both **Oxygen** and **IPPV**.*

Oxygen – Start Age

The age of the newborn, in minutes, to indicate the time oxygen was started for resuscitation. Abstract to a maximum of 2 decimals.

If unknown when oxygen was started, leave blank.

Oxygen – Stop Age

The age of the newborn, in minutes, to indicate the time oxygen was stopped for resuscitation. Abstract to a maximum of 2 decimals.

If unknown when oxygen ended, leave blank.

IPPV Mask

The newborn received intermittent positive pressure ventilation (IPPV) for resuscitative purposes with the use of a face or nasal mask during the birth episode, including bagging.

IPPV Mask – Start Age

The age of the newborn, in minutes, when IPPV Mask was started. Abstract to a maximum of 2 decimals.

If unknown when IPPV Mask was started, leave blank.

IPPV Mask – Stop Age

The age of the newborn, in minutes, when IPPV Mask was stopped. Abstract to a maximum of 2 decimals.

If unknown when IPPV Mask ended, leave blank.

IPPV ETT

The newborn received intermittent positive pressure ventilation (IPPV) for resuscitative purposes with the use of an endotracheal tube, including intubation with bagging.

IPPV ETT – Start Age

The age of the newborn, in minutes, when IPPV ETT was started. Abstract to a maximum of 2 decimals.

If unknown when IPPV ETT was started, leave blank.

IPPV ETT – Stop Age

The age of the newborn, in minutes, when IPPV ETT was stopped. Abstract to a maximum of 2 decimals.

If unknown when IPPV ETT ended, leave blank.

Chest Compression

The newborn received chest compression for resuscitative purposes to establish an adequate heart rate. *Includes cardiac and chest massage.*

Compression – Start Age

The age of the newborn, in minutes, when chest compressions were started. Abstract to a maximum of 2 decimals.

If unknown when compression was started, leave blank.

Compression – Stop Age

The age of the newborn, in minutes, when chest compressions were stopped. Abstract to a maximum of 2 decimals.

If unknown when compression ended, leave blank.

Cord Arterial Gases

pH

The pH value of the cord arterial blood gases. The blood sample for this test is obtained from the umbilical artery. Ensure values are not from a venous sample. Abstract to a maximum of two decimal places.

Base E/D

The base excess value (commonly a positive integer) and a base deficit value (commonly a negative integer) of the cord arterial blood gases. The blood sample for this test is obtained from the umbilical artery. Ensure values are not from a venous sample. Abstract to a maximum of one decimal place.

Gestational Age

If **Gestational Age** is documented as Term and there is no other gestational age documentation, leave blank.

If **Gestational Age** is documented as 37 – 38 weeks, abstract 37.

From Maternal Chart

The newborn gestational age at delivery documented on the maternal chart by the care provider.

By Exam

The newborn gestational age at delivery documented by the care provider's physical and neuromuscular assessment of the newborn at delivery.

Newborn Feeding

The substance given to the baby during the entire hospital stay, including at discharge, irrespective of mode.

Breast Milk

Baby was given only breast milk (including expressed breast milk) either orally, or by gavage feed, for the duration of their hospital stay. If water was given with the breast milk, it is not exclusive breast milk. The breast milk may be given by the mother, health care provider, or family member/supporter.

Exception: Undiluted drops of syrup consisting of vitamins, mineral supplements, or medicines. Includes Human Milk Fortifier (HMF) that consists of several nutrients and minerals that are needed for proper bone development in low birth weight babies. It is added directly to the expressed breast milk.

Formula

Baby was given formula during the hospital stay.

Includes Enfamil Premature Formula (EPF).

Breast Milk and Formula

Baby was given partial breast milk during the hospital stay.

Eg: Breast milk with supplements, including formula, water, or glucose water.

NA

Baby was immediately transferred to another hospital, or was a stillbirth or neonatal death.

Unknown

No documentation as to what the baby was fed during the hospital stay.

Breast Feeding Initiation

The time frame during which breastfeeding first commenced/attempted following delivery, regardless of whether the baby latched or not.

*Note: **Breast Feeding Initiation** refers to the attempt made to feed the baby by breast (mode of feeding), not to the type of feeding given to the baby (Eg: expressed breast milk).*

≤1 Hr

Less than or equal to 1 hour.

>1 Hr and ≤24 Hrs

Greater than 1 hour and less than or equal to 24 hours.

>24 Hrs

Greater than 24 hours.

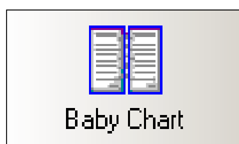
N/A

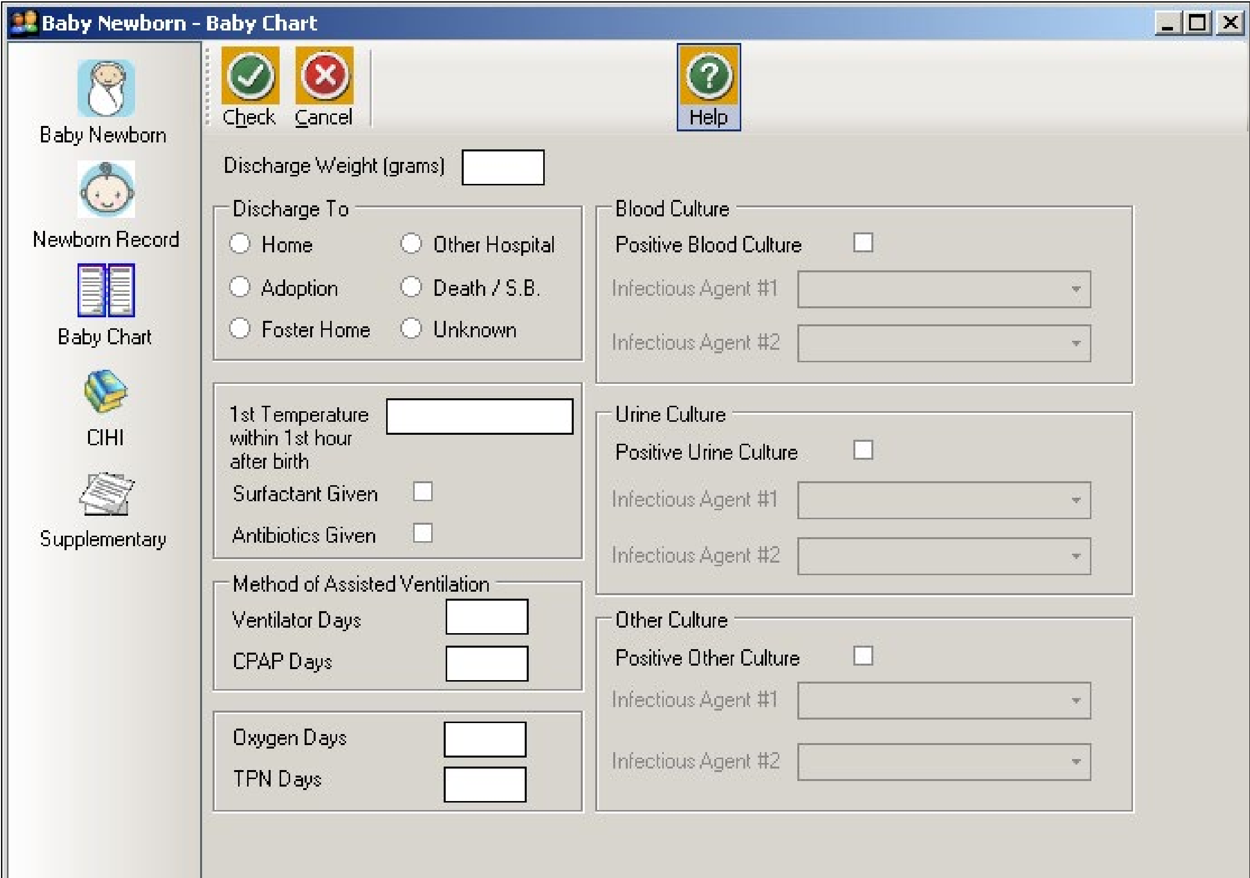
Baby was not breastfed, died or was a stillbirth.

Unknown

It is unknown when breastfeeding was started.

5.5 Baby Chart Screen





Discharge Weight (grams)

The baby's weight (in grams) at discharge from facility.

If there is no weight taken at discharge, abstract the last value documented, close to discharge.

Leave blank for stillbirths.

For same day discharges, abstract the birth weight.

Discharge To

Where the baby was discharged to or the status of the baby at the time of discharge.

Home

Discharged home.

Adoption

Discharged home with adoptive parents.

Foster Home

Baby was discharged home with foster parents.

Eg: Baby was apprehended by the Ministry, then discharged home with grandmother.

Other Hospital

Transferred to another hospital.

Death / S.B.

Baby was a neonatal death or stillbirth.

Unknown

It is unknown where the baby was discharged to.

1st Temperature within 1st hour after birth

The value of the first temperature (in Celsius to one decimal place) taken within the first hour of birth.

Surfactant Given

Surfactant was administered to the baby during hospital admission.

Other names for surfactant include: curosurf, exosurf, infosurf, survanta, and Bovine Lipid Extract Surfactant (BLES)

Antibiotics Given

Antibiotics were administered to the baby during hospital admission.

Do not include Erythromycin for eye prophylaxis.

Method of Assisted Ventilation

Applies to the time period following the initial resuscitation (begins one hour after birth or immediately upon arrival to the NICU, whichever comes first).

Use LOS calculation methods.

Eg:

Oct. 4 = 1 day
Oct. 4 and Oct. 5 = 1 day
Oct. 4, 5 and 6 = 2 days

Each field is independent of the other(s).

Eg: If baby receives CPAP for 5 days and receives oxygen via CPAP for two of these five days, abstract 5 ***CPAP Days*** *and 2* ***Oxygen Days****.*

Eg: If baby is on a ventilator for 4 days, is taken off the ventilator, and receives oxygen via nasal prongs for 3 days, abstract 4 ***Ventilator Days*** *and 3* ***Oxygen Days****.*

See Appendix 10.8 Newborn Resuscitation and Ventilation on page 252.

Ventilator Days

The total number of days (in whole numbers) the baby was on a ventilator.

CPAP Days

The total number of days (in whole numbers) the baby was on Continuous Positive Airway Pressure (CPAP).

Includes Biphasic CPAP, BiPAP, SiPAP, Bubble, and CPAP.

*If baby receives oxygen via CPAP, also abstract for **Oxygen Days.***

If you are unsure how CPAP is documented at your site, please contact your neonatal care providers.

Oxygen Days

The total number of days (in whole numbers) the baby received oxygen therapy.

0.21 or 21% is considered room air. Anything above this value is classified as oxygen.

Oxygen >21% can be delivered by CPAP, ventilator, oxyhood, incubator, or high flow nasal prongs.

Low flow nasal prongs are always considered oxygen.

Excludes brief intermittent therapy for apneic attacks.

TPN Days

The total number of days (in whole numbers) the baby received any total parenteral nutrition (sometimes called TPN).

Blood Culture

Positive Blood Culture

Abstract if the baby's blood culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive blood culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive blood culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Urine Culture

Positive Urine Culture

Abstract if the baby's urine culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive urine culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive urine culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Other Culture

Positive Other Culture

Abstract if other lab culture test results were positive for the baby other than blood and urine.

Eg: sputum, stool

Infectious Agent #1

The most significant infectious agent causing other positive culture results in the baby, other than blood and urine.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing other positive culture results in the baby, other than blood and urine.

Examples of Infection - Yes:

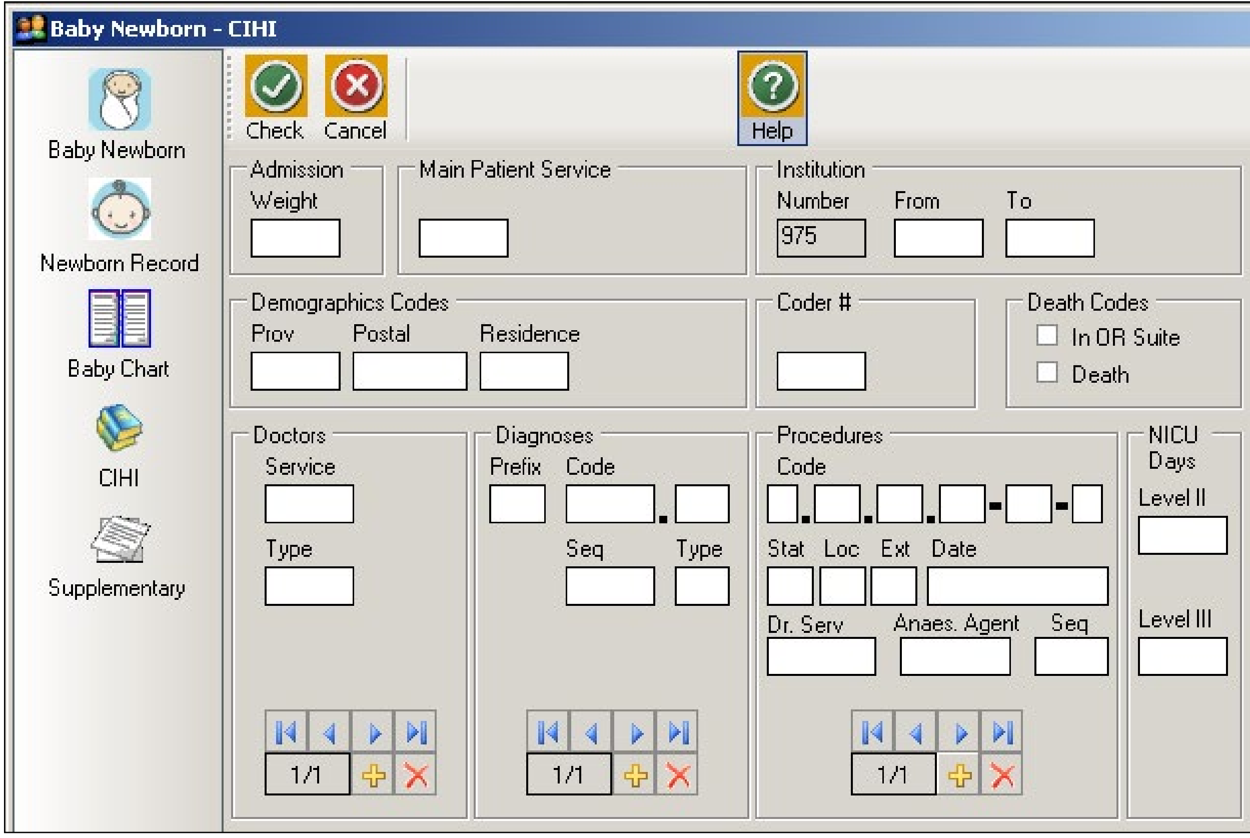
- *Positive culture, not treated but verifed with documentation as an infection; abstract appropriate culture and abstract documented organism.*

Example of Infection - No:

- *Postive culture due to contamination of specimen*

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

5.6 CIHI Data Screen (Baby Newborn)



CIHI data is imported into the CIHI Data Screen when the Period End Procedure is performed.

On occasion, manual entry of the data may be necessary.

*For assistance with DAD Code Tables and Definitions, please consult the **DAD Manual**.*

Admission Weight

The weight (in grams) on admission or at birth.

Main Patient Service

The main patient service categorizes patients according to related diseases, conditions and treatments.

Baby admissions are generally service 54 (Newborn) but other pediatric services are possible.

See DAD manual.

Institution

Number

An identification number assigned to the facility (hospital) by a province or territory Ministry of Health.

From

The four-digit CIHI institution number referring to the hospital from which the patient was transferred.

To

The four-digit CIHI institution number referring to the hospital to which the patient was transferred.

Demographics Codes

Prov

The one digit code that indicates the province of the hospital where the episode of care occurred.

Eg: British Columbia is 9

See DAD manual.

Postal

The full postal code as assigned by Canada Post to identify the patient's place of residence. Valid postal code format is: ANANAN. If postal code is unknown, leave blank and abstract a **Residence** code.

Residence

Use only when the postal code is unknown; in which case, abstract the two-digit alpha **Residence** code (per CIHI's mini postal code) to identify the province, state, or territory of the patient's residence.

See DAD manual.

Coder

The one or two digit coder number identifying the individual responsible for entering the CIHI data, also the last person editing the record.

Death Codes

In OR Suite

The patient died in the operating room or in the post intervention recovery room.

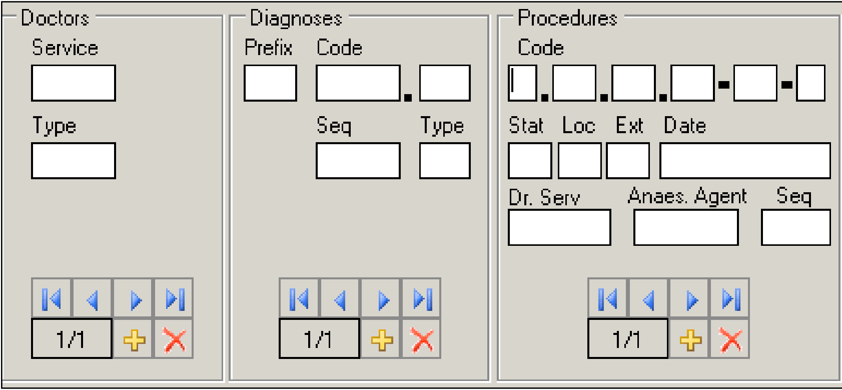
Death

The patient is pronounced dead.

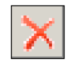
During the Period End Procedure, this field is captured (downloaded) from the Discharge Disposition of the hospital's Health Record Abstracting system.

How to enter Doctors / Diagnoses / Procedures

The CIHI Sub-form is used to enter the data.

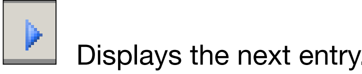


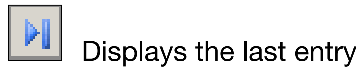
To enter data, press . The sequential number of the entry will automatically display in the box.

To delete data, press .

Displays the first entry.

Displays the previous entry.

 Displays the next entry.

 Displays the last entry.

Doctors

Service

The five-digit number identifying the doctor (provider) specialty service (per CIHI).

See DAD manual.

Type

A one digit number or letter describing the doctor's (provider) role in the care of the patient during hospitalization. A total of eight different doctors (providers) may be abstracted per patient.

See DAD manual.

Diagnoses

Prefix

A hospital assigned alpha or numeric character to further define a diagnosis code.

The following prefixes have been assigned a standard definition by CIHI and are only used for the defined purpose as described below.

Prefix	Standard Definition
C	Cause of death codes
Q	Questionable or query diagnoses

Code

The ICD-10-CA (International Statistical Classification of Diseases and Related Health Problems, 10th revision, Canadian edition) medical diagnostic code reflecting the diagnosis or condition of patient, while in hospital. The code may be up to seven characters in length.

A total of twenty-five different diagnoses may be abstracted per patient.

Seq

The hierarchical order of diagnoses within this admission.

Type

A Diagnosis Type (as per CIHI) is abstracted for each diagnostic code.

See DAD manual.

Procedures

Code

The medical classification of health interventions (procedures) performed during admission is coded using the Canadian Classification of Health Interventions (CCI).

Principal procedure (intervention) is the intervention considered to be the most significant during the patient's hospital stay.

Abstract other relevant procedural information (date, doctor service, anesthetic agent).

Abstract only one anesthetic technique per procedure regardless of the number of anesthetics given. Abstract the highest anesthetic technique.

A total of twenty procedures may be abstracted per patient.

Stat Loc Ext

Status, Location, and Extent are attributes (per CIHI) that provide extra useful detail that does not impact on the essence of the intervention.

Stat: details such as revision, abandoned procedure, delayed, staged, etc.

See DAD manual.

Loc: details such as specific anatomical location of the procedure

Eg: left, right, bilateral, superficial, deep, etc.

See DAD manual.

Ext: details of quantitative measure

Eg: length of laceration performed, number of anatomical structures involved

See DAD manual.

Date

The date (day, month, year) of procedure. When manually entering data, each procedure should have a procedure date.

Dr. Serv

The five-digit number identifying the procedure provider service (per CIHI).

See DAD manual.

Anaes. Agent

The one-digit number that identifies the anesthetic agent technique. Drug administered for medical or surgical procedures (interventions) that induces partial or total loss of sensation.

See DAD manual.

Seq

The hierarchical order of procedures performed during admission.

NICU Days

Use LOS calculation methods.

Eg:

In NICU on Oct. 4 = 1 day
In NICU on Oct. 4 and Oct. 5 = 1 day
In NICU on Oct. 4, 5 and 6 = 2 days

Level II

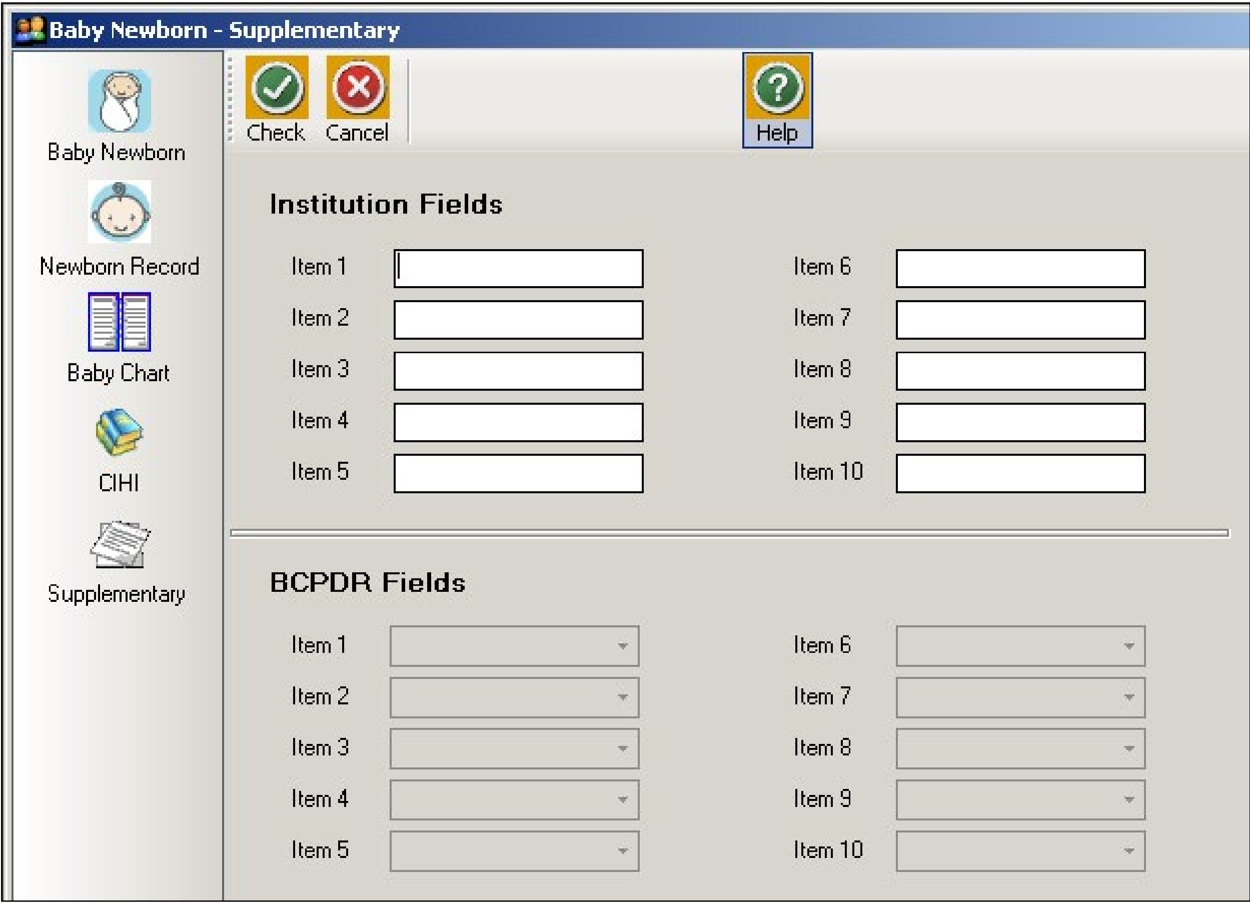
The total number of days (in whole numbers) baby required Level II care in the Neonatal Intensive Care Unit.

Level III

The total number of days (in whole numbers) baby required Level III care in the Neonatal Intensive Care Unit.

*Note: In BC, NICU days are assessed based on the **PSBC Neonatal Levels of Service Tool.** See Province-specific **DAD manual** for information on NICU day abstracting in BC.*

5.7 Supplementary Screen (Baby Newborn)



Institution Fields (Item 1 to 10)

These fields are for Health Authority/Hospital use to capture additional information outside of the current fields within the database. Maintenance and management of these fields will be the responsibility of the Health Authority/Hospital.

See Section 9.6.1 Institution Fields on page 222.

To view the relevant descriptions, policy and procedure, forms and definitions:

See Appendix 10.9 Supplementary Institution Fields on page 255.

BCPDR Fields (Item 1 to 10)

These fields will be assigned and activated by the BCPDR as necessary. The BCPDR will only implement the activation and use of the new fields after approval from the PSBC Executive.

See Section 9.6.2 BCPDR Fields on page 222.

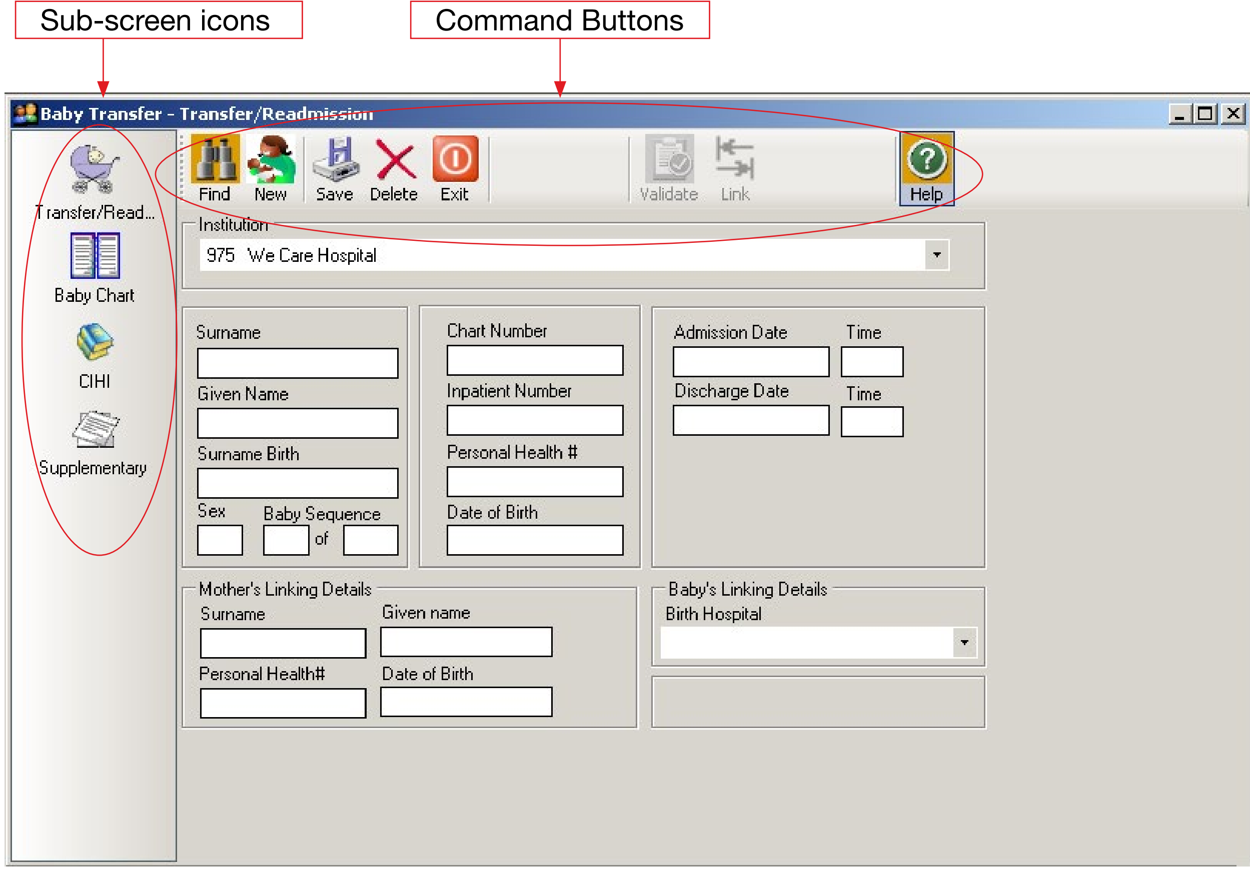
THIS PAGE INTENTIONALLY LEFT BLANK

6. BABY TRANSFER / READMISSION SUITE

6.1 Baby Transfer / Readmission Screen Command Buttons

The Baby Transfer / Readmission suite consists of the Baby Transfer / Readmission screen and sub-screens: Baby Chart, CIHI, and Supplementary.

When the Baby Transfer / Readmission Suite is selected, the following screen appears:



The sub-screen icons activate the Baby Transfer / Readmission sub-screens (Baby Chart, CIHI, and Supplementary).

The command buttons below are displayed across the top of the screen:

Find	Searches the database for a Baby Transfer/Readmission record.
New	Clears the screen for entry of a new Baby Transfer/Readmission record.
Save	Saves the Baby Transfer/Readmission record into the database if all errors are cleared.
Delete	Removes the current Baby Transfer/Readmission record from the database.
Exit	Closes the Baby Transfer/Readmission screen.
Help	Disabled – Do Not Use

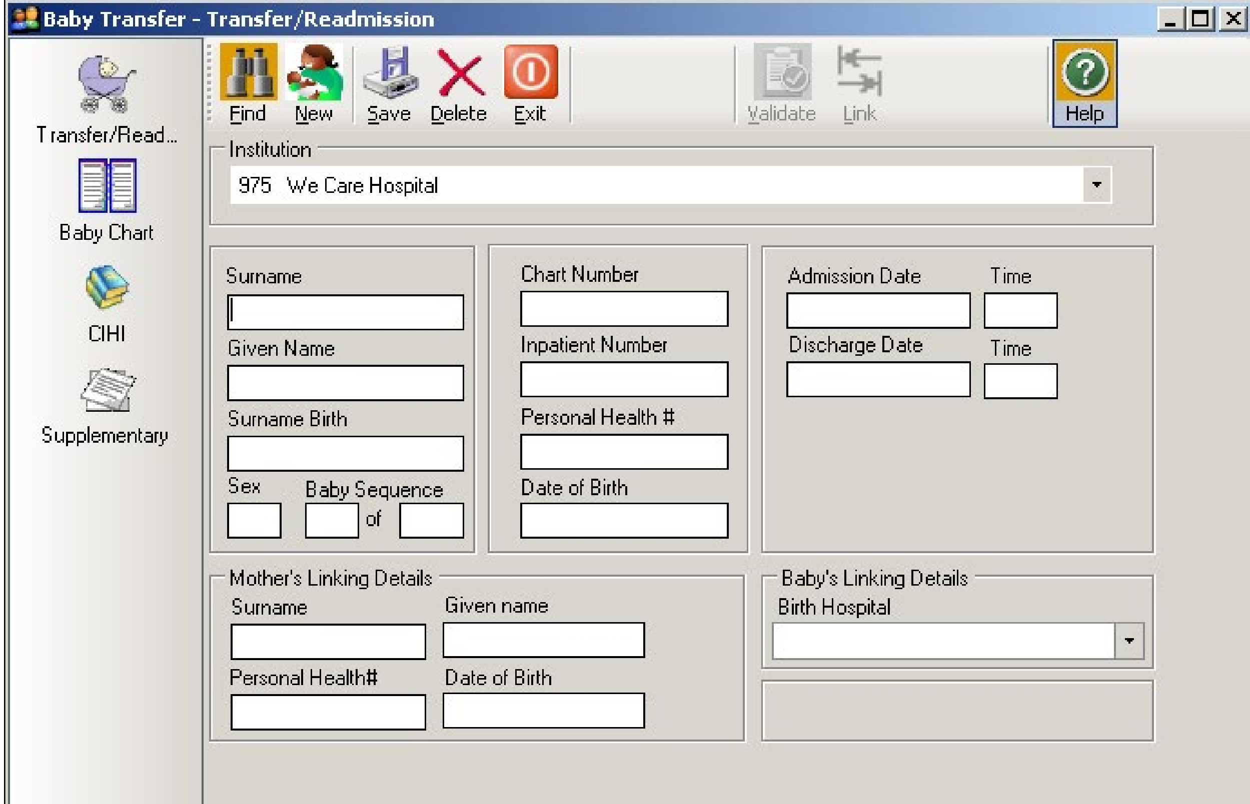
Once a Baby Transfer/Readmission record has been saved, two additional commands become available:

Validate	Identifies specific errors or omissions, if any, in the Baby Transfer/Readmission record. When validation is successful, the CTS (clear to send) flag populates the baby_admission table. The CTS flag is one of the identifiers that indicates a record is ready for exporting.
Link	Allows the current Baby Transfer/Readmission record to be linked to a previously entered Mother record.

6.2 Baby Transfer/Readmission Sub-Screen Command Buttons

Check	Checks for field completion for the screen.
Cancel	Cancels abstracted information for the screen.
Help	Disabled - Do Not Use

6.3 Baby Transfer / Readmission Screen



Surname

The currently used last name of the baby at time of discharge. The surname is the family name associated with the baby and is usually, but not always, shared by family members. All parts of a hyphenated or multi-part surname are included.

Given Name

The child's first given name. If left blank, system will default to Baby when the Baby Transfer screen is saved.

Surname Birth

The surname of the baby documented at birth. It is the mother's surname at the time of the baby's birth.

Sex

Biological and physiological characteristics defining the person.

'M' = Male
'F' = Female
'O' = Other (Eg. Hermaphrodite)

Baby Sequence

First Number

Incremental sequence number for each baby born during the current pregnancy. This sequencing is irrespective of live birth or stillbirth.

Eg: Twin A = sequence 1, Twin B = sequence 2.

Second Number

The total number of babies born during the current pregnancy.

Eg: Singleton = '1'. Twins = '2'.

Chart Number

The baby's unique unit number assigned by the facility. This number is used by the facility, to track all services provided, for the current and subsequent admissions.

***Chart Number** field must match the CIHI chart number exactly, as it appears in the hospital abstracting system, including leading zeros.*

Eg: 0123456, H0123456.

Inpatient Number

The admitting number assigned by the facility to identify the specific baby admission.

Used by the facility (hospital) for baby identification and linkage. Optional use. May be left blank.

Personal Health #

The 10-digit British Columbia Personal Health Number (PHN) is a unique numerical lifetime identifier used to specifically identify an individual having any interaction with the BC Health System. It is assigned to and used by one person and will not be assigned to any other person at any time. For Transfer/Readmission babies without an assigned Personal Health Number abstract the Mother's 10-digit PHN.

Abstract 0 if the PHN is not available or if the PHN is an out of province number.

Date of Birth

The date (day, month, year) the baby was born.

Admission Date

The date (day, month, year) the baby was admitted/transferred to the hospital.

Admission Time

The time the baby was admitted/transferred to the hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

Eg: If the baby is transferred to hospital at midnight New Year's Day, abstract as January 1 at 0000 hours.

Discharge Date

The date (day, month, year) the baby was discharged from, died at, or transferred from, the hospital.

Discharge Time

The time the baby was discharged from hospital, using the 24-hour clock.

Time must be between 0000 and 2359 hours. The day begins at midnight (0000) and ends at 2359.

If discharge time is not documented, abstract 1200 hours.

Eg: If the baby is discharged at midnight, New Year's Day, abstract as January 1 at 0000 hours.

Mother's Linking Details and Baby's Linking Details

Mother's Linking Details
Surname
Given name
Personal Health#
Date of Birth

Baby's Linking Details
Birth Hospital

Mother delivered baby at current hospital or within a shared database:[1]

> All linking details can be automatically populated if the mother delivered the newborn at the current recording hospital or within a shared database by using the Link button.
>
> *See Section 7.2.2 Linking Previously Entered Mother Suite to Baby Transfer / Readmission Suite on page 113.*

Mother delivered baby at another hospital or not within a shared database[1]:

> Manually enter as much detail as possible. Leave blank if unknown or unsure of information. The details may be found from your hospital ADT system or from the transfer information sent to your hospital from the birth hospital.
>
> *Eg: copies of Birth Summary, Antenatal Record*
>
> This information is an essential component of the Registry and is used at PSBC to link the baby to the mother as well as to link the baby to subsequent baby / transfer / readmissions.

Surname

The currently used last name of the mother. The surname is the family name associated with the mother and is usually, but not always, shared by family members. All parts of a hyphenated or multi-part surname are included.

Given name

The first given name of the mother. May be given ethnic name.

Personal Health

The 10-digit British Columbia Personal Health Number (PHN) is a unique numerical lifetime identifier used to specifically identify an individual having any interaction with the BC Health System. It is assigned to and used by one person and will not be assigned to any other person at any time.

Abstract 0 if the PHN is not available or if the PHN is an out of province number.

1 Shared database is a Regional database that contains data from more than one facility

Date of Birth

The date (day, month, year) the mother was born.

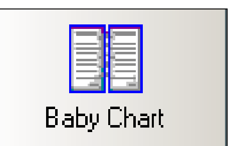
Birth Hospital

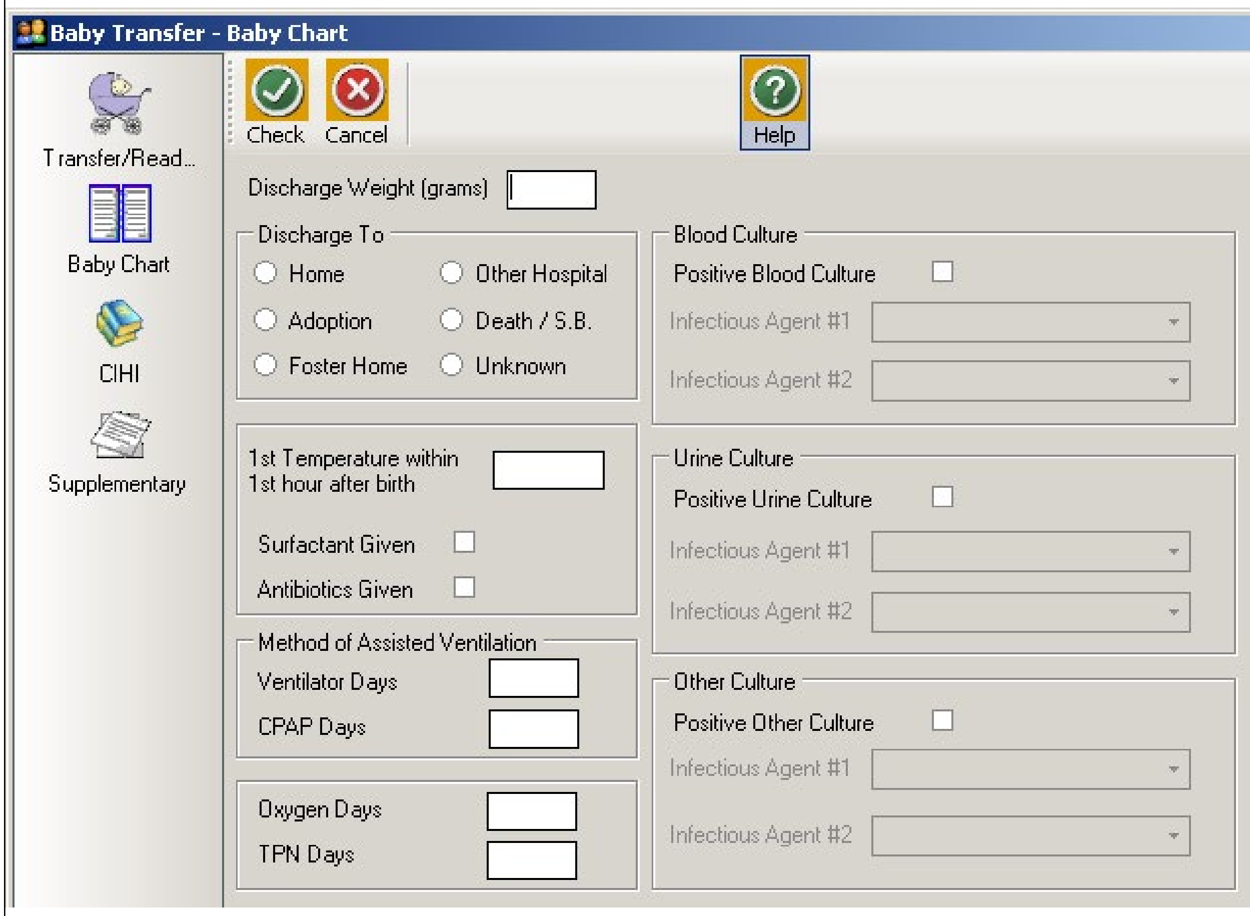
The hospital where the baby was born.

When manually abstracting the birth hospital, the drop down list should be used. Select the Down Arrow at the right of the field box, enter the first (or more) letter(s) of the birth hospital, and choose the appropriate hospital from the list. The user may also cursor down to choose the appropriate hospital.

The birth hospital may be different than the hospital the baby was transferred from or to.

6.4 Baby Chart Screen (Baby Transfer / Readmission)





Discharge Weight

The baby's weight (in grams) at discharge from facility.

If there is no weight at discharge, abstract the last value documented, close to discharge.

Discharged To

Where the baby was discharged to or the status of the baby at the time of discharge.

Home

Discharged home.

Adoption

Discharged home with adoptive parents.

Foster Home

Baby was discharged home with foster parents.

Eg: Baby was apprehended by the Ministry, then discharged home with grandmother.

Other Hospital

Transferred to another hospital.

Death / SB

Baby was a neonatal death.

Unknown

It is unknown where the baby was discharged to.

1st Temperature within 1st hour after birth

The value of the first temperature (in Celsius to one decimal place) taken within the first hour of birth.

Abstract only for newborns transferred to your hospital within the first hour of birth.

Surfactant Given

Surfactant was administered to the baby during the current hospital admission.

Other names for surfactant include: curosurf, exosurf, infosurf, survanta, and Bovine Lipid Extract Surfactant (BLES).

Antibiotics Given

Antibiotics were administered to the baby during hospital admission.

Method of Assisted Ventilation

Use LOS calculation methods.

Eg:

Oct. 4 = 1 day
Oct. 4 and Oct. 5 = 1 day
Oct. 4, 5 and 6 = 2 days

Each field is independent of the other(s).

*Eg: If baby receives CPAP for 5 days and receives oxygen via CPAP for two of these five days, abstract 5 **CPAP Days** and 2 **Oxygen Days**.*

*Eg: If baby is on a ventilator for 4 days, is taken off the ventilator, and receives oxygen via nasal prongs for 3 days, abstract 4 **Ventilator Days** and 3 **Oxygen Days**.*

Ventilator Days

The total number of days (in whole numbers) the baby was on a ventilator.

CPAP Days

The total number of days (in whole numbers) the baby was on Continuous Positive Airway Pressure (CPAP).

Includes Biphasic CPAP, BiPAP, SiPAP, Bubble, and CPAP.

*If baby receives oxygen via CPAP, also abstract for **Oxygen Days.***

If you are unsure how CPAP is documented at your site, please contact your neonatal care providers.

Oxygen Days

The total number of days (in whole numbers) the baby received oxygen therapy or nasal prongs.

0.21 or 21% is considered room air. Anything above this value is classified as oxygen.

Oxygen >21% can be delivered by CPAP, ventilator, oxyhood, incubator, or high flow nasal prongs.

Low flow nasal prongs are always considered oxygen.

TPN Days

The total number of days (in whole numbers) the baby received any total parenteral nutrition (sometimes called TPN).

Blood Culture

Positive Blood Culture

Abstract if the baby's blood culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive blood culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive blood culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Urine Culture

Positive Urine Culture

Abstract if the baby's urine culture test results were positive.

Infectious Agent #1

The most significant infectious agent causing positive urine culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing positive urine culture results in the baby.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Other Culture

Positive Other Culture

Abstract if other lab culture test results were positive for the baby other than blood and urine.

Eg: sputum, stool

Infectious Agent #1

The most significant infectious agent causing other positive culture results in the baby, other than blood and urine.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

Infectious Agent #2

Other infectious agent causing other positive culture results in the baby, other than blood and urine.

See Section 9.5.1.14 Coded Field Values: Infectious Agents on page 215.

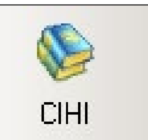
Examples of Infection - Yes:

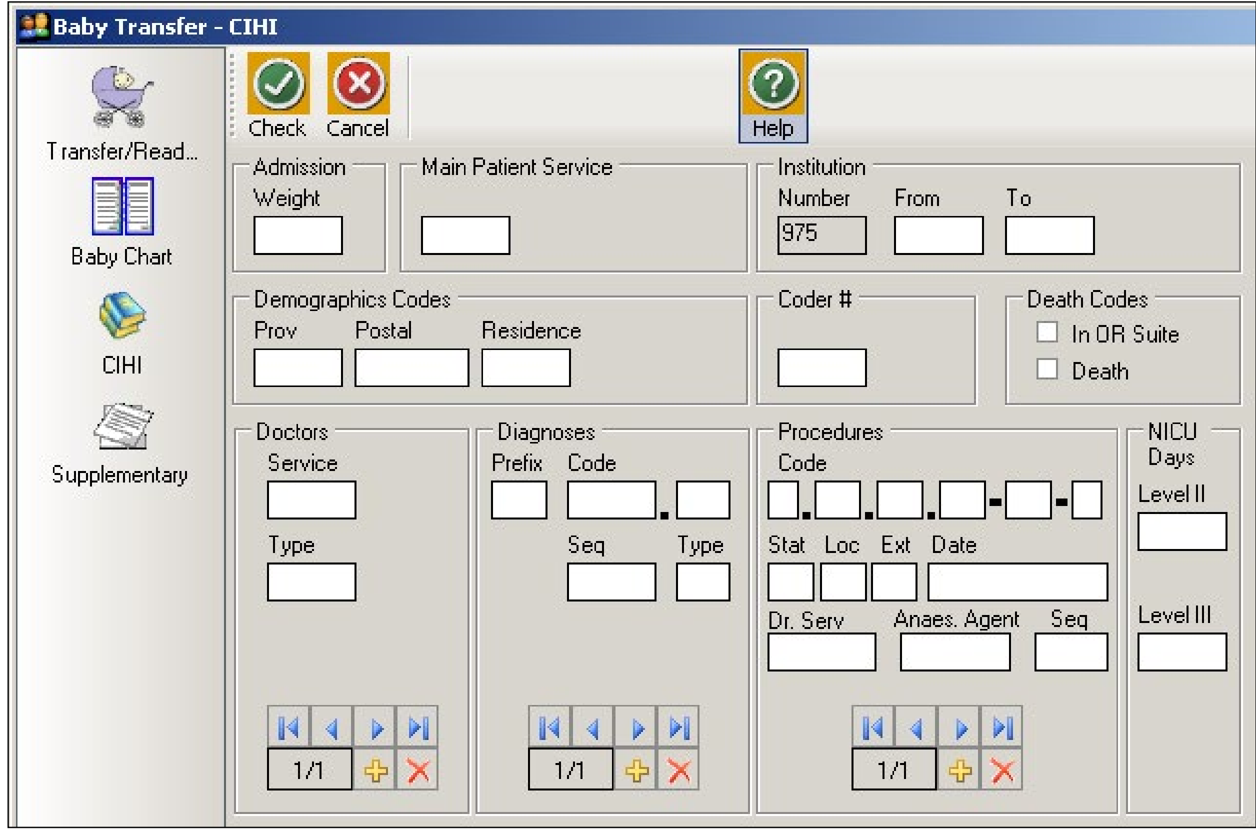
- *Positive culture, not treated but verifed with documentation as an infection; abstract appropriate culture and abstract documented organism.*

Example of Infection - No:

- *Postive culture due to contamination of specimen*

6.5 CIHI Data Screen (Baby Transfer / Readmission)





CIHI data is imported into the CIHI Data Screen when the Period End Procedure is performed.

On occasion, manual entry of the data may be necessary.

For assistance with DAD Code Tables and Definitions, please consult the ***DAD Manual***.

Admission Weight

The weight (in grams) on admission.

Main Patient Service

The main Patient Service categorizes patients according to related diseases, conditions and treatments.

Baby Transfer / Readmissions are generally service 20 (Pediatrics) or 97 (Neonatology), but other pediatric services are possible.

See DAD manual.

Institution

Number

An identification number assigned to the facility (hospital) by a province or territory Ministry of Health.

From

The four-digit CIHI institution number referring to the hospital from which the patient was transferred.

To

The four-digit CIHI institution number referring to the hospital to which the patient was transferred.

Demographics Codes

Prov

The one digit code that indicates the province of the hospital where the episode of care occurred.

Eg: British Columbia is 9

See DAD manual.

Postal

The full postal code as assigned by Canada Post to identify the patient's place of residence. Valid postal code format is: ANANAN. If postal code is unknown, leave blank and abstract a **Residence** code.

Residence

Use only when the postal code is unknown; in which case, abstract the two-digit alpha **Residence** code (per CIHI's mini postal code) to identify the province, state, or territory of the patient's residence.

See DAD manual.

Coder

The one or two digit coder number identifying the individual responsible for entering the CIHI data, also the last person editing the record.

Death Codes

In OR Suite

The patient died in the operating room or in the post intervention recovery room.

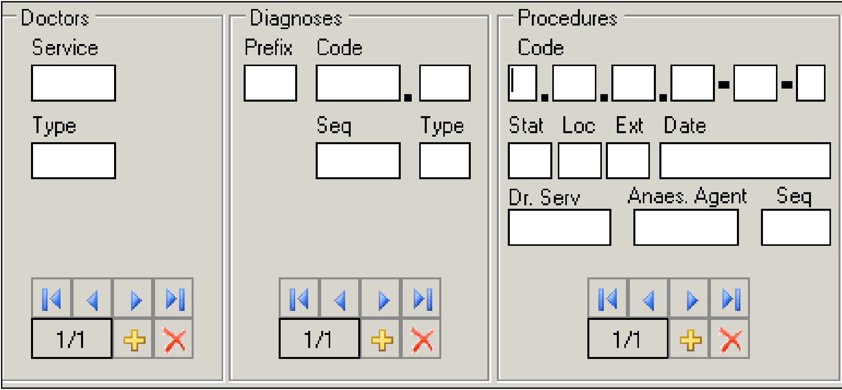
Death

The patient is pronounced dead.

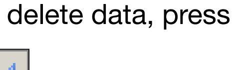
During the Period End Procedure, this field is captured (downloaded) from the Discharge Disposition of the hospital's Health Record Abstracting system.

How to enter Doctors / Diagnoses / Procedures

The CIHI Sub-form is used to enter the data.

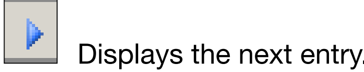


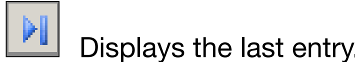
To enter data, press . The sequential number of the entry will automatically display in the box.

To delete data, press .

Displays the first entry.

Displays the previous entry.

 Displays the next entry.

 Displays the last entry.

Doctors

Service

The five-digit number identifying the doctor (provider) specialty service (per CIHI).

See DAD manual.

Type

A one digit number or letter describing the doctor's (provider) role in the care of the patient during hospitalization. A total of eight different doctors (providers) may be abstracted per patient.

See DAD manual.

Diagnoses

Prefix

A hospital assigned alpha or numeric character to further define a diagnosis code.

The following prefixes have been assigned a standard definition by CIHI and are only used for the defined purpose as described below.

Prefix	Standard Definition
C	Cause of death codes
Q	Questionable or query diagnoses

Code

The ICD-10-CA (International Statistical Classification of Diseases and Related Health Problems, 10th revision, Canadian edition) medical diagnostic code reflecting the diagnosis or condition of patient, while in hospital. The code may be up to seven characters in length.

A total of twenty-five different diagnoses may be abstracted per patient.

Seq

The hierarchical order of diagnoses within this admission.

Type

A Diagnosis Type (as per CIHI) is abstracted for each diagnostic code.

See DAD manual.

Procedures

Code

The medical classification of health interventions (procedures) performed during admission is coded using the Canadian Classification of Health Interventions (CCI).

Principal procedure (intervention) is the intervention considered to be the most significant during the patient's hospital stay.

Abstract other relevant procedural information (date, doctor service, anesthetic agent).

Abstract only one anesthetic technique per procedure regardless of the number of anesthetics given. Abstract the highest anesthetic technique.

A total of twenty procedures may be abstracted per patient.

Stat Loc Ext

Status, Location, and Extent are attributes (per CIHI) that provide extra useful detail that does not impact on the essence of the intervention.

Stat: details such as revision, abandoned procedure, delayed, staged, etc.

See DAD manual.

Loc: details such as specific anatomical location of the procedure

Eg: left, right, bilateral, superficial, deep, etc.

See DAD manual.

Ext: details of quantitative measure

Eg: length of laceration performed, number of anatomical structures involved

See DAD manual.

Date

The date (day, month, year) of procedure. When manually entering data, each procedure should have a procedure date.

Dr. Serv

The five-digit number identifying the procedure provider service (per CIHI).

See DAD manual.

Anaes. Agent

The one-digit number that identifies the anesthetic agent technique. Drug administered for medical or surgical procedures (interventions) that induces partial or total loss of sensation.

See DAD manual.

Seq

The hierarchical order of procedures performed during admission.

NICU Days

Use LOS calculation methods.

Eg:

In NICU on Oct. 4 = 1 day
In NICU on Oct. 4 and Oct. 5 = 1 day
In NICU on Oct. 4, 5 and 6 = 2 days

Level II

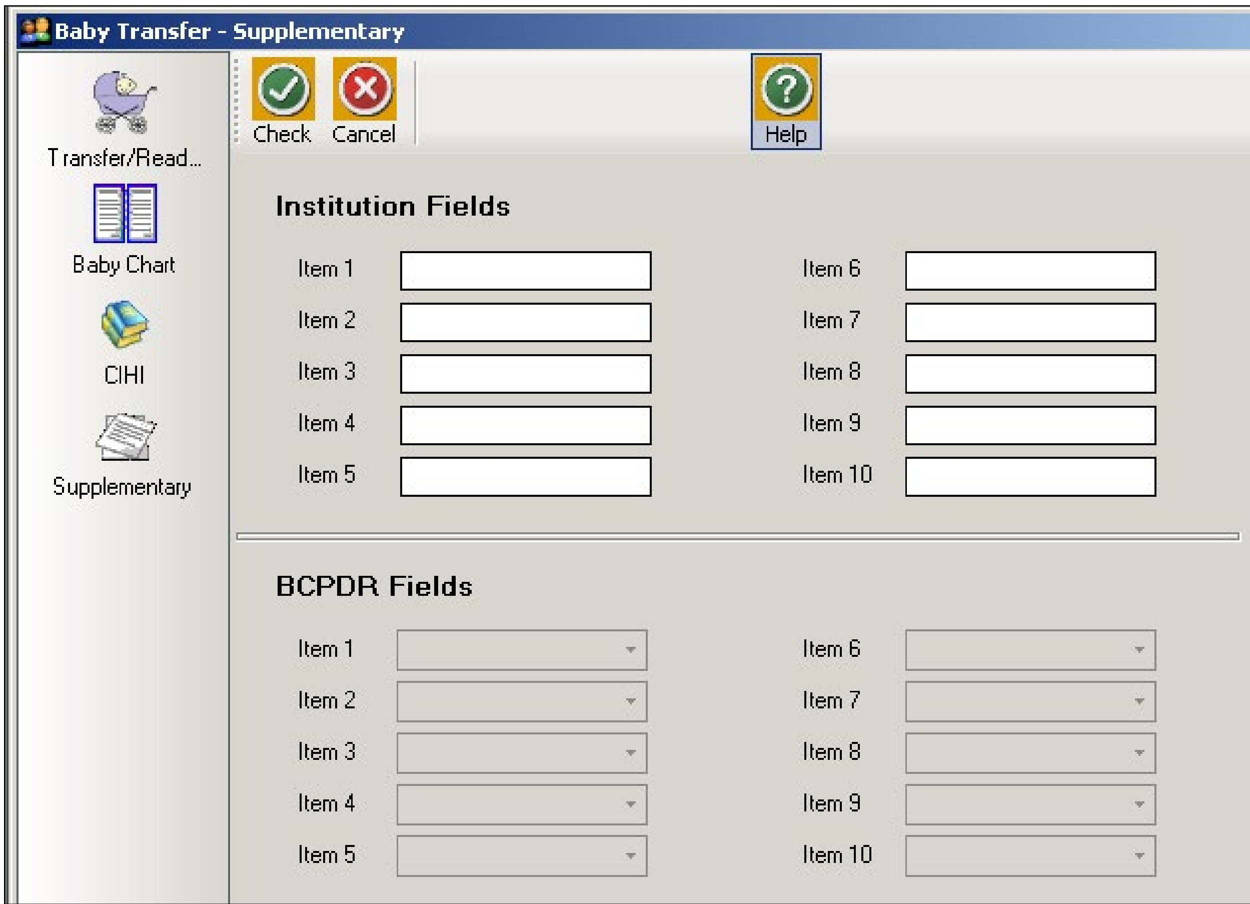
The total number of days (in whole numbers) baby required Level II care in the Neonatal Intensive Care Unit.

Level III

The total number of days (in whole numbers) baby required Level III care in the Neonatal Intensive Care Unit.

*Note: In BC, NICU days are assessed based on the **PSBC Neonatal Levels of Service Tool.** See Province-specific **DAD manual** for information on NICU day abstracting in BC.*

6.6 Supplementary Screen (Baby Transfer / Readmission)



Institution Fields (Item 1 to 10)

These fields are for Health Authority/Hospital use to capture additional information outside of the current fields within the database. Maintenance and management of these fields will be the responsibility of the Health Authority/Hospital.

See Section 9.6.1 Institution Fields on page 222.

To view the relevant descriptions, policy and procedure, forms and definitions:

See Appendix 10.9 Supplementary Institution Fields on page 255.

BCPDR Fields (Item 1 to 10)

These fields will be assigned and activated by the BCPDR as necessary. The BCPDR will only implement the activation and use of the new fields after approval from the PSBC Executive.

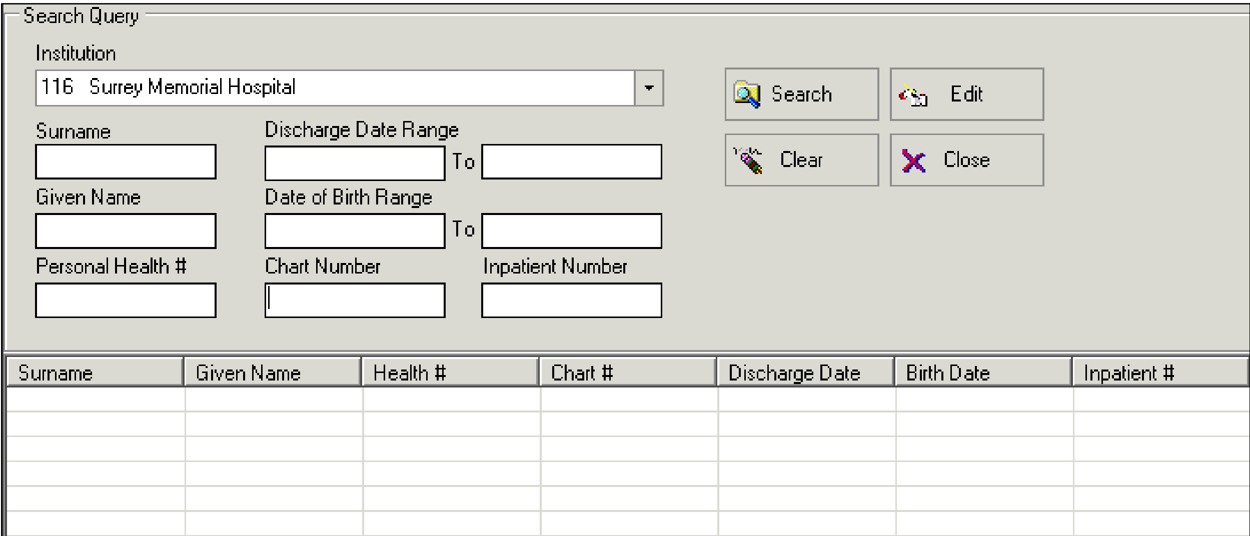
See Section 9.6.2 BCPDR Fields on page 222.

7. FUNCTIONS

7.1 Finding Existing Records

To find an existing record previously entered into the database, select the **Find** button displayed across the top of the first screen of each Suite

The Search Query screen will appear:



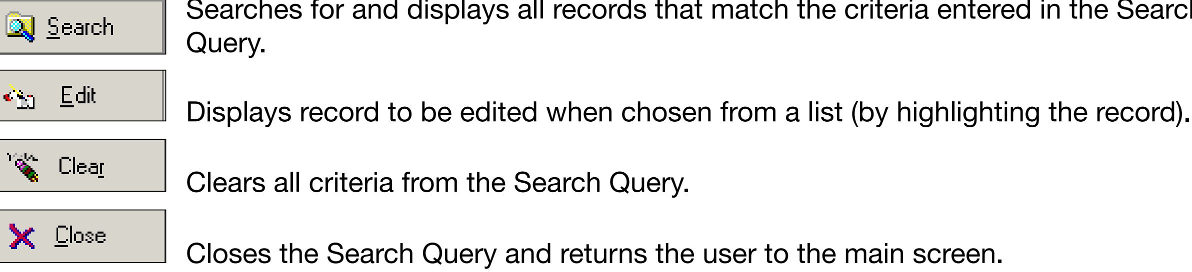
Only records from the institution identified on the **Institution** field will be found.

If no criterion is entered in the Search Query screen and **Search** is selected, ALL records from the active institution will display.

7.1.1 Searching for a Range of Records

The search query is defaulted to the **Chart Number** field but the user may also search for a single record by entering the **Surname**, **Given Name**, **Personal Health #** or **Inpatient Number** in the Search Query fields. For querying ranges, enter a **Discharge Date Range**, **Date of Birth Range** or part of a name in the Search Query fields. After the criteria are entered, select the **Search** button. Records matching the criteria entered into the Search Query screen fields will display at the bottom of the screen.

Highlight and click on **Edit** for the selected record or double-click directly on the selected record. Sort records by clicking on the Column Headings (**Surname**, **Given Name**, **Health#**, **Chart#**, etc).



Searches for and displays all records that match the criteria entered in the Search Query.

Displays record to be edited when chosen from a list (by highlighting the record).

Clears all criteria from the Search Query.

Closes the Search Query and returns the user to the main screen.

7.2 Linking and Unlinking Suites

It is preferable to link from the Baby Newborn Suite to the Mother Suite to minimize linking errors. A mother and a newborn will only come to the BCPDR linked when these four conditions have been met:

1. Mother and Baby Newborn records have both been saved and validated
2. Mother and Baby Newborn records are linked in your hospital database
3. Mother and Baby Newborn records both have CIHI information

4a. Mother and Baby Newborn records are sent to PSBC in the same data submission file

or

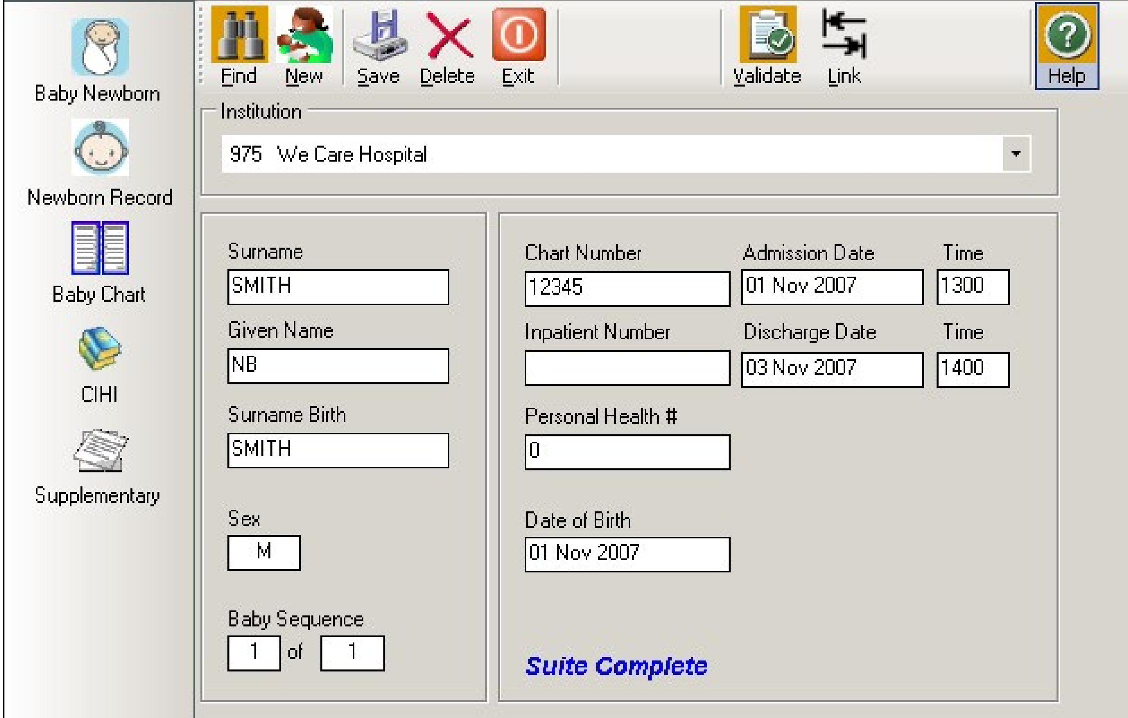
4b. Baby Newborn record is sent in a later file submission than the mother

Note: If the Baby Newborn record is sent from an earlier file submission than the Mother record, link the Mother record from the Baby Newborn record.

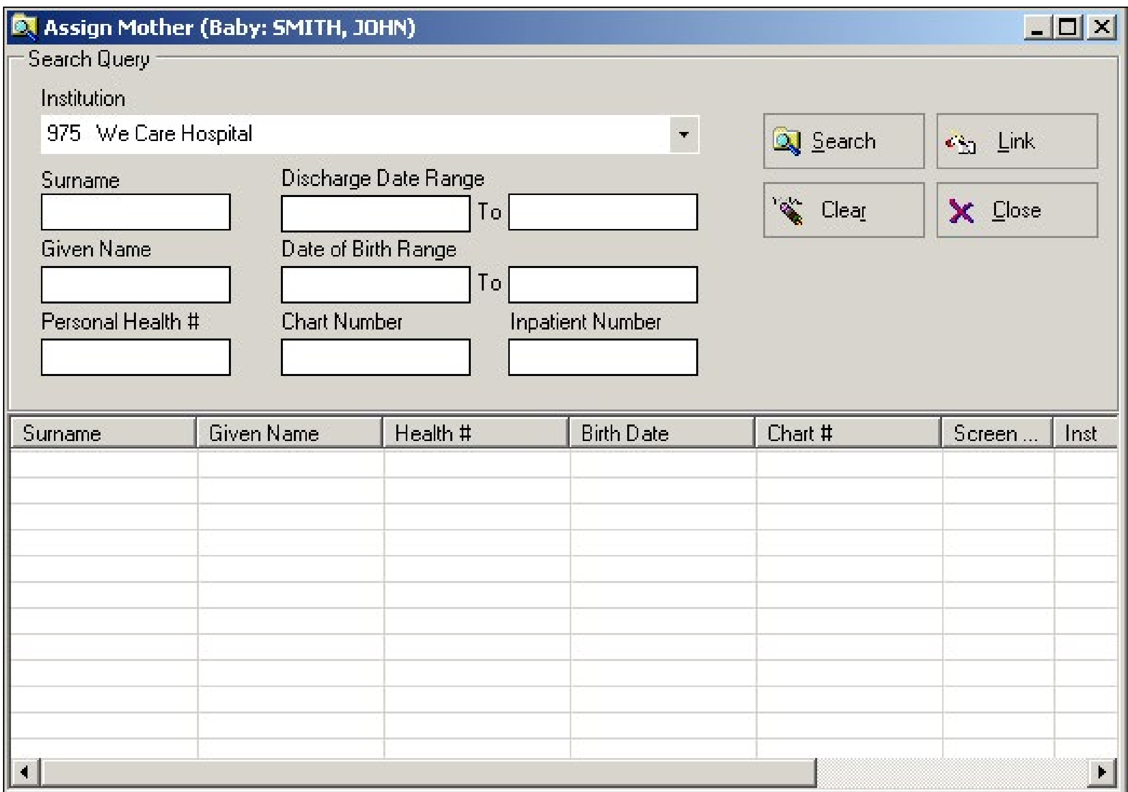
7.2.1 Linking Previously Entered Mother Suite to Baby Newborn Suite

This procedure allows a previously entered Mother Suite (that has been saved and validated) to be linked to the Baby Newborn Suite currently being entered.

a) After entry is complete, **Save** and **Validate** the Baby Newborn Suite. Select **Link**.

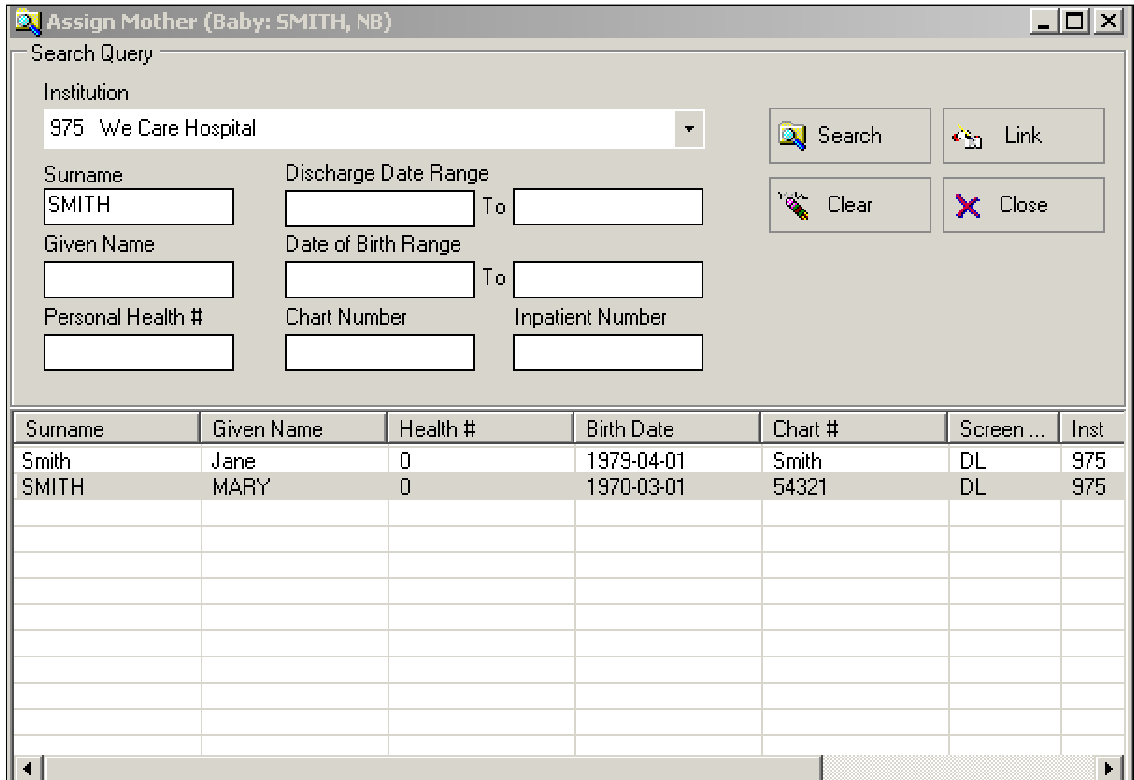


b) An Assign Mother – Search Query screen will display.

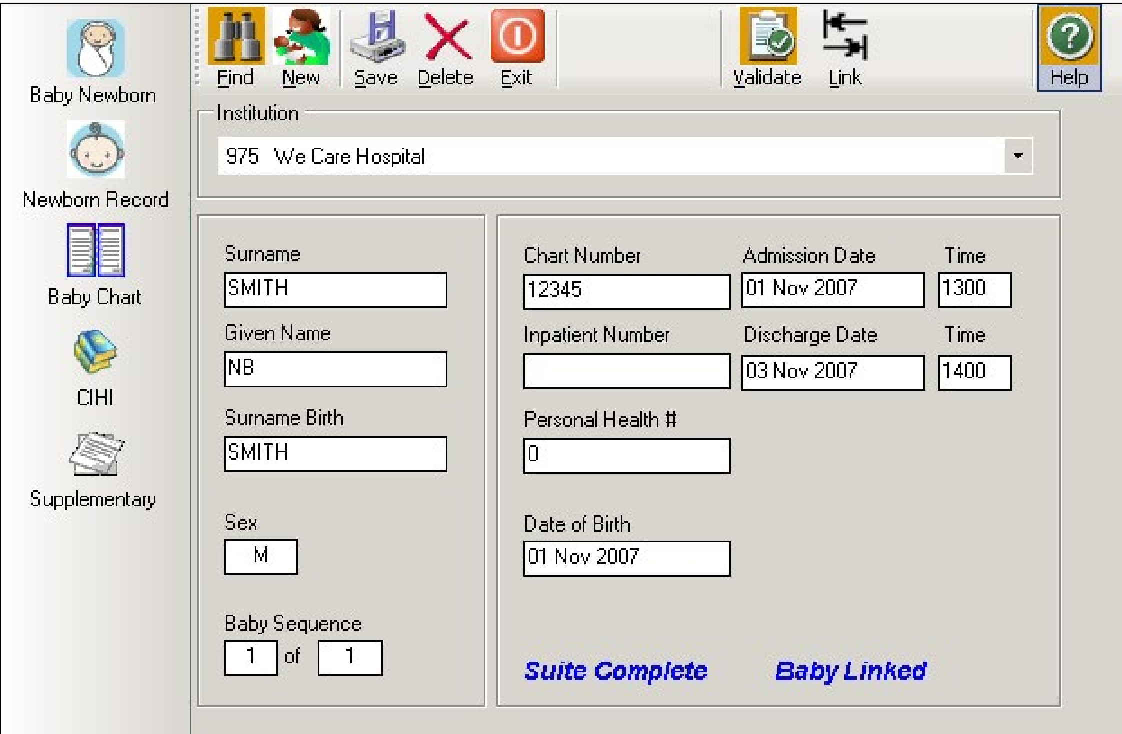


c) How to find and assign the appropriate Mother record:

- Enter identifying information for one field (ie: **Surname**, **Given Name**, **Chart Number**, **Inpatient Number** or **Personal Health #**) to find the appropriate Mother record.
- If the identifying information is not known, the user may search for a range of records, such as Mother's date of birth or discharge date.
- If no data is entered into this screen and **Search** is selected, all Mother records in the database will be displayed.
- Use the up and down arrows and/or scroll bar to find the appropriate Mother record.
- Highlight the correct Mother record by clicking on the appropriate Mother record.
- Select **Link** to link the Mother record to the Baby Newborn record. It is possible to link more than one Baby Newborn record to a Mother record.
- Select **Close** to return to the Main Screen.

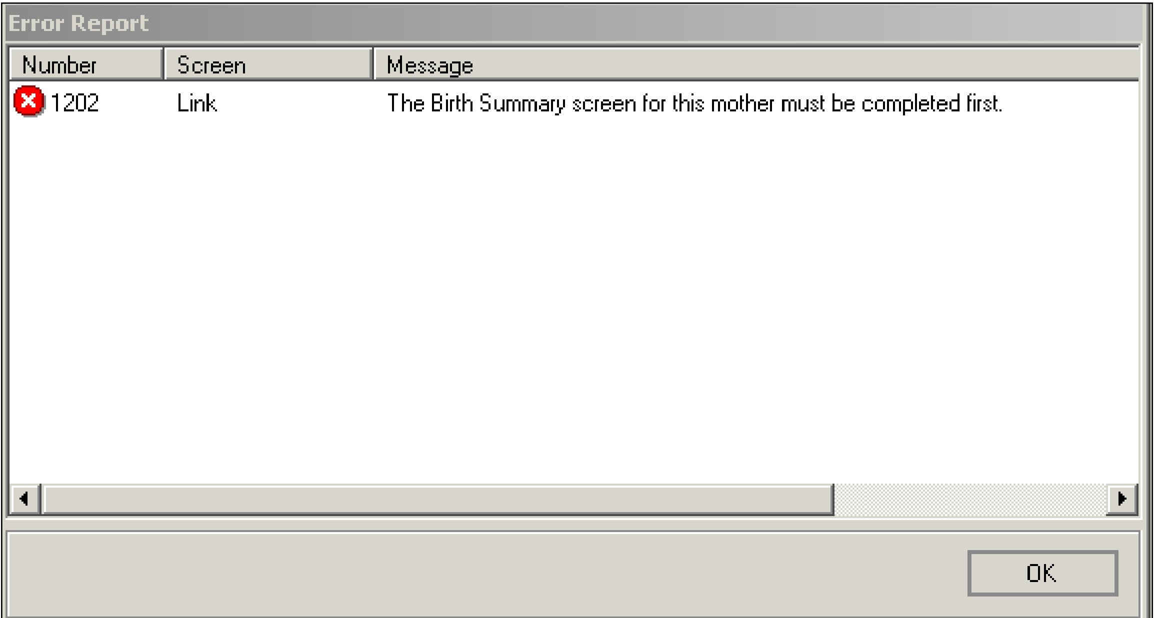


d) Select **Save** and **Validate** to complete the link. If the record is exited prior to saving the record, the link between the records will be lost.

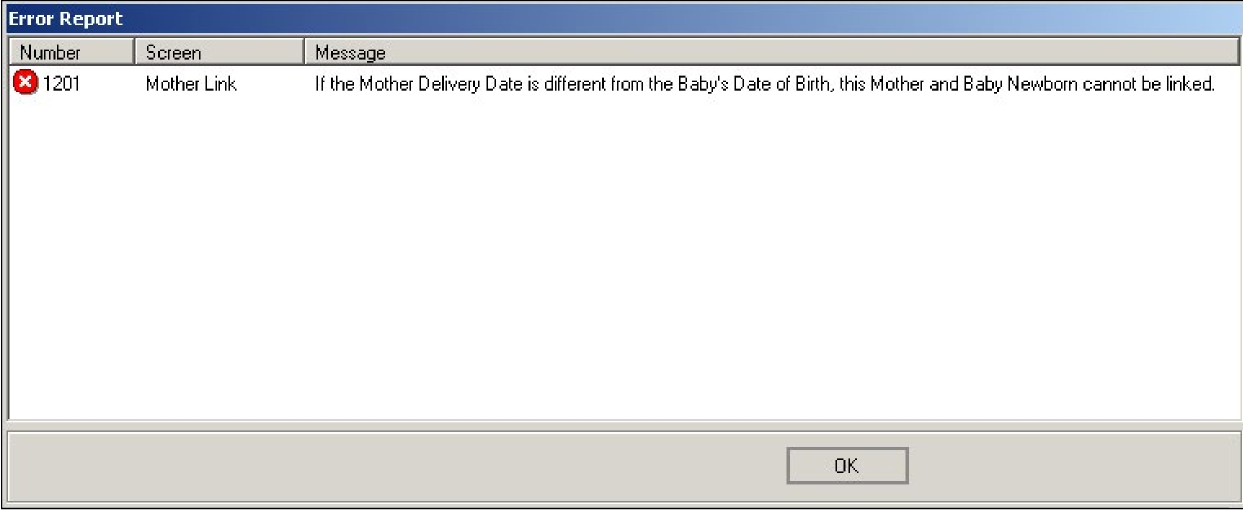


The linkage is now complete. The message *Baby Linked* will display.

If the user attempts to link a Baby Newborn record prior to completion of the Birth Summary Screen in the Mother Suite the following error will appear:



If the Baby Newborn's **Date of Birth** is different than the **Delivery Date** on the Birth Summary Screen in the Mother Suite the following error will appear:

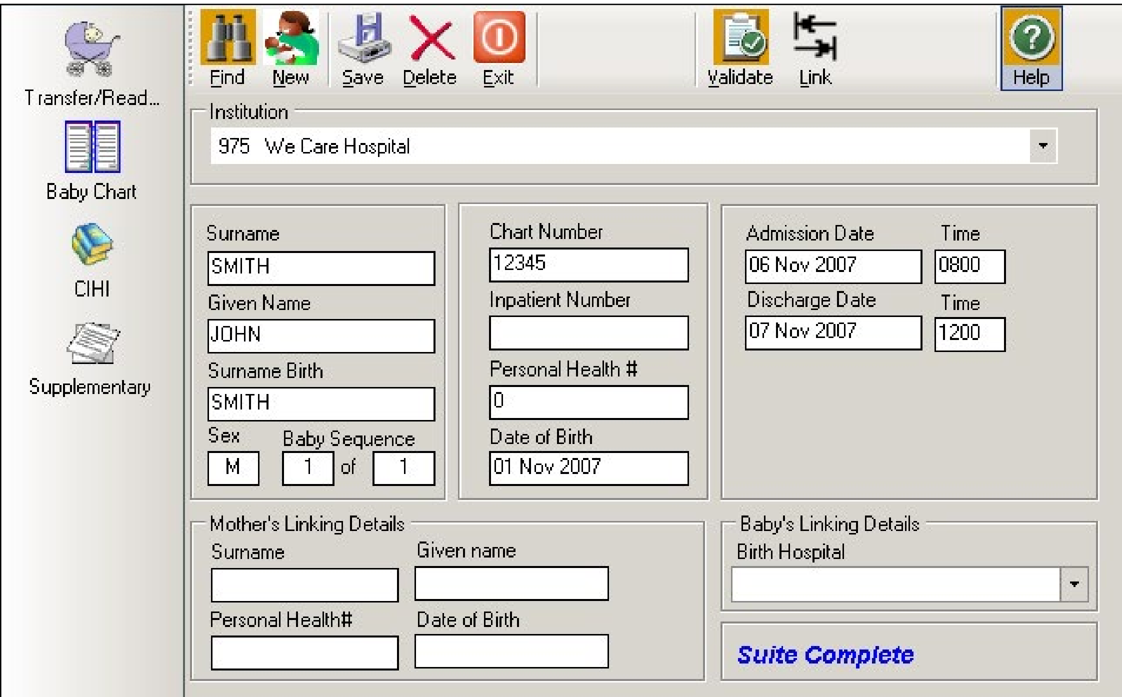


7.2.2 Linking Previously Entered Mother Suite to Baby Transfer/Readmission Suite

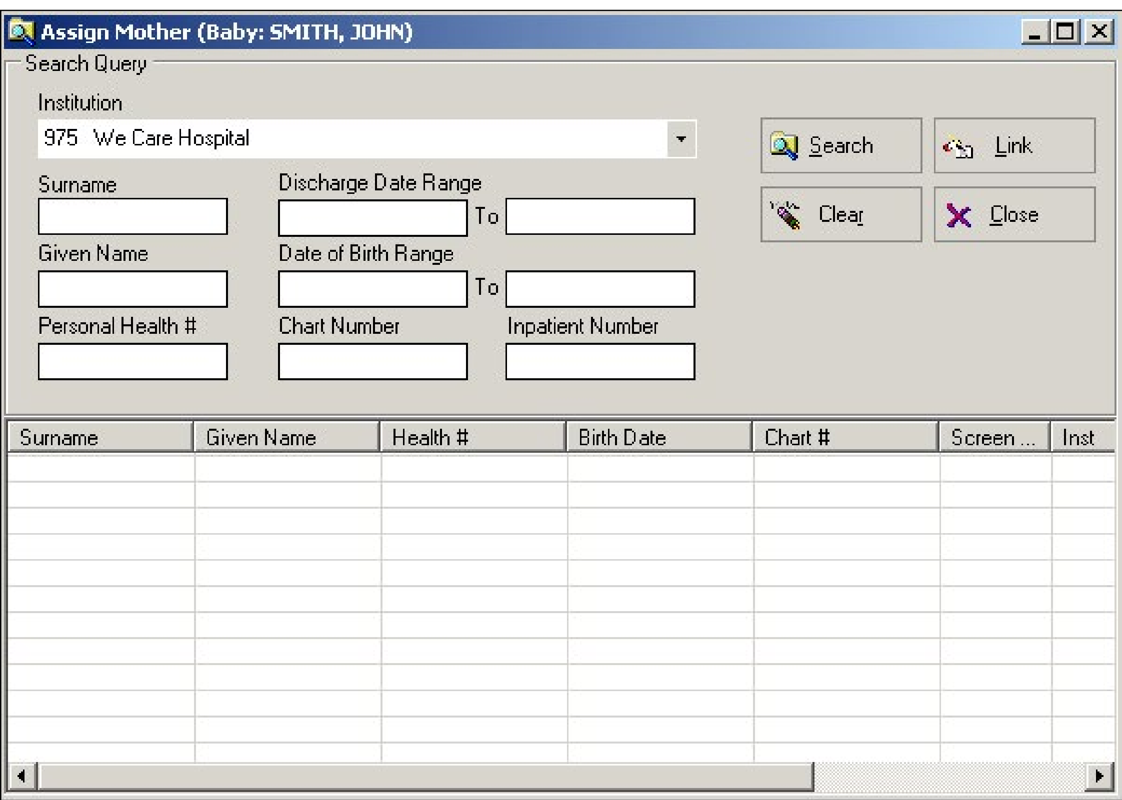
Mother delivered baby at current hospital or within a shared database:

This procedure allows a previously entered Mother Suite (that has been saved and validated) to be linked to the Baby Transfer/Readmission Suite.

a) After entry is complete, **Save** and **Validate** the Baby/Transfer Readmission Suite. Select **Link**.

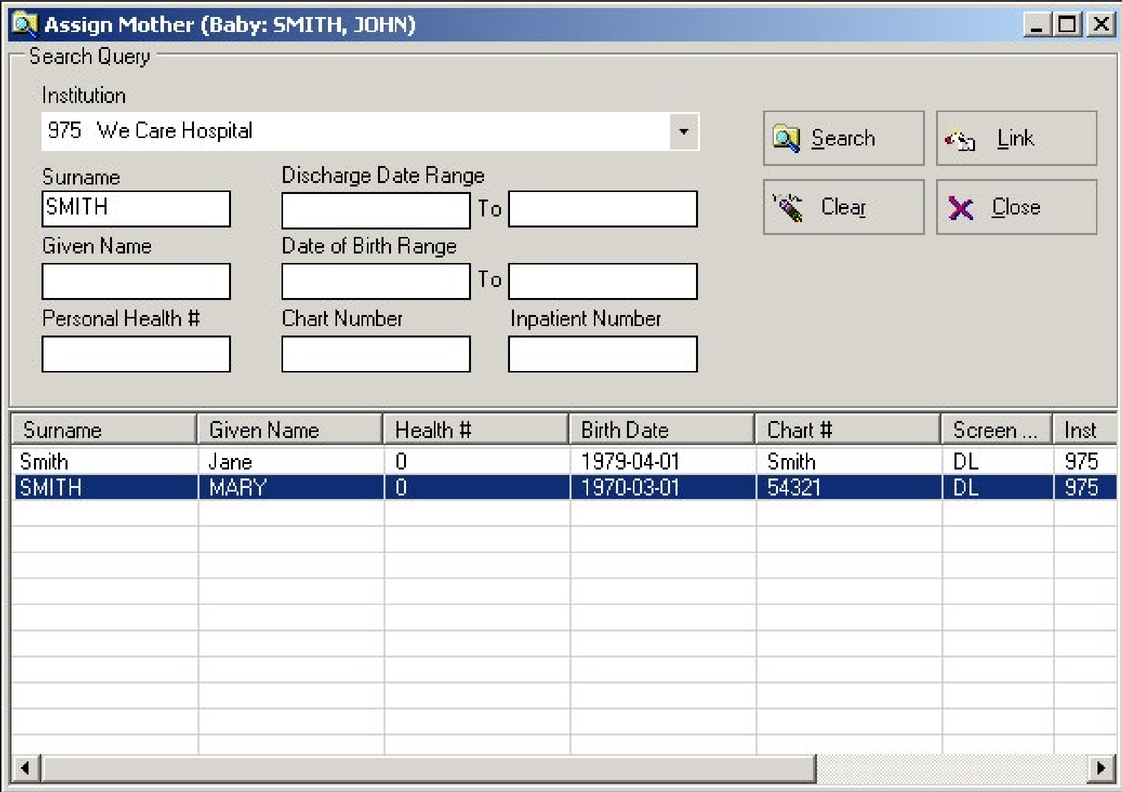


b) An Assign Mother – Search Query screen will display.

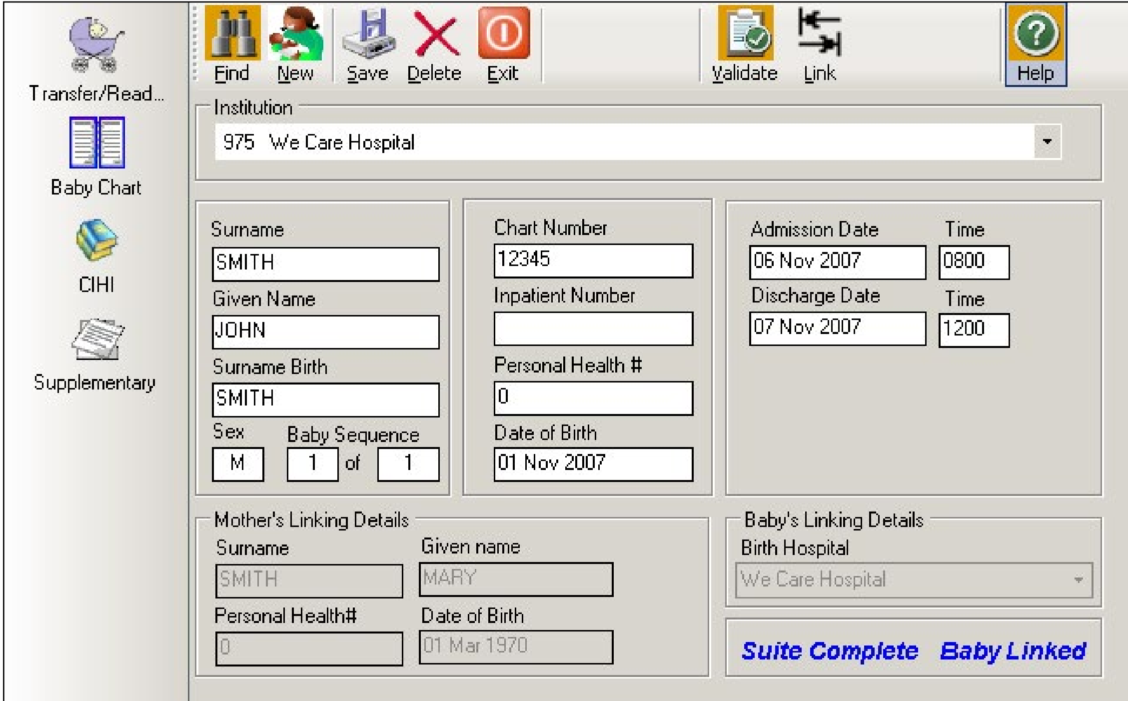


c) How to find and assign the appropriate Mother record:

- Change the **Institution** to the delivery hospital within the shared database, if it is different than the default institution.
- Enter identifying information for one field (ie: **Surname**, **Given Name**, **Chart Number**, **Inpatient Number** or **Personal Health #**) to find the appropriate Mother record.
- If the identifying information is not known, the user may search for a range of records, such as Mother's date of birth or discharge date.
- If no data is entered into this screen and **Search** is selected, all Mother records in the database will be displayed.
- Use the up and down arrows and/or scroll bar to find the appropriate Mother record.
- Highlight the correct Mother record by clicking on the appropriate Mother record.
- Select **Link** to link the Mother record to the Baby/Transfer Readmission record.
- Select **Close** to return to the main Baby/Transfer Readmission screen.



d) Select **Save** and **Validate** to link the Mother to the Baby Transfer/Readmission screen.



The **Mother's Linking Details** and **Baby's Linking Details** will be automatically populated. The message *Baby Linked* will display.

Mother delivered baby at another hospital or not within a shared database:

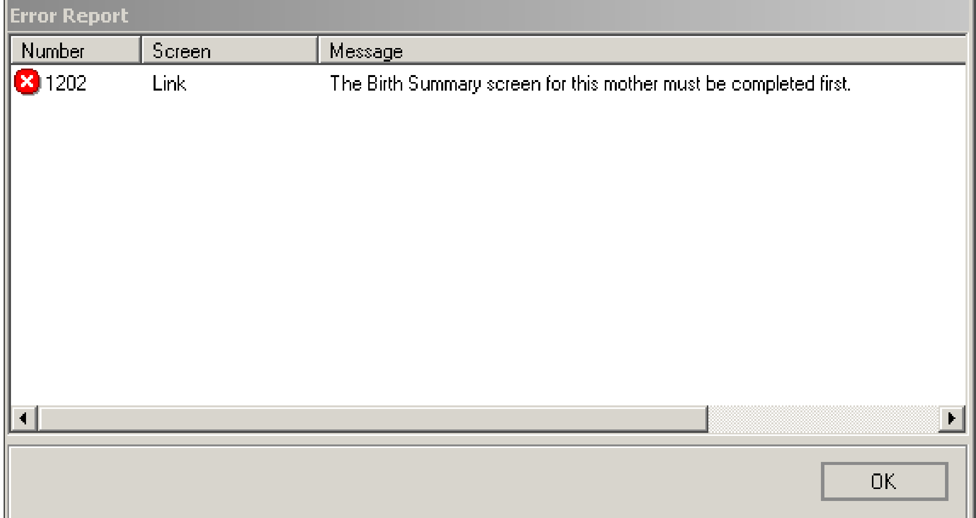
The **Mother's Linking Details** fields must be entered manually. Ensure that the information entered is accurate. Leave blank if the information is unknown or uncertain. The details may be found from the transfer information sent to your hospital from the birth hospital (Eg: copies of Birth Summary, Antenatal Record).

The **Baby's Linking Details – Birth Hospital** field should be completed by using the drop-down list. Select the Down Arrow from the **Birth Hospital** field. Enter the first (or first few) letter(s) of the birth hospital. Choose the appropriate hospital from the list.

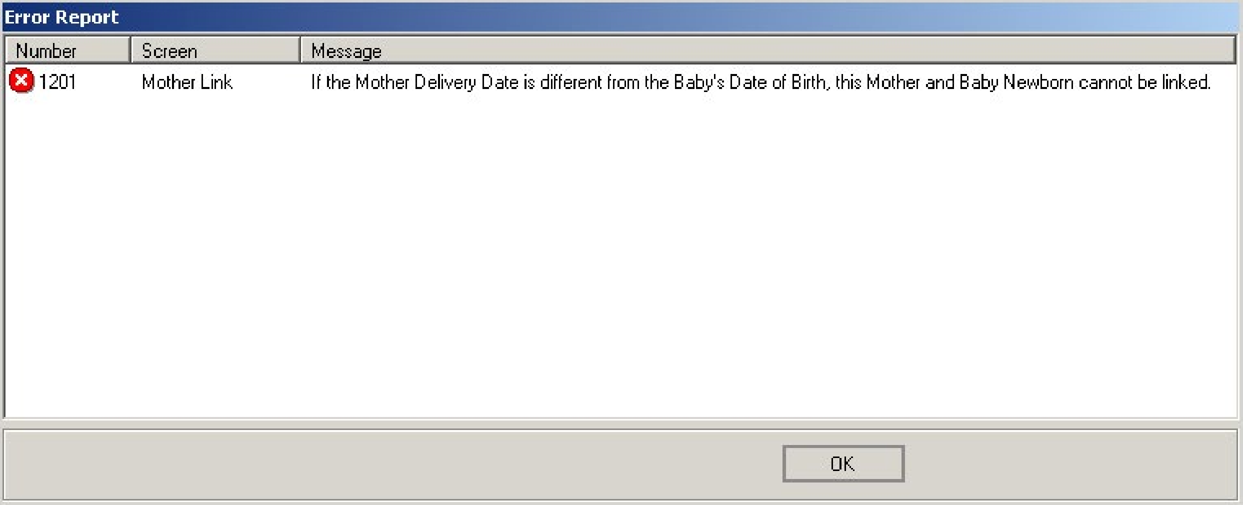
This information is an essential part of the Registry and is used at PSBC to link the Baby Newborn record with the Mother record as well as to link the Baby Newborn record to subsequent Baby/ Transfer Readmission records.

Note: If baby is readmitted to the same hospital as the birth hospital, ensure that the ***Mother's Linking Details*** *are filled out using the Linkage procedure – 7.2.4. Do not enter the information manually*.

If the user attempts to link a Baby Transfer/Readmission record prior to completion of the Birth Summary Screen in the Mother Suite the following error will appear:



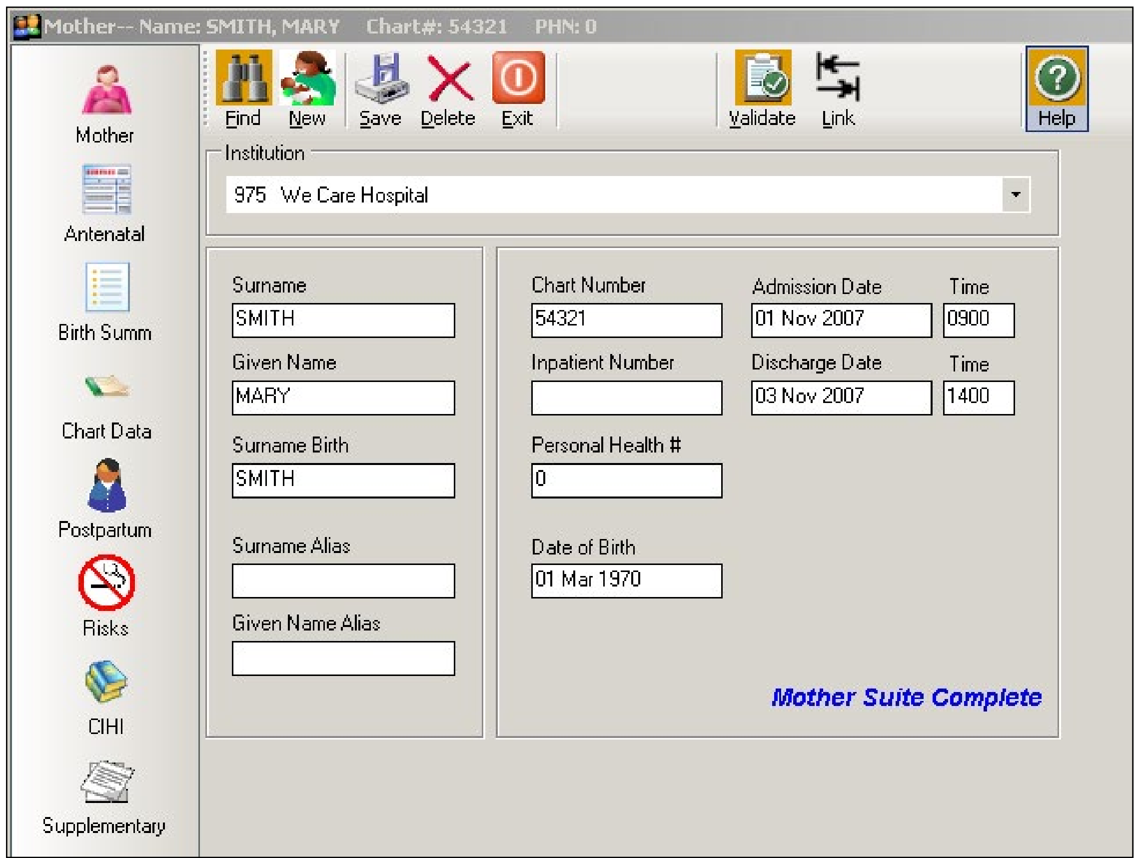
If the Baby Transfer/Readmission's **Date of Birth** is different than the **Delivery Date** on the Birth Summary Screen in the Mother Suite the following error will appear:



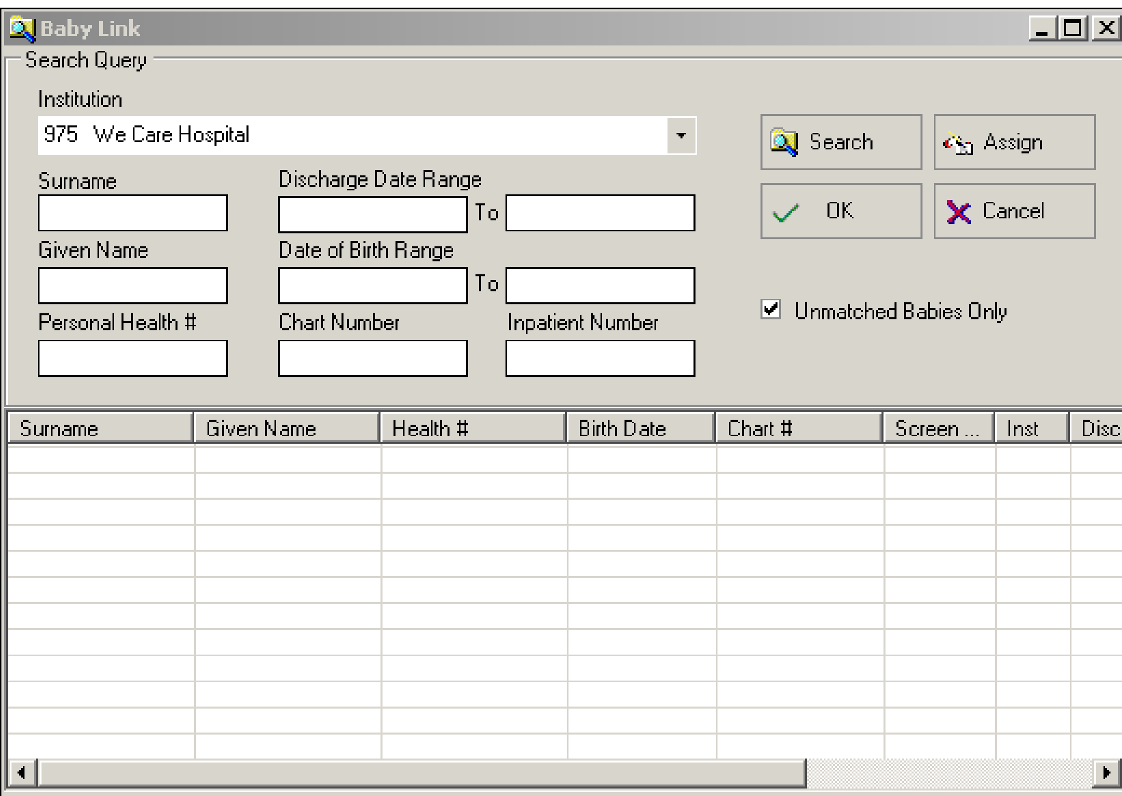
7.2.3 Linking Previously Entered Baby Newborn Suite to Mother Suite

This procedure allows a previously entered Baby Newborn Suite (that has been saved and validated) to be linked to the Mother Suite currently being entered.

a) After entry is complete, **Save** and **Validate** the Mother Suite. Select **Link**.



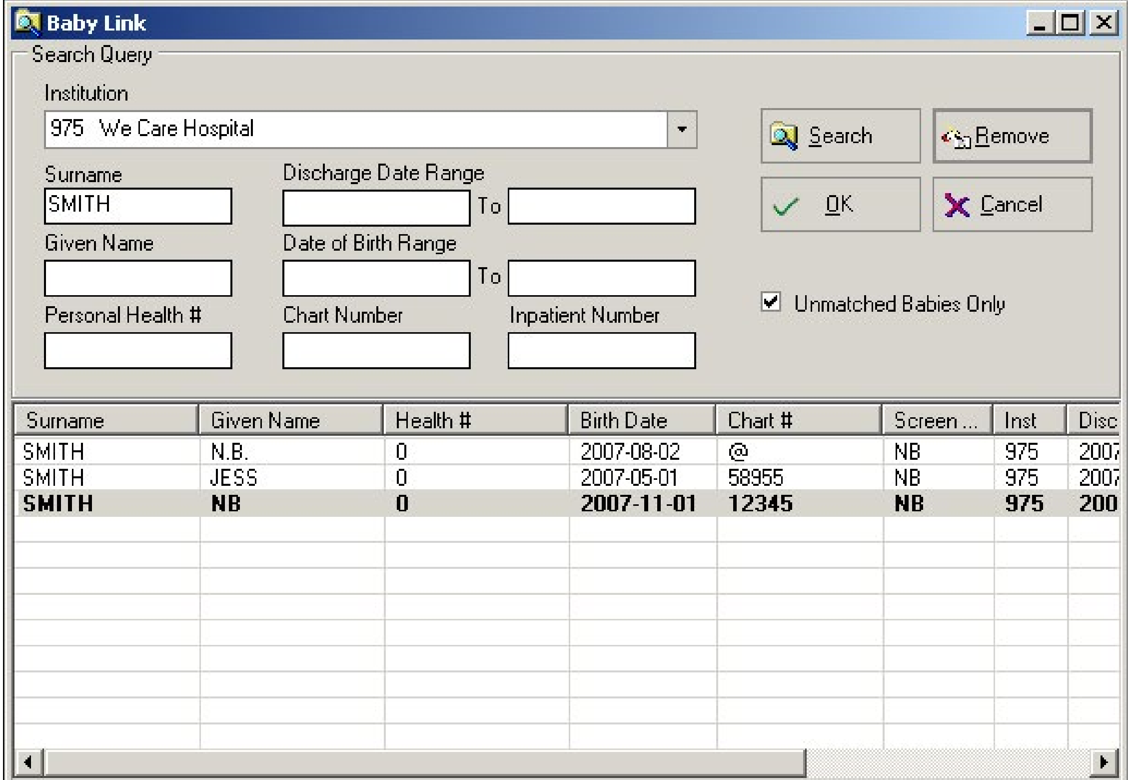
b) A Baby Link – Search Query screen will display.



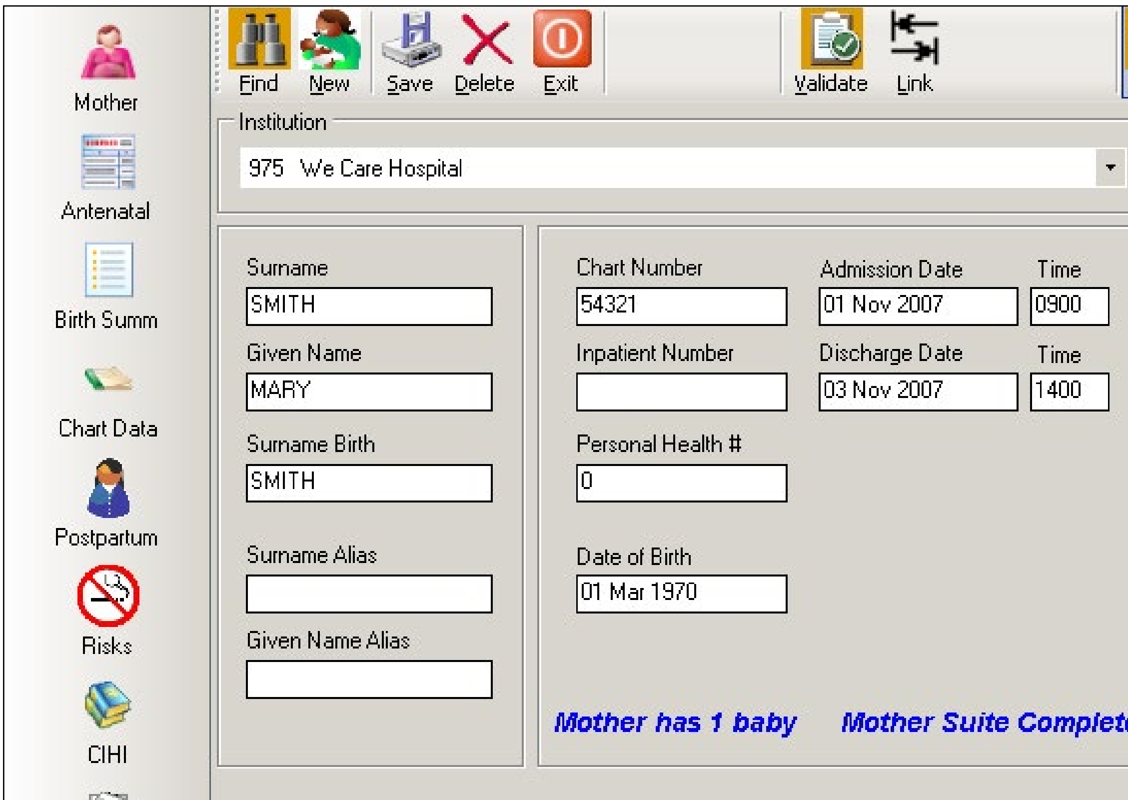
c) How to find and assign the appropriate Baby Newborn record:

- Enter identifying information for one field (ie: **Surname**, **Given Name**, **Chart Number**, **Inpatient Number** or **Personal Health #**) to find the appropriate Baby Newborn record.
- If the identifying information is not known, the user may search for a range of records, such as Baby Newborn's date of birth or discharge date.
- If no data is entered into this screen and **Search** is selected, all Baby Newborn records in the database will be displayed (if the Unmatched Babies Only box is not checked off).
- Use the up & down arrows and/or scroll bar to find the appropriate Baby Newborn Record.
- Highlight the correct baby by clicking on the appropriate Baby Newborn record.
- Select **Assign** to link the Baby Newborn record to the Mother record.

  Note: Once ***Assign*** *is selected, the button will change to* ***Remove****.*
- Select **OK** to return to the main Mother screen.

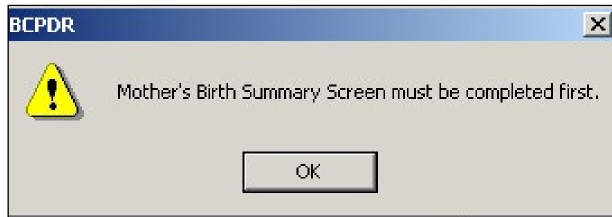


d) Select **Save** and **Validate** to link the Baby Newborn record to the Mother record.



The linkage is now complete. The message *Mother has 1 baby* will display.

If the user attempts to link a Baby Newborn record prior to completing the Birth Summary Screen, the following screen will display:

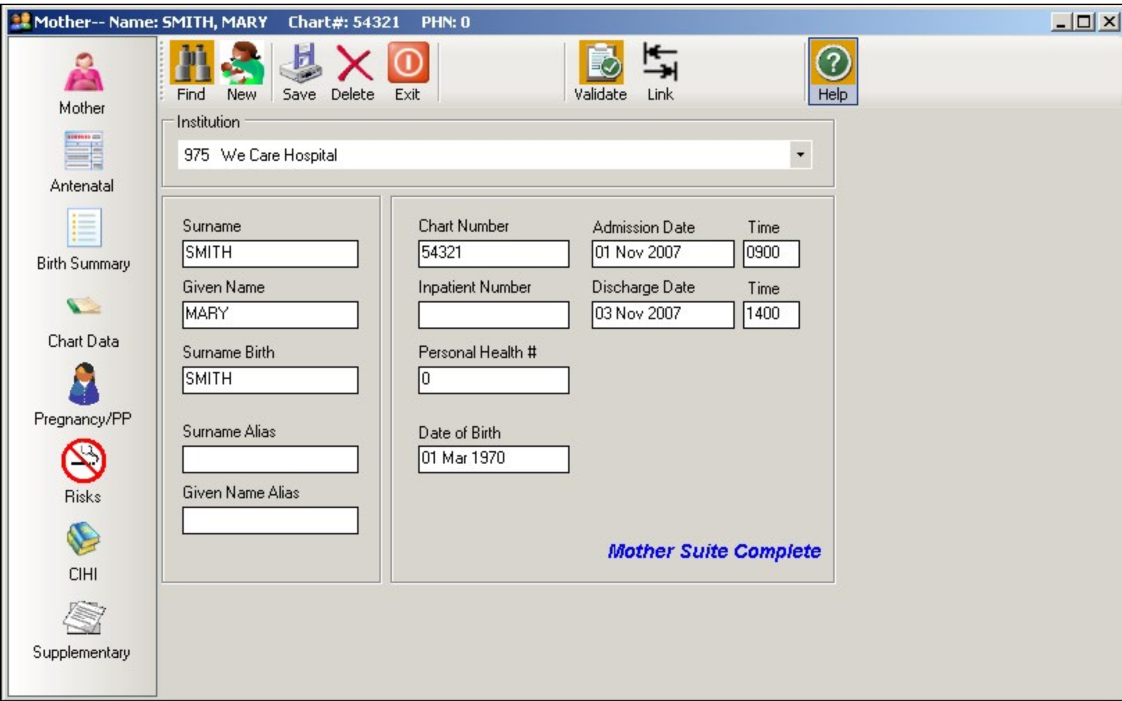


If the Baby Newborn's **Date of Birth** is different than the **Delivery Date** on the Birth Summary Screen, the following screen will display:

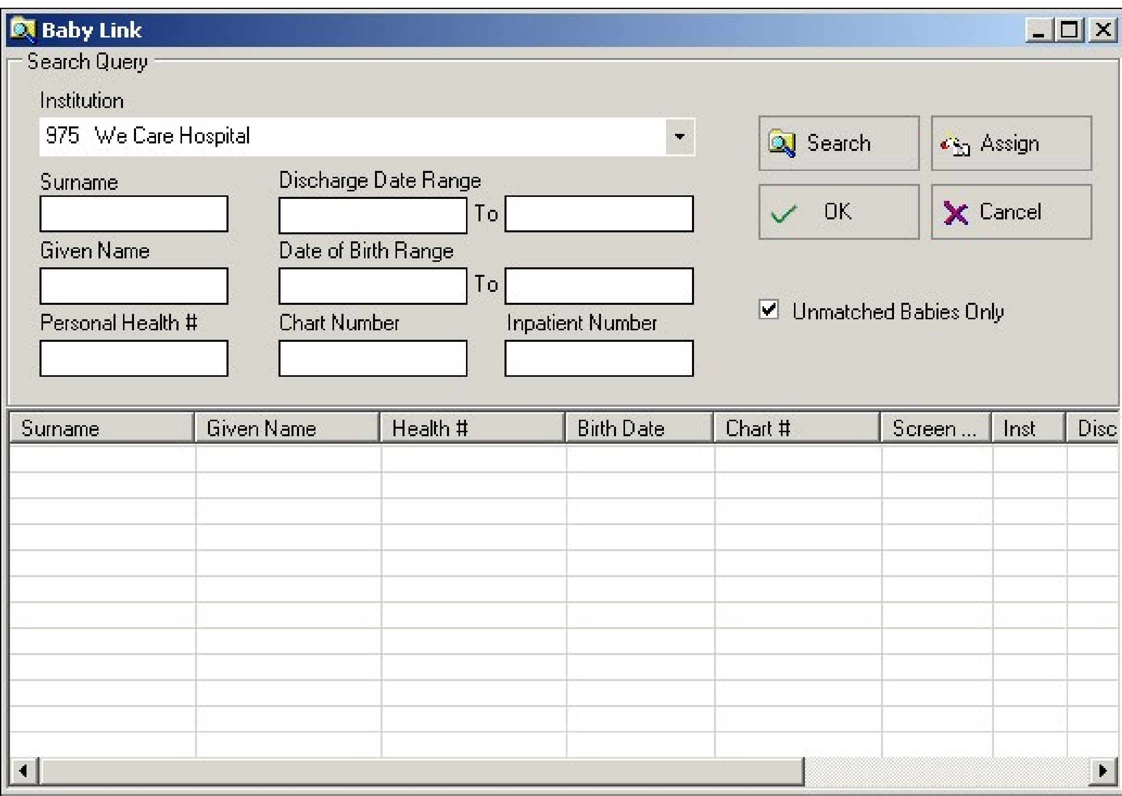
7.2.4 Linking Previously Entered Baby Transfer / Readmission Suite to Mother Suite

This procedure allows a previously entered Baby Transfer/Readmission Suite (that has been saved and validated) to be linked to the Mother Suite currently being entered.

a) After entry is complete, **Save** and **Validate** the Mother Suite. Select **Link**.



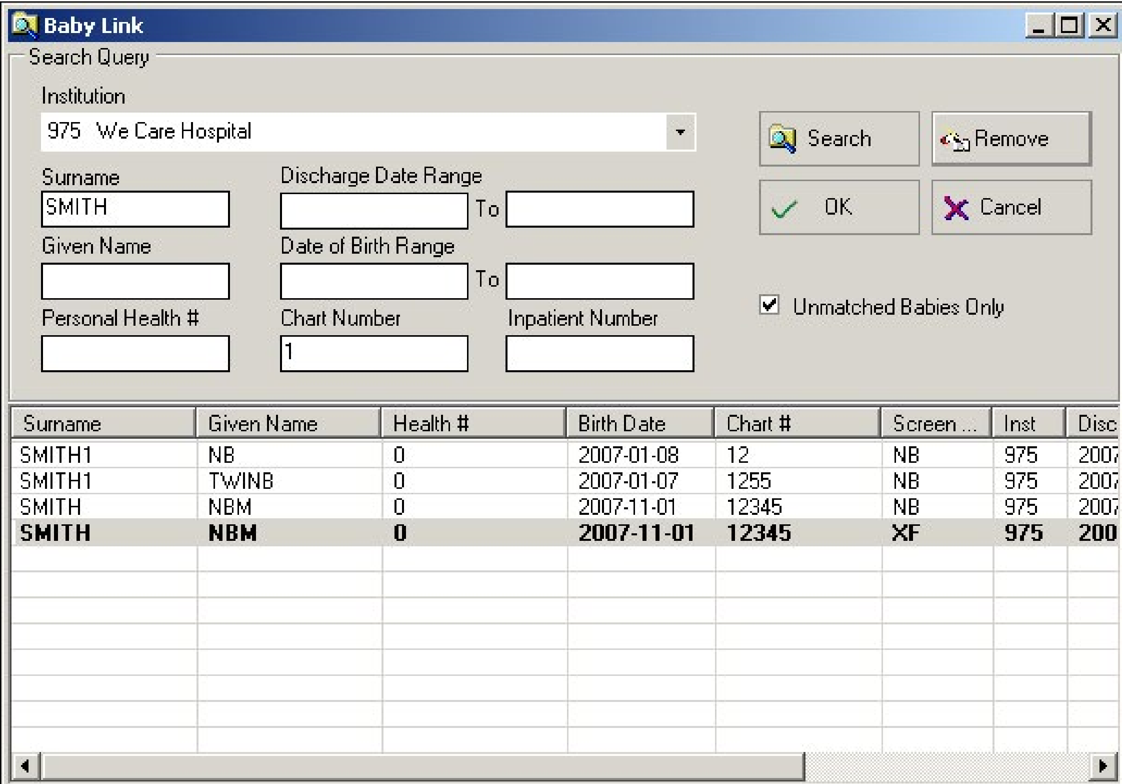
b) A Baby Link – Search Query screen will display.



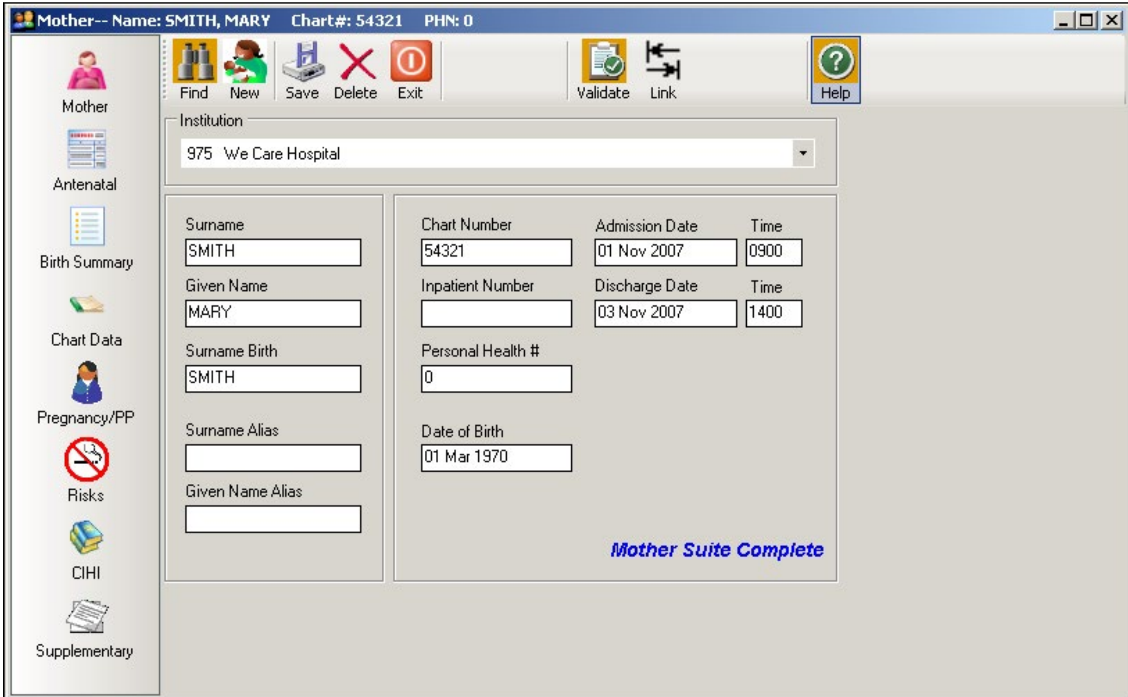
c) How to find and assign the appropriate baby:

- Change the **Institution** to the birth hospital within the shared database, if it is different than the default institution.
- Enter identifying information for one field (ie: **Surname**, **Given Name**, **Chart Number**, **Inpatient Number** or **Personal Health #**) to find the appropriate Baby Transfer/Readmission record.
- If the identifying information is not known, the user may search for a range of records, such as Baby Transfer/Readmission's date of birth or discharge date.
- If no data is entered into this screen and **Search** is selected, all Baby Newborn and Baby Transfer Readmission records in the database will be displayed (if the Unmatched Babies Only box is not checked off).
- Use the up & down arrows and/or scroll bar to find the appropriate Baby Transfer/ Readmission record.
- Highlight the correct baby by clicking on the appropriate Baby Transfer/Readmission record.
- Select **Assign** to link the Baby Transfer/Readmission record to the Mother record.

  *Note: Once **Assign** is selected, the button will change to **Remove**.*
- Select **OK** to return to the main Mother screen.



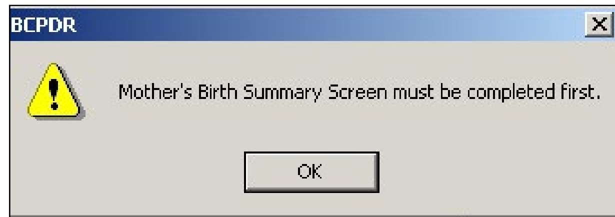
d) Select **Save** and **Validate** to link the Baby Transfer/Readmission record to the Mother record.



The linkage is now complete.

Note: The message <u>Mother has 1 baby</u> will not be displayed when a Mother suite is linked to a Baby Transfer/Readmission Suite.

If the user attempts to link a Baby Transfer/Readmission record prior to completing the Birth Summary Screen, the following screen will display:



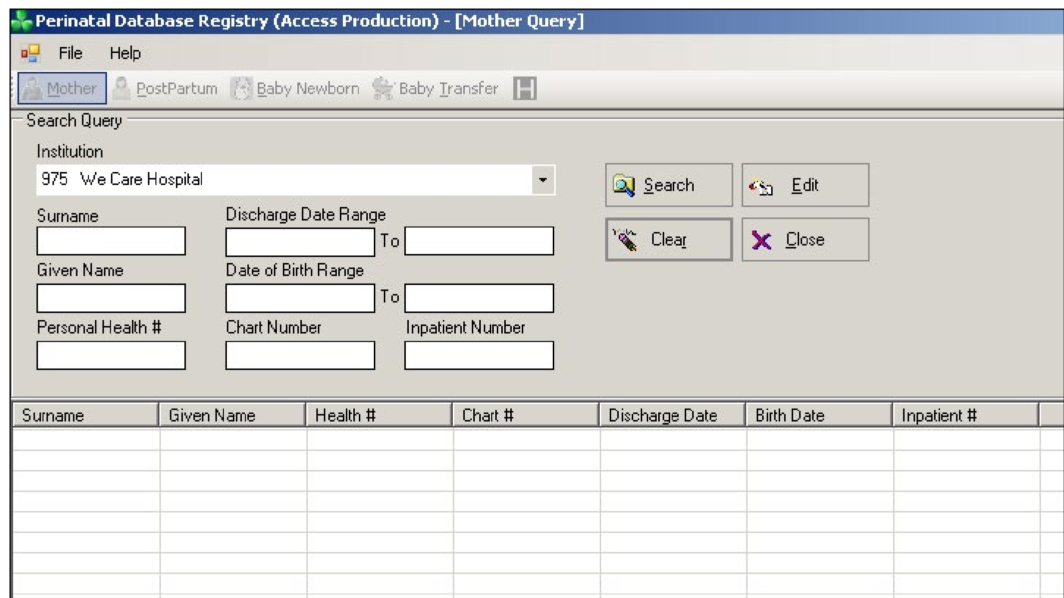
If the Baby Transfer/Readmission's **Date of Birth** is different than the **Delivery Date** on the Birth Summary Screen, the following screen will display:

7.2.5 Unlinking Suites

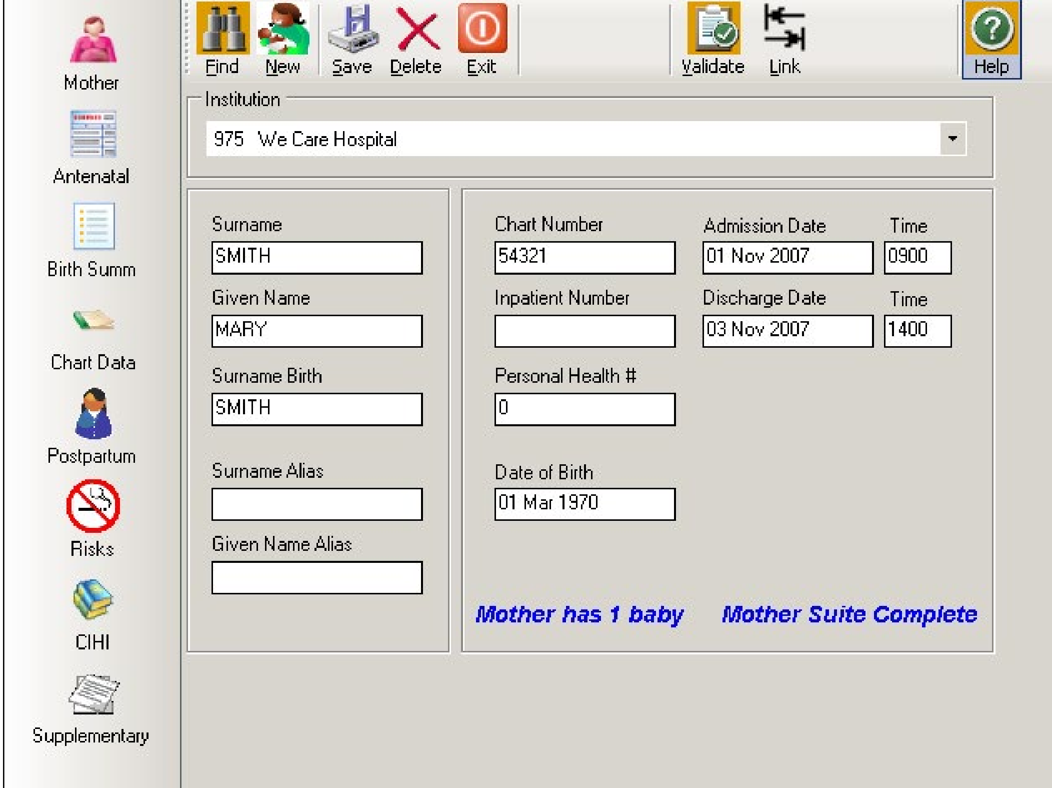
Unlinking suites can only be completed through the Mother Suite.

a) In the Mother Suite, **Find** the appropriate mother that requires unlinking.

b) Enter identifying information (Eg: **Chart Number**) in the Mother–Search Query screen.

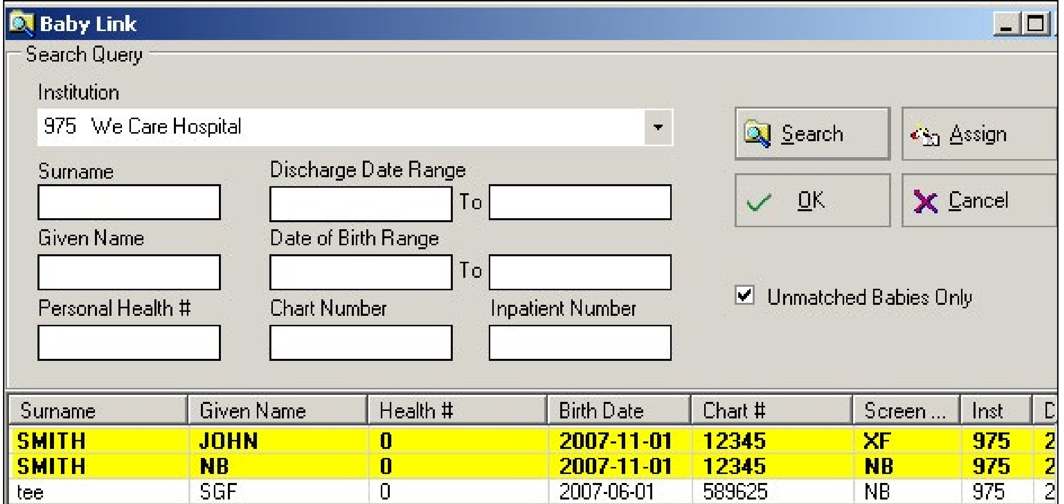


c) The selected Mother record will display in the Mother Screen and if linked to a Baby Newborn record, the *Mother has 1 baby* will display at the bottom of the screen.



d) Select **Link** to find the Baby Newborn or Baby Transfer/Readmission record linked to this Mother record. The Baby Link – Search Query screen will display.

e) Select **Search**. The Baby Newborn and/or Baby Transfer/Readmission records linked to this Mother record will be highlighted and will appear at the top of the list (it is not necessary to enter any information).



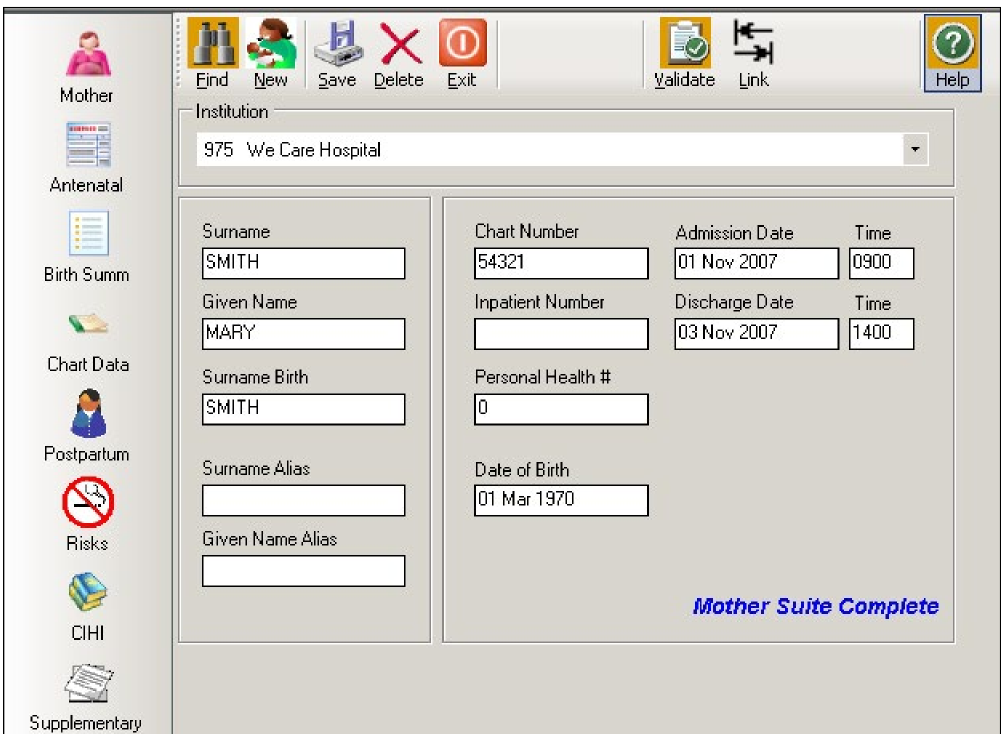
f) If more than one Baby Newborn and/or Baby Transfer/Readmission record is linked to the Mother record, select the appropriate Baby Newborn or Baby Transfer/Readmission record.

g) Select **Remove** from the top right-hand corner of the screen to unlink the Baby Newborn or Baby Transfer/Readmission record from the Mother record.

*Note: Once **Remove** is selected, the button will change to **Assign**.*

h) Select **OK** to return to the main Mother screen.

i) Select **Save** and **Validate** to unlink the Mother record from the Baby Transfer/ Readmission record.



7.3 Deleting a Record

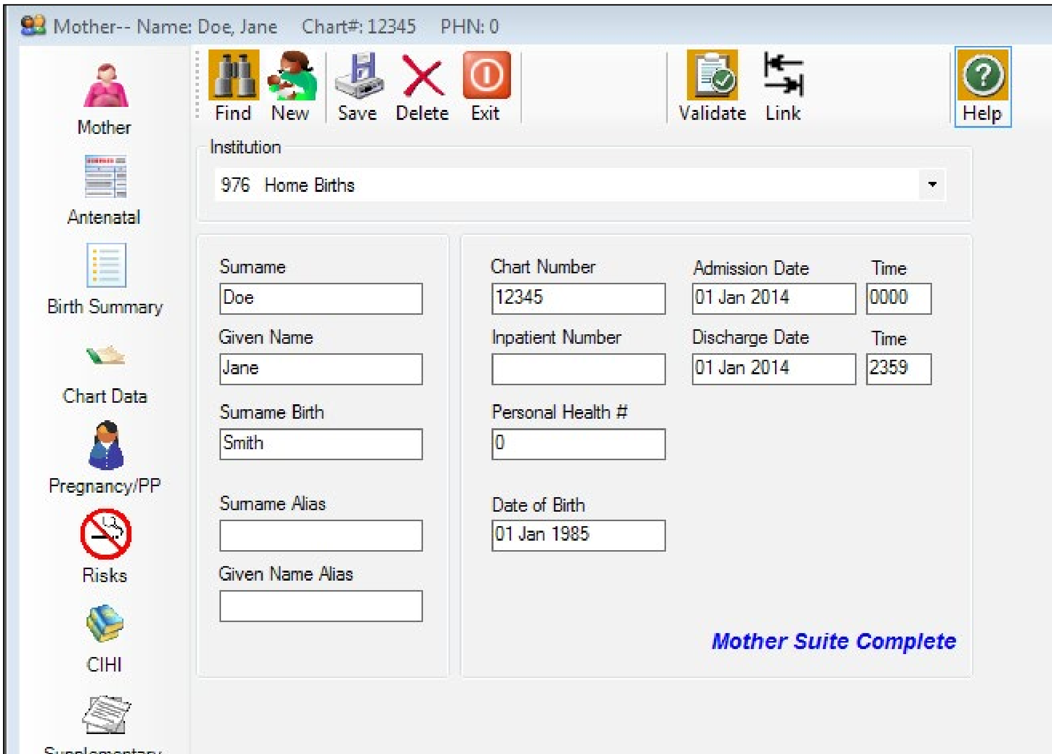
Record deletion can be done before or after exporting of Mother, Newborn, Postpartum or Baby Transfer/Readmission records. Please refer to the appropriate section before deleting a record.

7.3.1 Deleting Records Before Exporting

Deleting unlinked or linked records before exporting can be done at any time during data entry. A *Record to Delete from the BCPDR* form does not need to be completed.

7.3.1.1 Deleting Unlinked Records Before Exporting

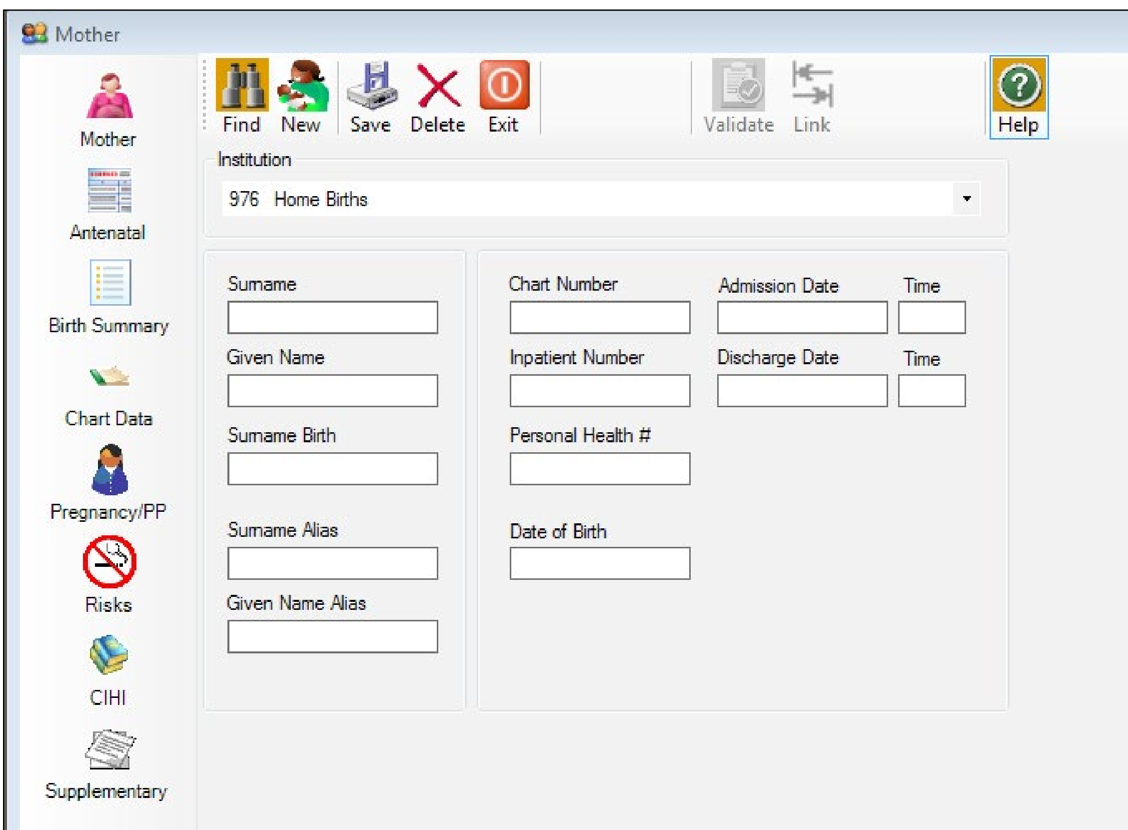
a) **Find** the unlinked record from the Mother, Postpartum, Baby Newborn or Baby Transfer/ Readmission Suite. Select **Delete.**



b) A Delete Record screen will display. Select **Yes** to delete the record.

*Note: If **No** is selected, the record will not be deleted and the user will return to the Mother, Postpartum, Baby Newborn or Baby Transfer/Readmission demographic screen.*

c) The screen will return to a blank Mother, Postpartum, Baby Newborn or Baby Transfer/ Readmission demographic screen. Select **Exit.**

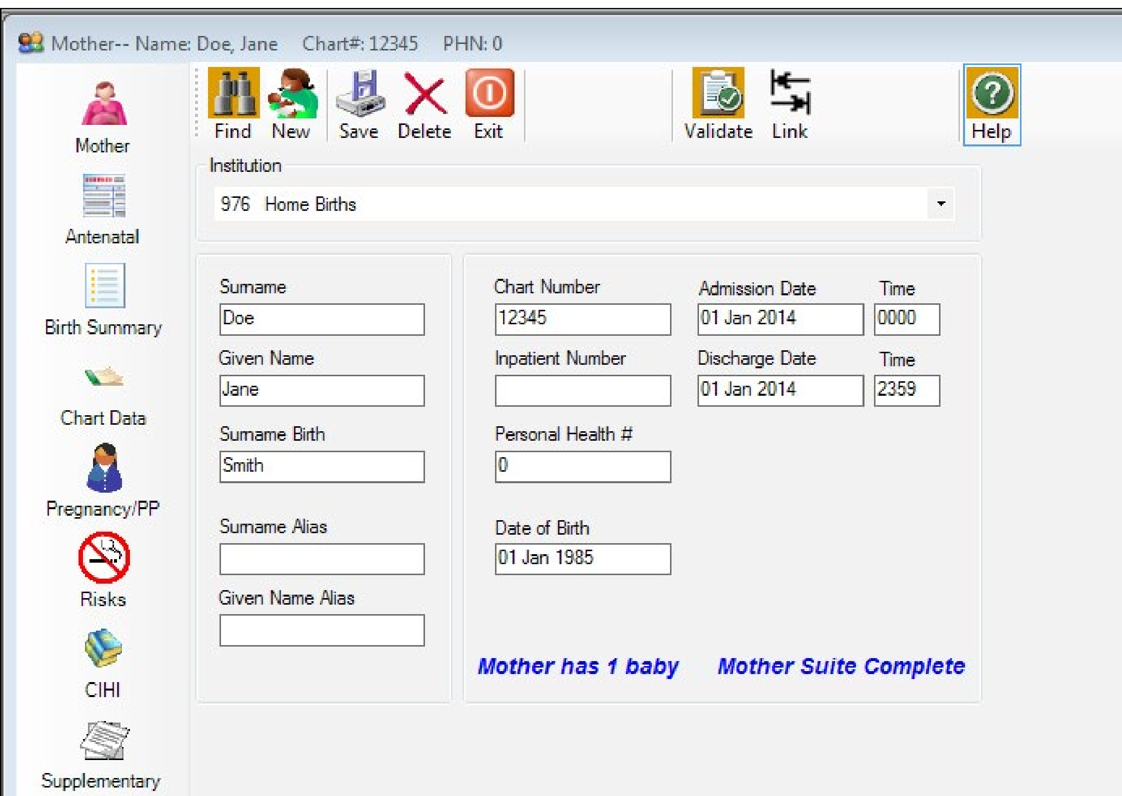


7.3.1.2 Deleting Linked Records Before Exporting

It is highly recommended that Mother, Baby Newborn and Baby Transfer/Readmission records are deleted separately from their own suites.

Deleting from Linked Mother Suite

a) **Find** the linked record from the Mother Suite. Select **Delete**.



b) A Delete Record screen will display. Select **Yes** to delete the record.

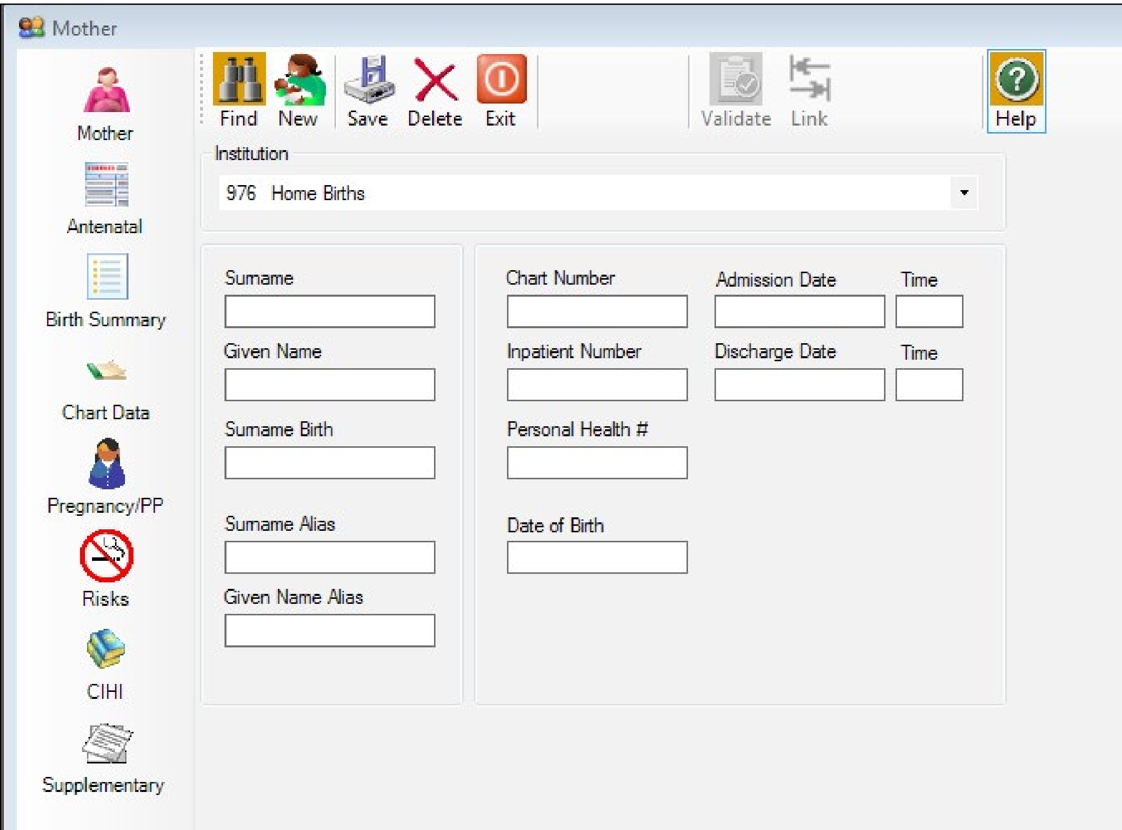
*Note: If **No** is selected, the record will not be deleted and the user will return to the Mother demographic screen.*

c) A BCPDR screen will display with the message, Mother has linked babies, delete them too? Select **No.**

*Note: If **Yes** is selected, the Mother and all linked Baby Newborn and/or Baby Transfer/ Readmission records will be deleted.*

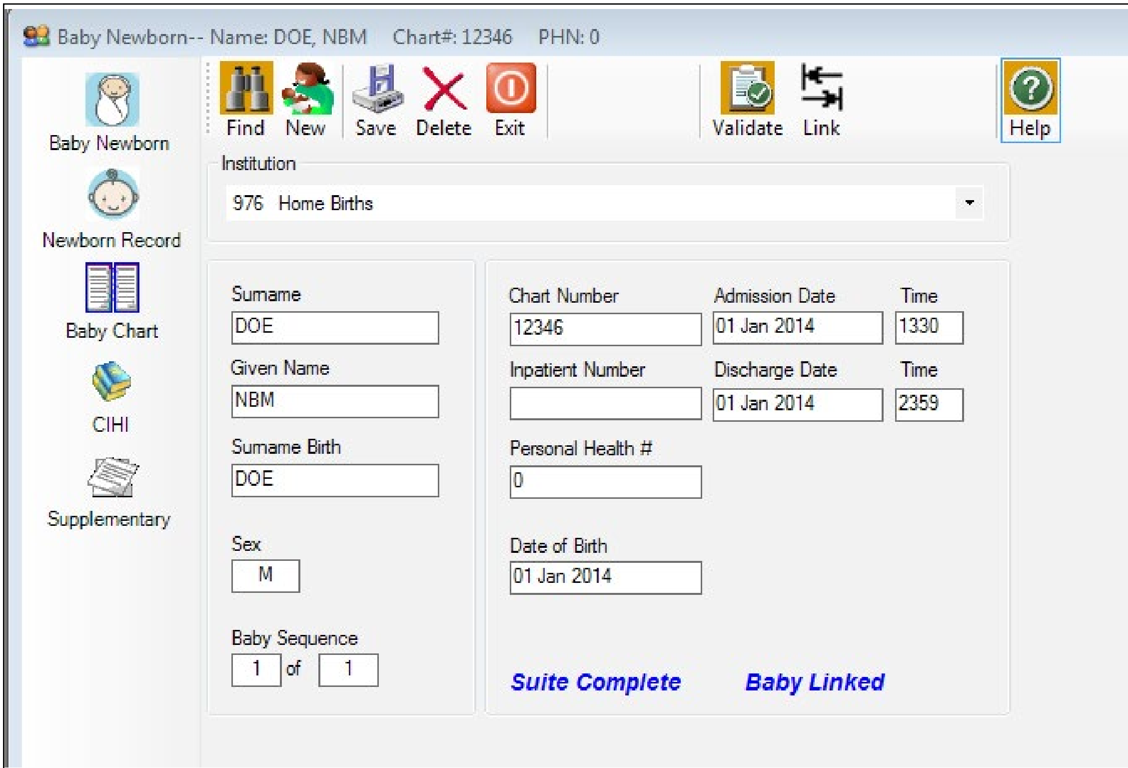
d) The screen will return to a blank Mother demographic screen. Select **Exit**.

If applicable, always delete the Baby Newborn or Baby Transfer/Readmission record from the Baby Newborn or the Baby Transfer/Readmission Suite.

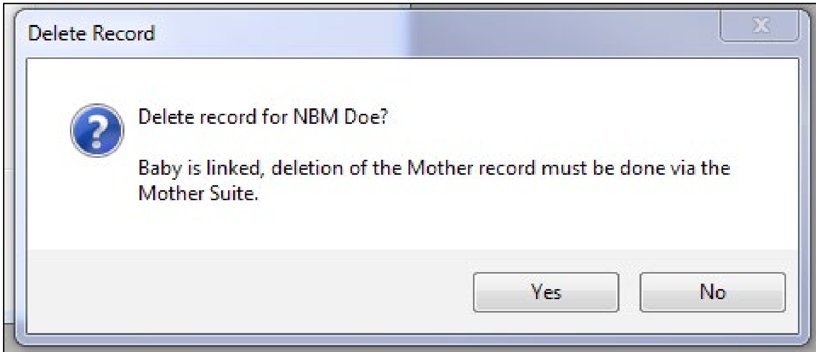


Deleting from Linked Baby Newborn or Baby Transfer/Readmission Suite

e) **Find** the linked record (that is linked to the Mother record) from the Baby Newborn Suite or Baby Transfer/Readmission Suite. Select **Delete.**



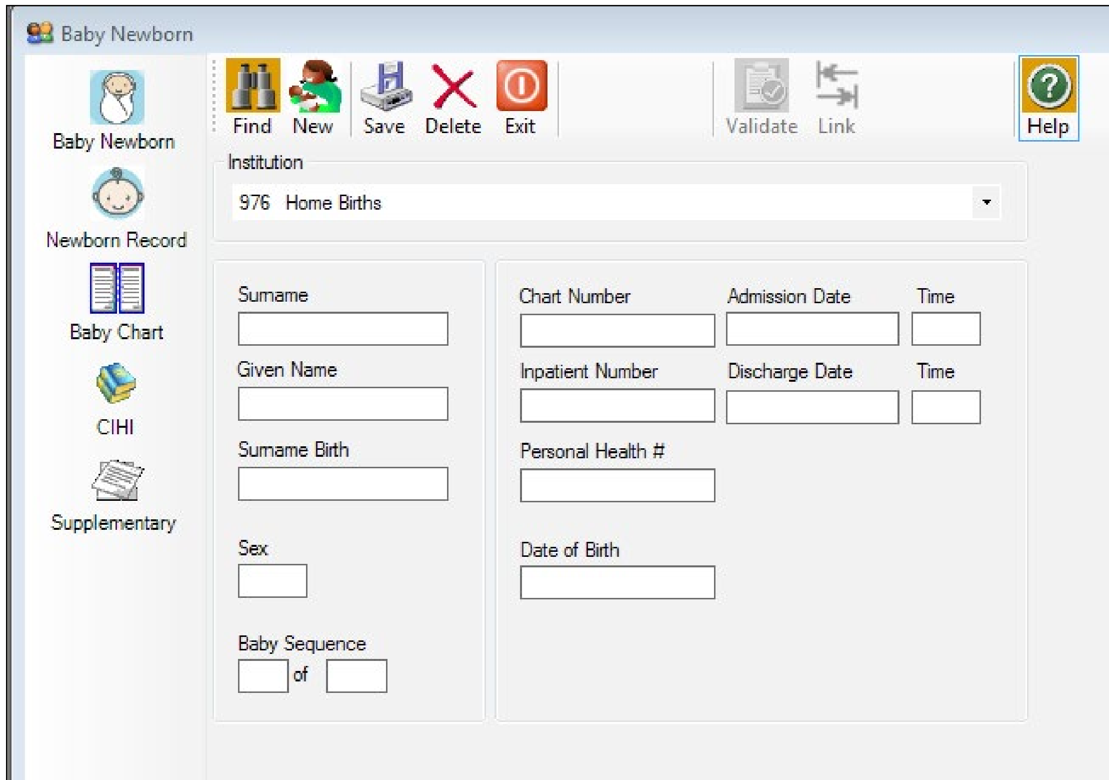
f) A Delete Record screen will display with the message, Baby is linked, deletion of the Mother record must be done via the Mother Suite. Select **Yes** to delete the record.



*Note: If **No** is selected, the record will not be deleted and the user will return to the Baby Newborn or Baby Transfer/Readmission demographic screen.*

The Mother record can only be deleted from the Mother Suite.

g) The screen will return to a blank Baby Newborn or Baby Transfer/Readmission demographic screen. Select **Exit**.



7.3.2 Deleting Records After Exporting

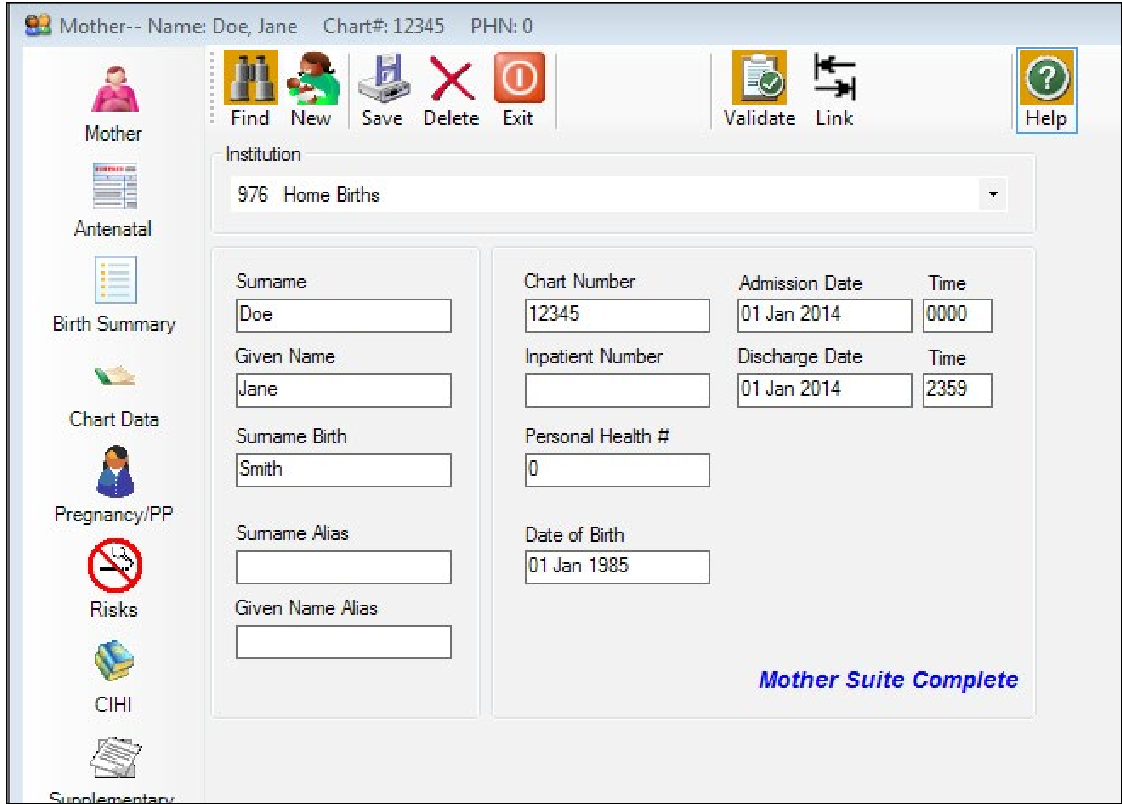
Please notify the PSBC Product Support team by calling the Help Line, 604-877-2121 ext 223753, or by email to ***psbc@phsa.ca*** before deleting all exported records.

Note: When applicable, identify which records are to be deleted and to be kept (Eg: deleting a duplicate record). Both transfer_batch_ids for records to be deleted and to be kept needs to be determined and completed on the Record to Delete from the BCPDR form.

A ***Record to Delete from the BCPDR*** form (refer to Section 7.4.3) must be completed for each exported record that is to be deleted.

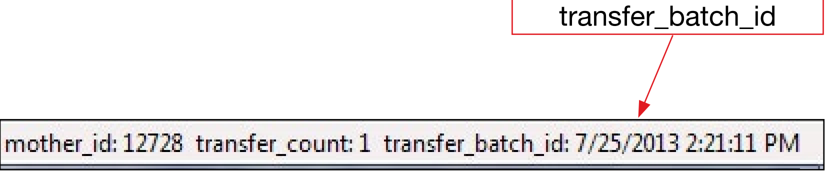
7.3.2.1 Deleting Unlinked Records After Exporting

a) **Find** the unlinked record from the Mother, Postpartum, Baby Newborn or Baby Transfer/ Readmission Suite.

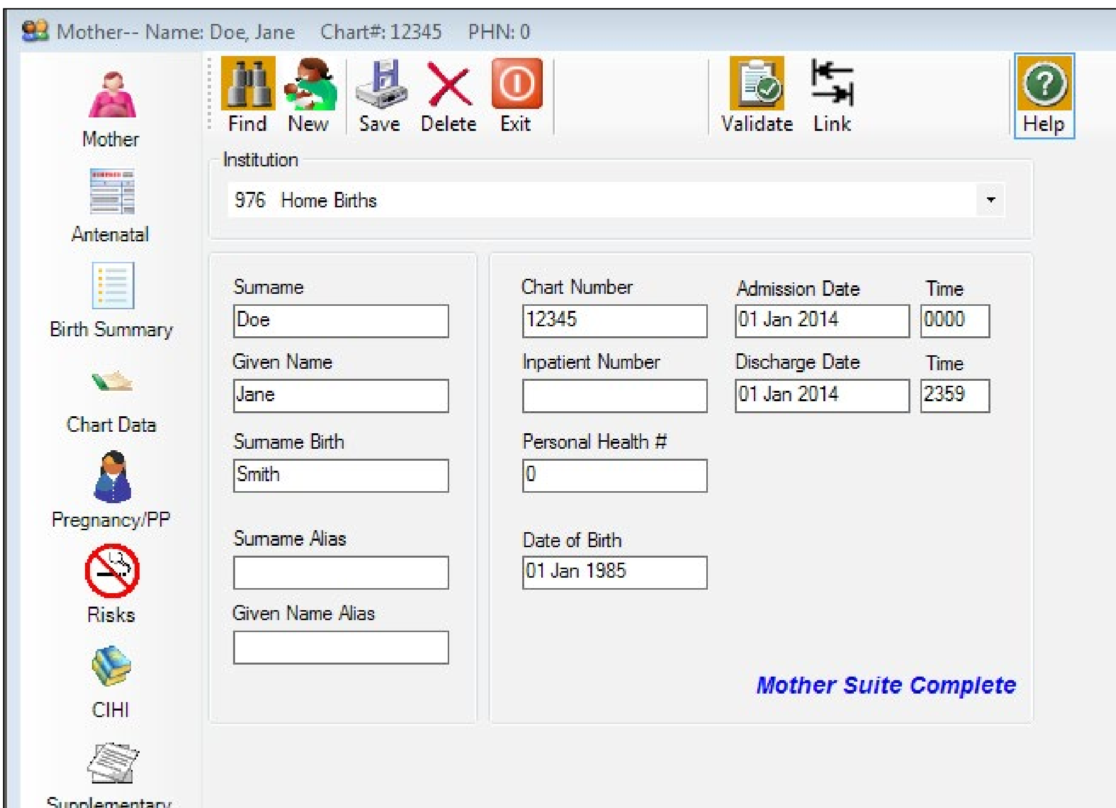


b) Complete all the information on the ***Record to Delete from the BCPDR*** form before deleting the record from the suite.

To document for the transfer_batch_id (exporting date and time) on the form, refer to the lower right-hand corner of any screen in the Mother, Postpartum, Baby Newborn or Baby Transfer/Readmission Suite.



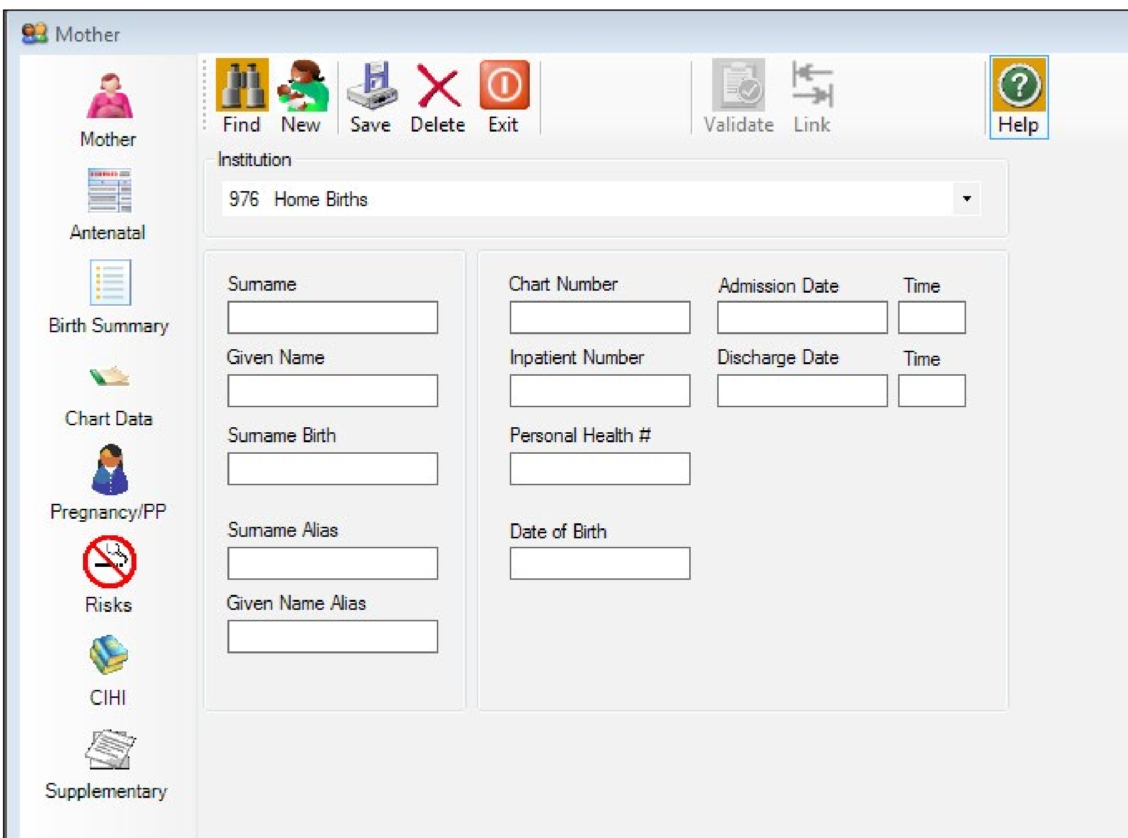
c) After completing the form, select **Delete** to delete the record.



d) A Delete Record screen will display. Select **Yes** to delete the record.

*Note: If **No** is selected, the record will not be deleted and the user will return to the Mother, Postpartum, Baby Newborn <u>or</u> Baby Transfer/Readmission demographic screen.*

e) The screen will return to a blank Mother, Postpartum, Baby Newborn or Baby Transfer/ Readmission demographic screen. Select **Exit.**



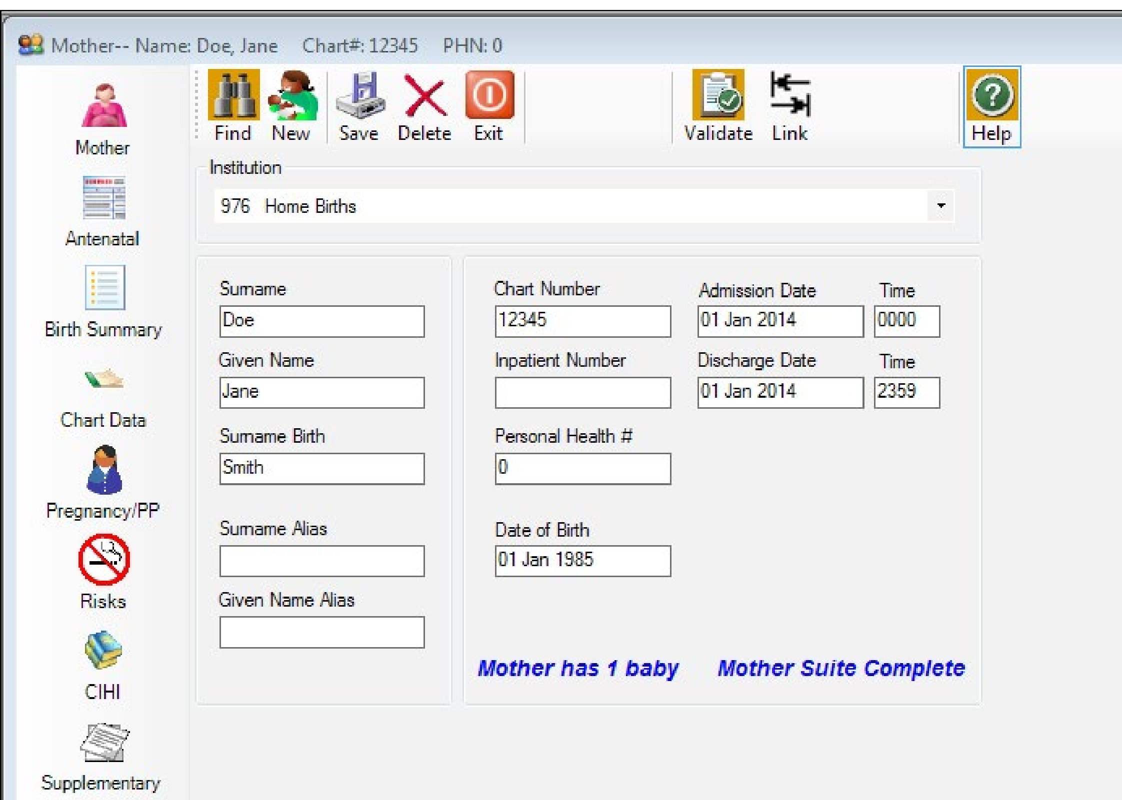
f) Scan and upload the completed ***Record to Delete from the BCPDR*** form to PSBC by the eHealth Network Gateway (eNG). Notify the PSBC Product Support team of all submissions to the eNG by email, ***psbc@phsa.ca***. Or, send this form by courier to PSBC (refer to the form for PSBC's mailing address).

7.3.2.2 Deleting Linked Records After Exporting

It is highly recommended that Mother, Baby Newborn and Baby Transfer/Readmission records are deleted separately from their own suites.

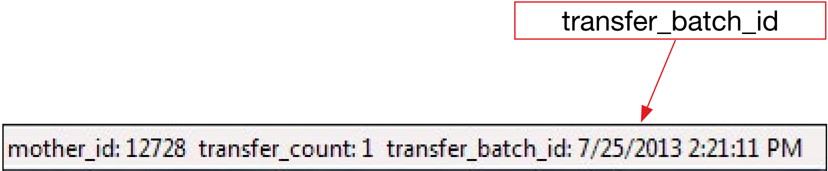
Deleting from Linked Mother Suite

a) **Find** the linked record from the Mother Suite.

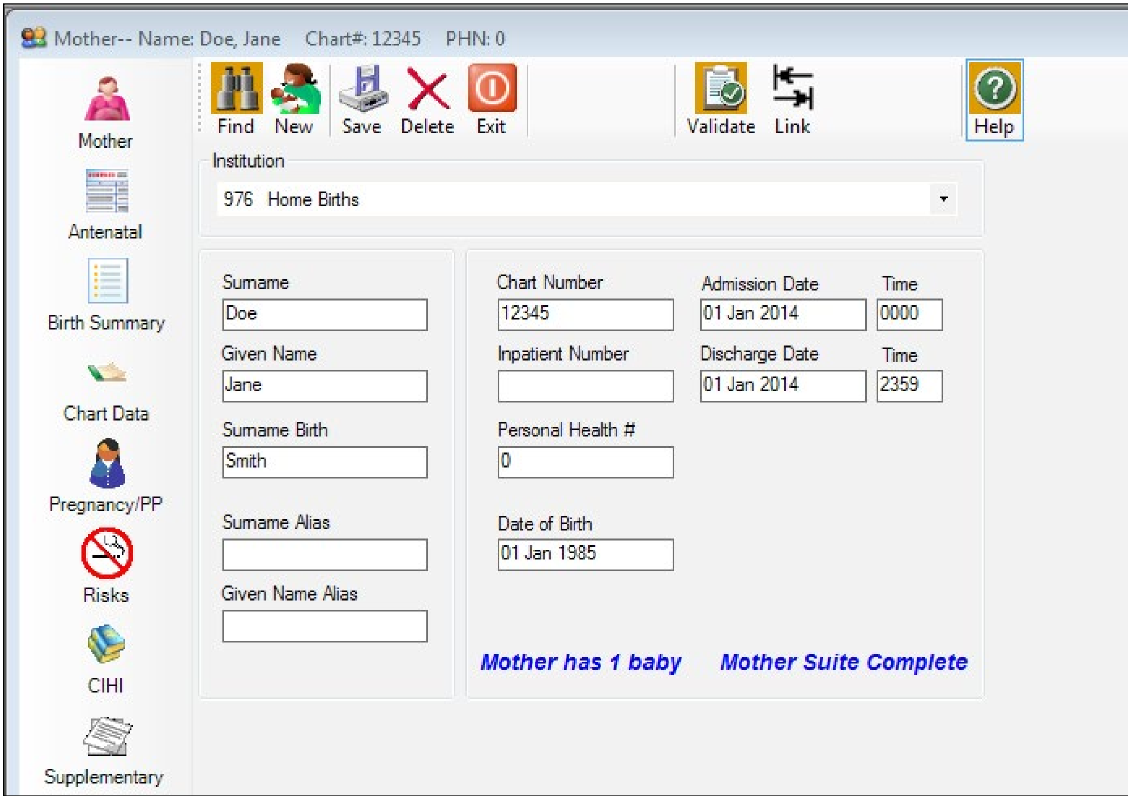


b) Complete all the information on the ***Record to Delete from the BCPDR*** form before deleting the record from the Mother Suite.

To document for the transfer_batch_id (exporting date and time) to be deleted on the form, refer to the lower right-hand corner of any screen in the Mother Suite.



c) After completing the form, select **Delete** to delete the record.



d) A Delete Record screen will display. Select **Yes** to delete the record.

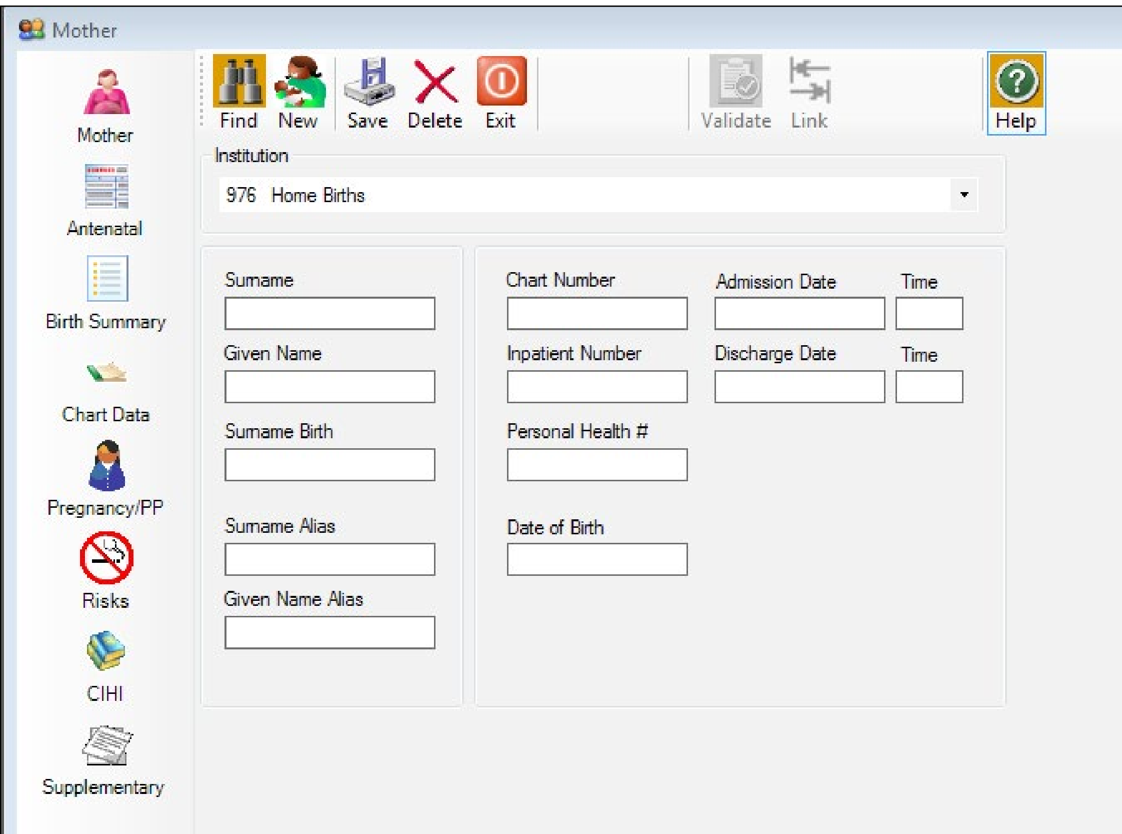
*Note: If **No** is selected, the record will not be deleted and the user will return to the Mother demographic screen.*

e) A BCPDR screen will display with the message, Mother has linked babies, delete them too? Select **No.**

*Note: If **Yes** is selected, the Mother and all linked Baby Newborn and/or Baby Transfer/ Readmission records will be deleted.*

f) The screen will return to a blank Mother demographic screen. Select **Exit**.

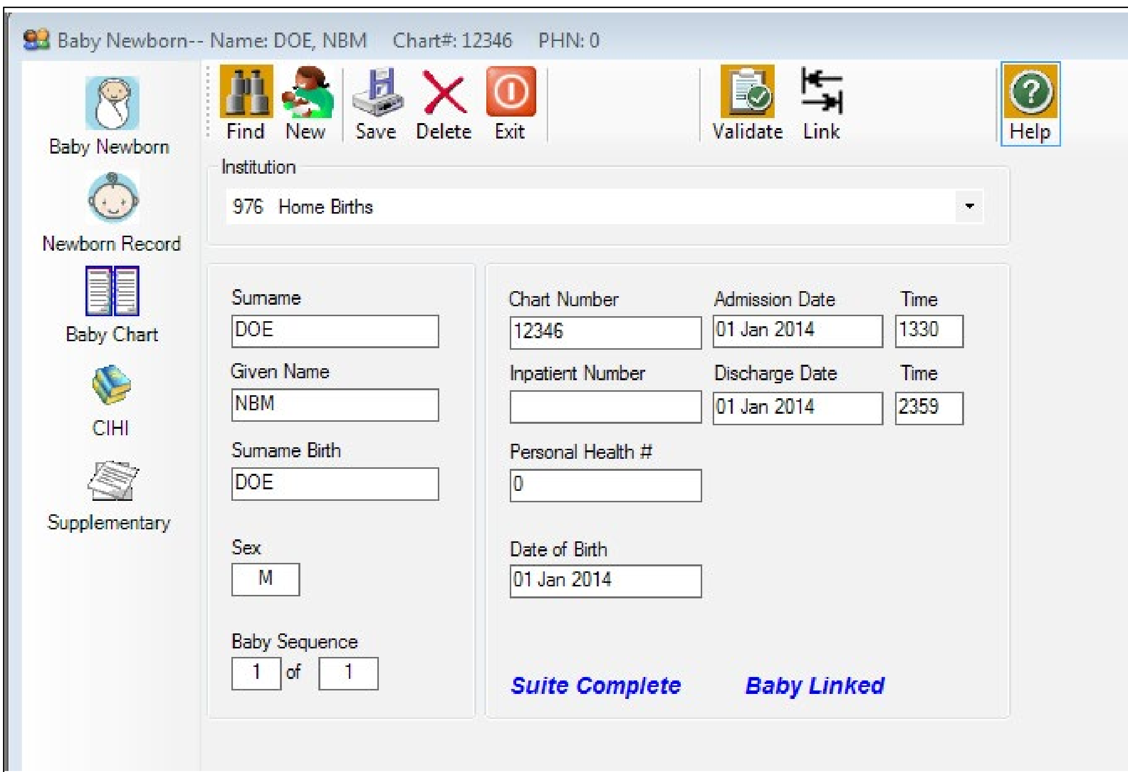
If applicable, always delete the Baby Newborn or Baby Transfer/Readmission record from the Baby Newborn or the Baby Transfer/Readmission Suite.



g) Scan and upload the completed ***Record to Delete from the BCPDR*** form to PSBC by the eHealth Network Gateway (eNG). Notify the PSBC Product Support team of all submissions to the eNG by email, ***psbc@phsa.ca***. Or, send this form by courier to PSBC (refer to the form for PSBC's mailing address).

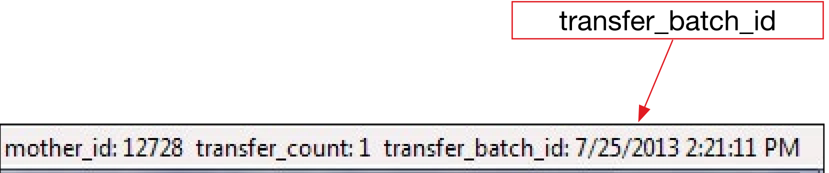
Deleting from Linked Baby Newborn or Baby Transfer/Readmission Suite

h) **Find** the linked record (that is linked to the Mother record) from the Baby Newborn Suite or Baby Transfer/Readmission Suite.

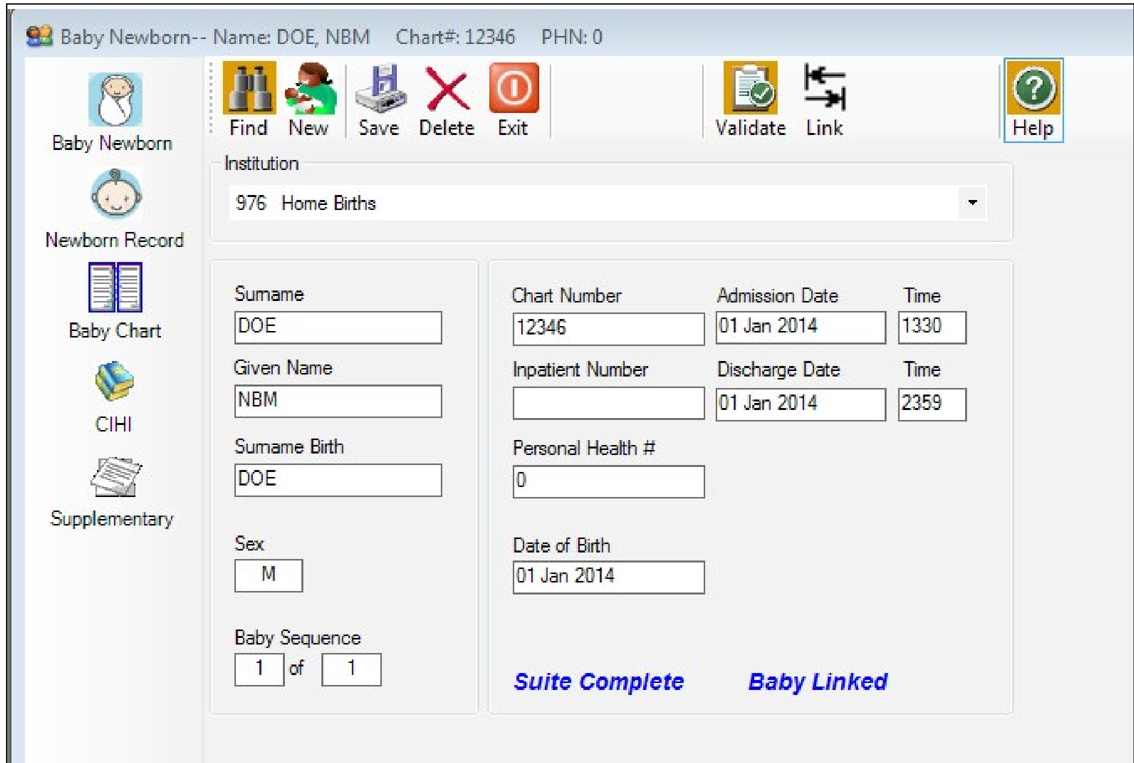


i) Complete all the information on the ***Record to Delete from the BCPDR*** form before deleting the record from the Baby Newborn or Baby Transfer/Readmission Suite.

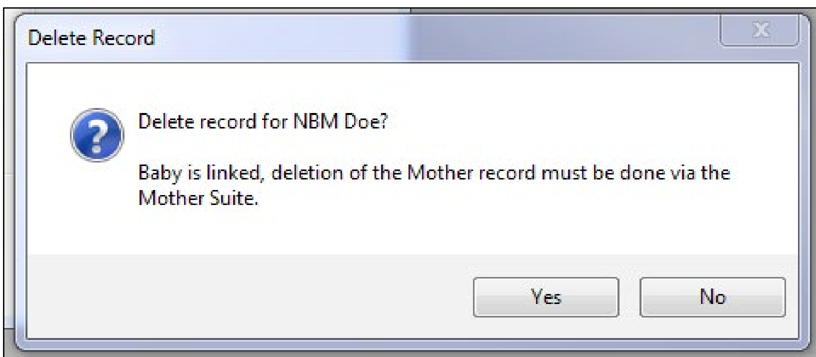
To document for the transfer_batch_id (exporting date and time) on the form, refer to the lower right-hand corner of any screen in the Baby Newborn or Baby Transfer/Readmission Suite.



j) After completing the form, select **Delete** to delete the record.



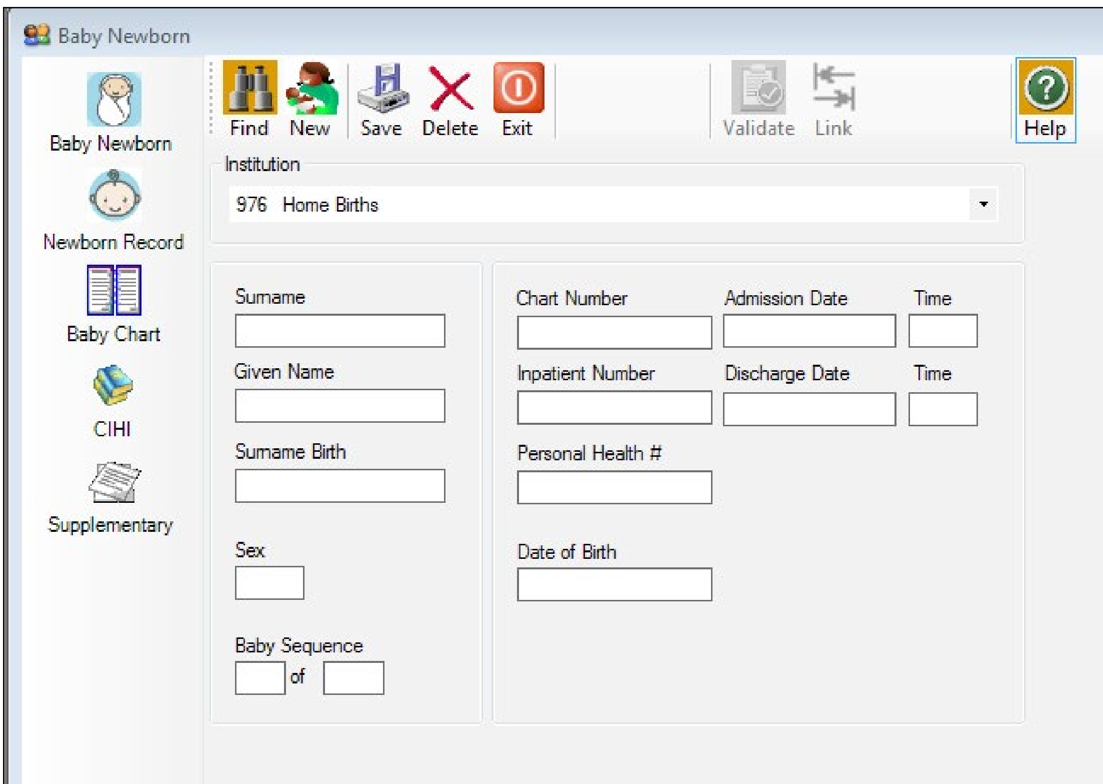
k) A Delete Record screen will display with the message, Baby is linked, deletion of the Mother record must be done via the Mother Suite. Select **Yes** to delete the record.



*Note: If **No** is selected, the record will not be deleted and the user will return to the Baby Newborn or Baby Transfer/Readmission demographic screen.*

The Mother record can only be deleted from the Mother Suite.

l) The screen will return to a blank Baby Newborn _or_ Baby Transfer/Readmission demographic screen. Select **Exit**.



m) Scan and upload the completed ***Record to Delete from the BCPDR*** form to PSBC by the eHealth Network Gateway (eNG). Notify the PSBC Product Support team of all submissions to the eNG by email, ***psbc@phsa.ca***. Or, send this form by courier to PSBC (refer to the form for PSBC's mailing address).

7.3.3 Deleting a Record After Exporting

If the record to delete had been exported, please complete this form. Once this form is received the record will be deleted from the Provincial Database.

Instructions:

1. Find the record to delete from the applicable suite.
2. Locate the transfer Batch ID at the bottom of the record on the ID/Status bar in each of the Suites. mother_id: 12728 transfer_count: 1 transfer_batch_id: 7/25/2013 2:21:11 PM
3. Complete this form and then delete record.

Record to Delete from the BCPDR

HOSPITAL: ______________________ INSTITUTION NO.: ______________________

CHART NUMBER: ______________________ PHN: ______________________

DISCHARGE DATE: ______________________

PATIENT'S SURNAME: ______________________

PATIENT'S GIVEN NAME: ______________________

TYPE OF RECORD: ☐ MOTHER ☐ MOTHER POSTPARTUM ☐ BABY NEWBORN ☐ BABY TRANSFER/ READMISSION

REASON FOR DELETION: ______________________

TRANSFER_BATCH_ID OF RECORD DELETED: ______________________

TRANSFER_BATCH_ID OF RECORD KEPT: ______________________

DATE FORM COMPLETED: ____/____/____ (DD MM YY) PERSON COMPLETING FORM: ______________________

Form Submission to PSBC:

1. Scan and upload the form by the eHealth Network Gateway (eNG). Notify the PSBC Product Support team of the submission by email, ***psbc@phsa.ca***.

   OR

2. Courier form to PSBC at: Perinatal Services BC
   West Tower, Suite 350
   555 West 12th Avenue
   Vancouver, BC V5Z 3X7

PSBC USE ONLY

Date Form Received: ____/____/____ (DD MM YY) Date Deleted from Provincial Database: ____/____/____ (DD MM YY)

Analyst Deleting from Provincial Database: ______________________

BCPDR ID# of Record Deleted: ______________________ BCPDR ID# of Record Kept: ______________________

Import Log Updated: ____/____/____ (DD MM YY) Deletion Log Updated: ____/____/____ (DD MM YY)

8. DATA TRANSFER

8.1 Overview

The Transfer Programs portion of the BCPDR facilitates reduction of duplicate data collection through electronic transfer of data. The transfer software loads ASCII (text) files into the hospital's Perinatal Data Registry (PDR).

The transfer application also includes validation functionality, which is run against the imported data. Records that do not match are rejected during the import process, details of which are viewed using the Import Errors or Rejections Utility.

Two electronic data transfer imports are available: Hospital Data Transfer and CIHI Data Transfer.

8.1.1 Hospital ADT System

An import program has been created that allows demographic data to be mapped into BCPDR fields (first screen for the Mother, Baby Newborn and Baby Transfer/Readmission Suites) from your hospital ADT system. This is an optional feature. Data that is imported from the hospital ADT system must be an exact match to the BCPDR's data field specifications. The document, Hospital Interface Specification, outlines these requirements and is available upon request.

Before initial creation of the import file, please contact PSBC's Product Support team at 604-877-2121 ext 223753. We will be pleased to work with you to identify compatible data fields.

The benefits of using this data transfer are:

- Substantial reduction of duplication of data collection, requiring fewer demands on the abstractor's time.
- More reliable data; there will be no ambiguity between identical fields on two systems.

  Eg: Surname misspelled or numbers transposed in the chart number and/or PHN.
- Data more readily available.

8.1.2 CIHI Import – Period End Procedure

PSBC has worked with individual CIHI abstracting vendors to provide standardized specifications for the transfer of selected CIHI fields into the CIHI data screen of the BCPDR. CIHI data can be imported into the BCPDR or manually entered into the CIHI data screens. The completion of the CIHI data screens is one of the mandatory steps necessary to enable your hospital's perinatal data to be exported and then sent to PSBC.

The Period End Procedure also includes data quality checks and creation of the export file.

8.2 Performing Data Transfers

Ensure that there are no users signed into the Perinatal Data Registry System before Performing Data Transfers.The import cannot occur if the database is in use.

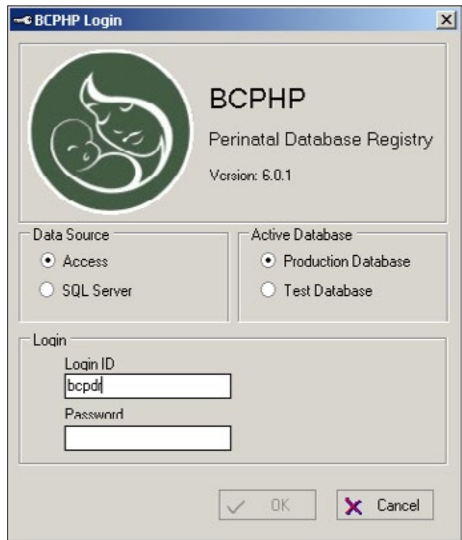
8.2.1 Signing into Transfer Programs

Step 1

a) Login to the Perinatal Data Registry.

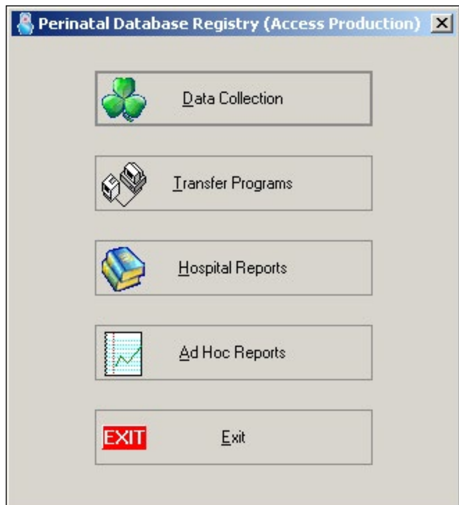
b) Enter your **Login ID** and **Password**.

c) After entering the password, select **OK** or <Tab> to **OK** and press <Enter>.



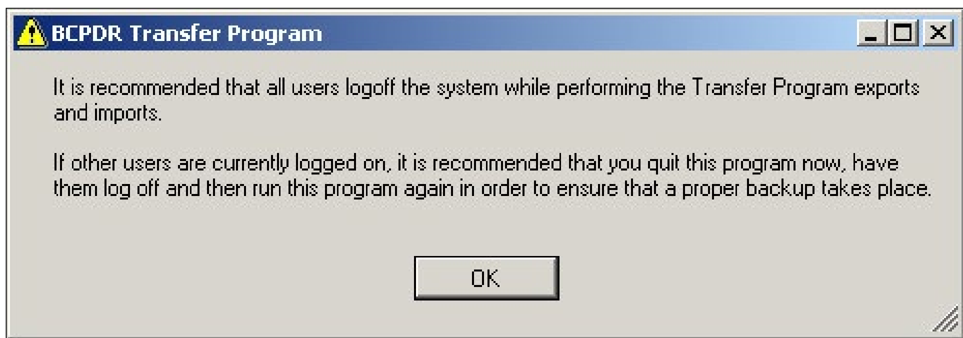
Step 2

a) Select **Transfer Programs** or press <Alt> <T>.



Step 3

a) The user will be prompted to ensure that all other users have signed off the hospital's BCPDR system. Select **OK** or press <Enter>.



You have successfully opened the **BCPDR Transfer Programs** application.

8.2.2 Data Transfer – Hospital ADT System

ADT data from three patient types (Mother, Newborn and Baby Transfer/Readmission) can be imported into the BCPDR. These can be imported as separate text files or combined into one large file.

Note: Postpartum cases are not imported into the BCPDR.

Although optional, import of patient demographic information provides efficiency and accuracy of data.

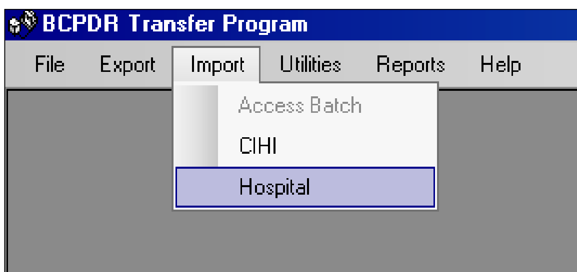
Following import or manual entry of demographic information, manual completion of perinatal records can begin.

8.2.2.1 Performing a Hospital ADT Import

Step 1

a) Open the BCPDR **Transfer Programs** application (refer to Section 8.2.1).

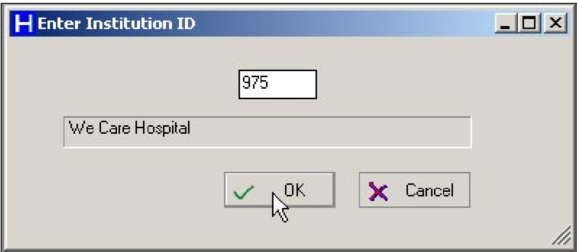
b) Select **Import** from the menu bar. Select **Hospital**.



Step 2

a) The Enter Institution ID screen will display.

b) Enter the 3-digit institution number of your hospital. The corresponding institution title will display.



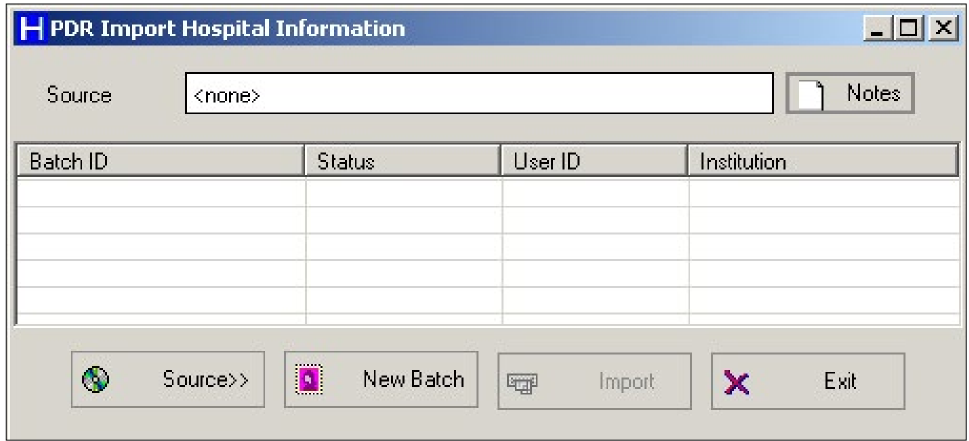
c) Select **OK** or <Tab> to **OK** and press <Enter> to complete your Institution selection.

*Note: If you are importing data for multiple institutions, exit and re-open the BCPDR **Transfer Programs** and enter another institution number.*

Step 3

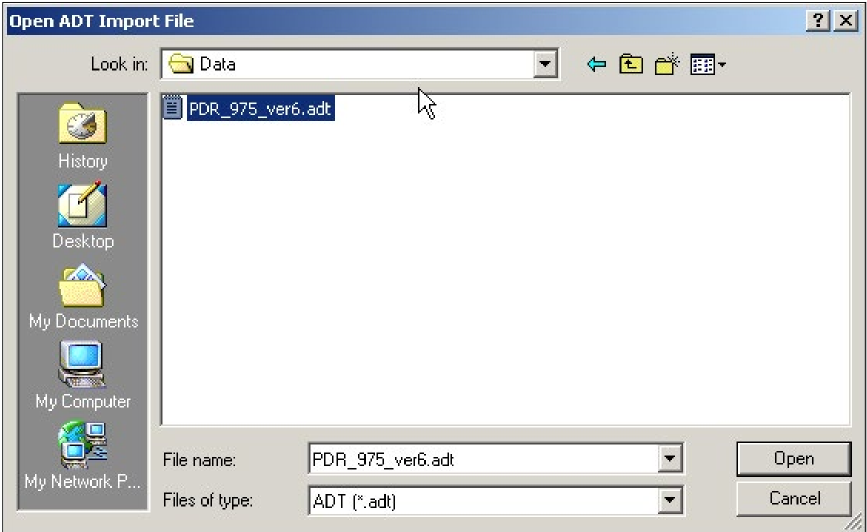
a) The PDR Import Hospital Information screen will display. This screen shows the status of previous imports. A status of CMPL shows that a previous import batch was completed.

Select **Source** or press <Alt><S>.

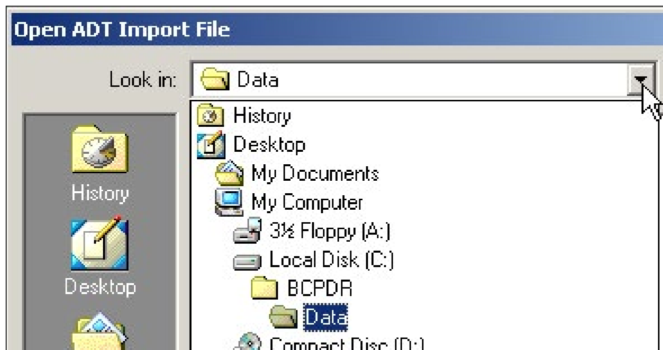


b) The Open ADT Import File screen will appear.

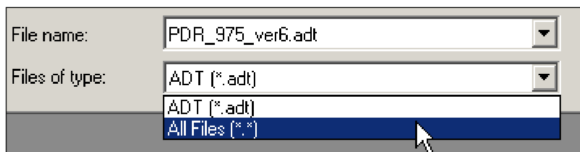
This window displays the default folder. If your hospital admitting text file has been saved in the default folder, select and open file to be imported.



c) If the import file has been saved elsewhere, select the down arrow to the right of the **Look In** field to display all available folders. Find and select the path and file name where the ADT data file is located.

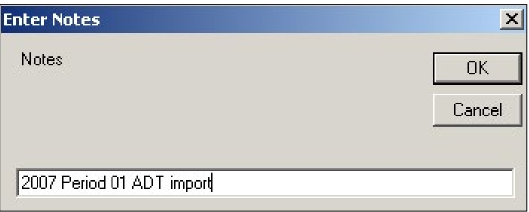


d) If you do not see your file in the window, it may not have an ADT extension. Change the **Files of Type** option to All Files (*.*) to show all files in the folder. Once you have found and selected the correct file to import, select **Open**.



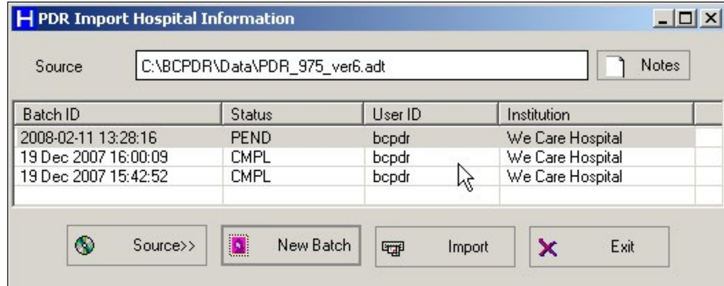
e) The Import Hospital Information screen returns. The selected path and file name will display in the **Source** field.

f) Select **New Batch** or press <Alt><N>. The Enter Notes screen will display. It is mandatory to enter information in this screen (Eg: fiscal period or date range of file). Select **OK** or <Tab> to **OK** and press <Enter>.



g) The PDR Import Hospital Information screen will return. The **Batch ID**, **Status**, **User ID** and **Institution** will display on the top line. The **Status** will show as PEND (pending) until the Import is completed.

To import select **Import** or press <Alt><I>.

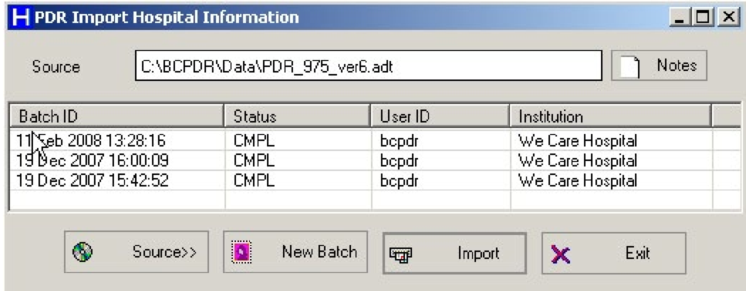


h) A progress bar will appear in the bottom left corner of the screen.

i) After the Import is completed, the XfrNet screen displays how many records were imported and how many records were rejected. After reading the XfrNet screen, select **OK** or press <Enter> to close the screen.

Note: This summary cannot be recalled once the screen is closed.

j) The PDR Import Hospital Information screen will return. The status of PEND has changed to CMPL. Select **Exit** or press <Alt><E> to exit.

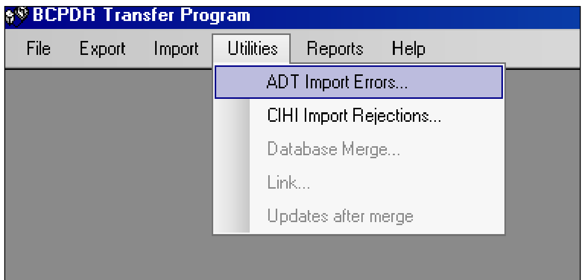


8.2.2.2 ADT Import Errors

Records from the hospital ADT system must exactly match the formats in the BCPDR import specification data definitions for each field being imported. Records that do not match will be rejected and displayed in the ADT Import Errors Utility file. To view rejected records, follow the steps outlined below.

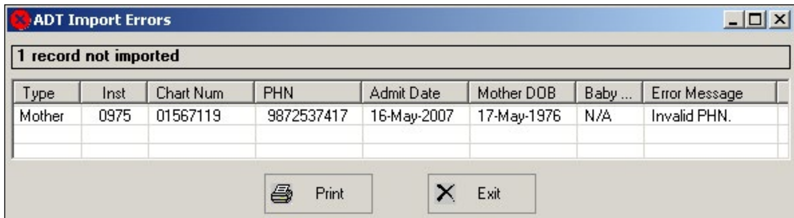
Step 1

a) If records were rejected during import, select **Utilities** from the menu bar. Select **ADT Import Errors.**



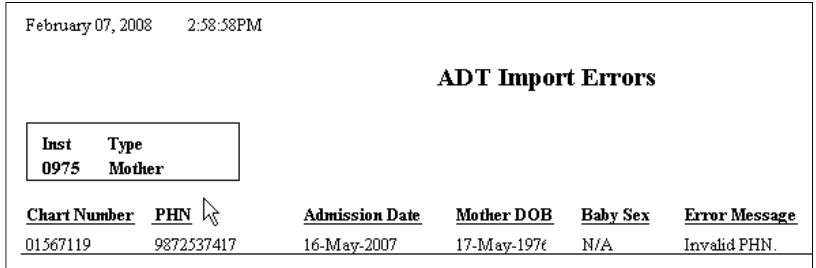
Step 2

a) The ADT Import Errors screen will display.



b) The ADT Import Errors screen can be resized and the columns can be stretched wider to better display the information in the error report.

For a printed copy, select **Print** or press <Alt><P>.


February 07, 2008 2:58:58PM

ADT Import Errors

Inst	Type
0975	Mother

Chart Number	PHN	Admission Date	Mother DOB	Baby Sex	Error Message
01567119	9872537417	16-May-2007	17-May-197	N/A	Invalid PHN.

c) Select the printer icon from the menu bar to start the print job:

Common examples of why records are rejected:

- If a record already exists in the database and has been Saved and Validated, the ADT file will not overwrite the information. This record will be displayed in the ADT Import Errors table.
- If an alpha or non-numeric character is present in a numeric field in the ADT file (Eg: has " – " in the PHN).
- If the field contains more characters than is allowed in the ADT file (Eg: PHN has more than 12 digits)

Step 3

a) Make any required corrections in the hospital ADT system.

b) When all corrections have been completed in the hospital ADT system, create the ADT file again.

c) Re-import the ADT file. Re-importing will overwrite records that have not been saved and validated in the BCPDR.

d) Instead of re-importing records, record(s) containing error(s) may be corrected manually in the BCPDR. Corrections should, however, still be made in the hospital ADT system to maintain data quality.

8.2.3 Period End Procedure – CIHI Transfer & Data Quality

Following completion of data entry, prepare the data for electronic submission to PSBC. The first phase is importing CIHI data from the hospital's Health Record Abstracting system.

Purpose of period end:

- To perform several data quality checks.
- To transfer the CIHI data into the BCPDR.
- To send the completed data file to PSBC.

When to do procedure:

- May be completed for a chosen time period determined by the hospital (Eg: by fiscal period, quarterly, or yearly), depending on the hospital size.
- Should be completed after the CIHI Default Error Reports have been corrected in the hospital's Health Record Abstracting system.
- The procedure should be done in its entirety for the chosen time period.

How to document period end:

- If desired you may document your steps in the period end process by utilizing the *Period End Checklist on page 179.*

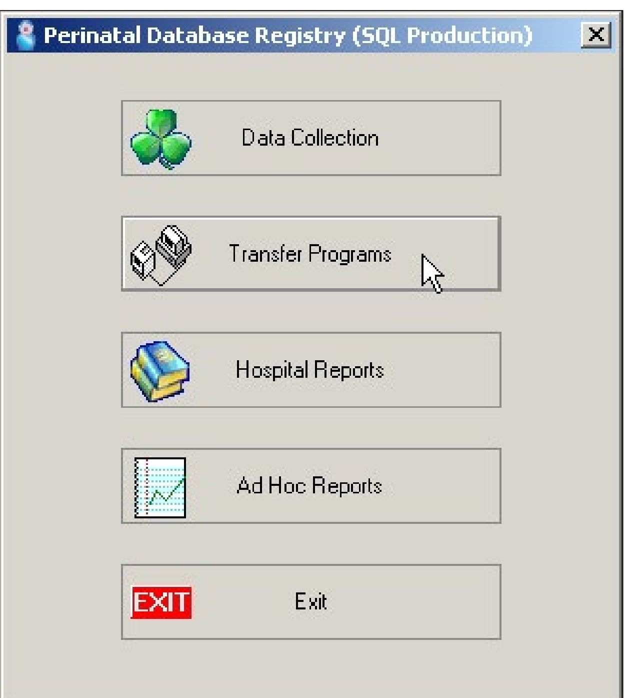
Note: This process will overwrite any manually entered CIHI data in the BCPDR. The hospital's abstracting system is considered the most accurate source of CIHI data.

8.2.3.1 Performing a CIHI Import

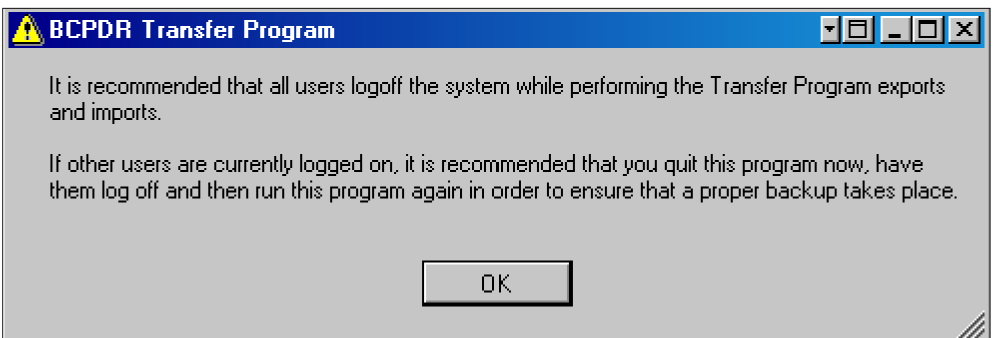
Step 1: Ensure records and Mother and Newborn and/or Transfer Baby linkages are complete

This step is to ensure that all records in the selected date range are ready to be sent to Perinatal Services BC (ie: all records should be saved and validated and Mother and Baby Newborn and/or Baby Transfer/Readmission linkages are complete in your hospital's BCPDR system).

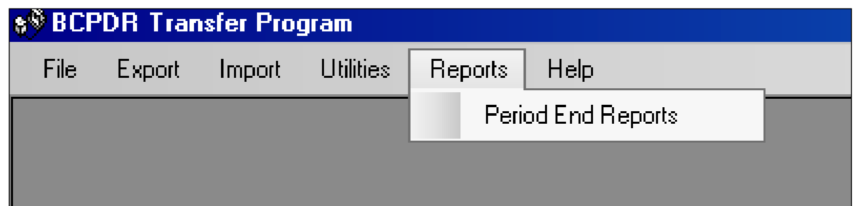
a) Select **Transfer Programs** from the Perinatal Data Registry application menu:



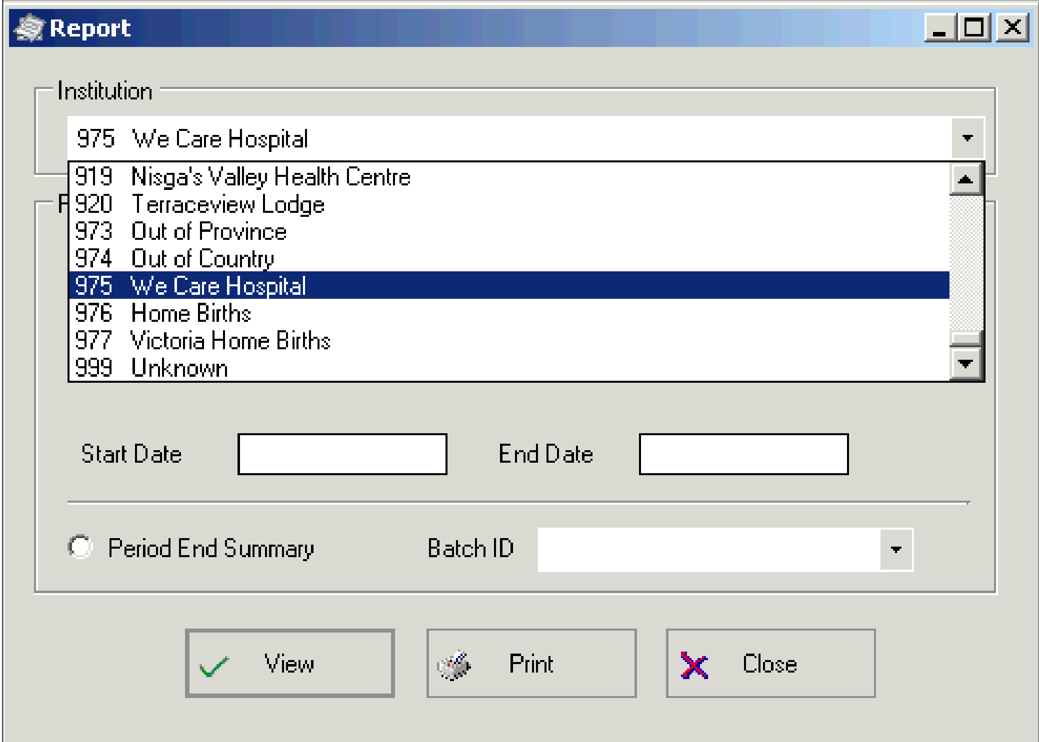
b) The user will be prompted to ensure that all other users at your site have signed off the hospital BCPDR system. If you are part of a merged database system in your Health Authority, you are not required to be off your system when another hospital is performing the Period End Procedure. Press <Enter> or select **OK**.



c) Select **Reports** from the menu bar. Select **Period End Reports**.



d) Select the appropriate institution from the institution field (select from the down arrow to the right):



e) Select and Run these four Period End Reports to identify any linking or validation errors:

   i) 'Unlinked Babies (Newborn and Transfer)'

   ii) 'Unlinked Mothers'

   iii) 'Discharges not Validated (Babies)'

   iv) 'Discharges not Validated (Mothers)'

f) To run a Period End report, select the specific report, enter the **Start Date** and **End Date** and select **View**.

g) Make corrections in the BCPDR as required until the four reports are clear of errors. The following message will display if there are no errors.

Step 2: Obtain CIHI Data from the Health Record Abstracting System

a) Run the CIHI application that creates the CIHI text file to be imported.

   Make sure the same start and end dates are used to run the four reports in the previous section.

   The procedure depends on the CIHI abstracting vendor at the hospital. Please refer to your hospital's procedure for exporting data from your hospital's Health Record Abstracting system.

b) You may place the CIHI text file in the default transfer folder location.

The following criteria are used to determine record selection from the vendor's CIHI Data File:

Baby Records:

- Patient Service 54: Newborns
- Patient Service 89: Stillbirth
- Records with an Admission Category of SB or NB.
- Babies who have been admitted to hospital >24 hours after birth and ≤28 days.
- Babies who have been transferred from another hospital and have reached one year of age.

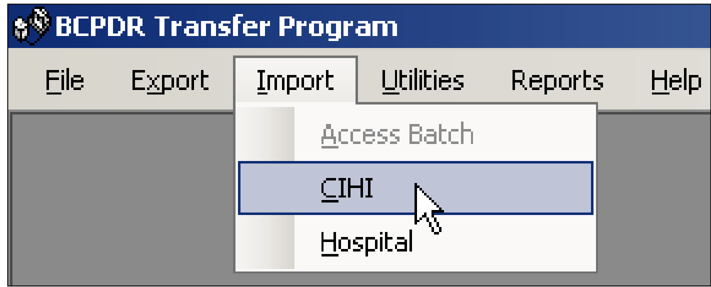
Mother Records:

- Patient Service 51: Obstetrics Delivered
- Patient Service 53: Obstetrics Aborted. These records may indicate a birth ≥20 weeks gestation in which the pregnancy was terminated.
- Patient Service 59 : Postpartum Mother. These patients delivered prior to admission to hospital but admitted within 24 hours of delivery.

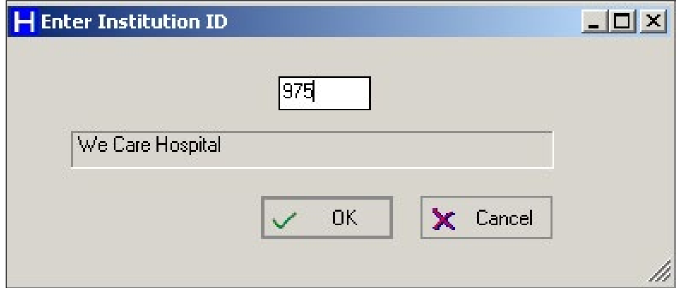
- Mothers admitted as inpatients or surgical day care patients >24 hours post delivery but ≤42 days post delivery.
- Records with an ICD-10 postpartum code: Patients, regardless of the patient service, with a code between O10 and O99 with a 6th digit of 4; or codes F53.0, F53.1, F53.8, F53.9, Z39.0, Z39.1, or Z39.2. These records will be imported into the Postpartum Suite.

Step 3: Transfer CIHI Data to BCPDR

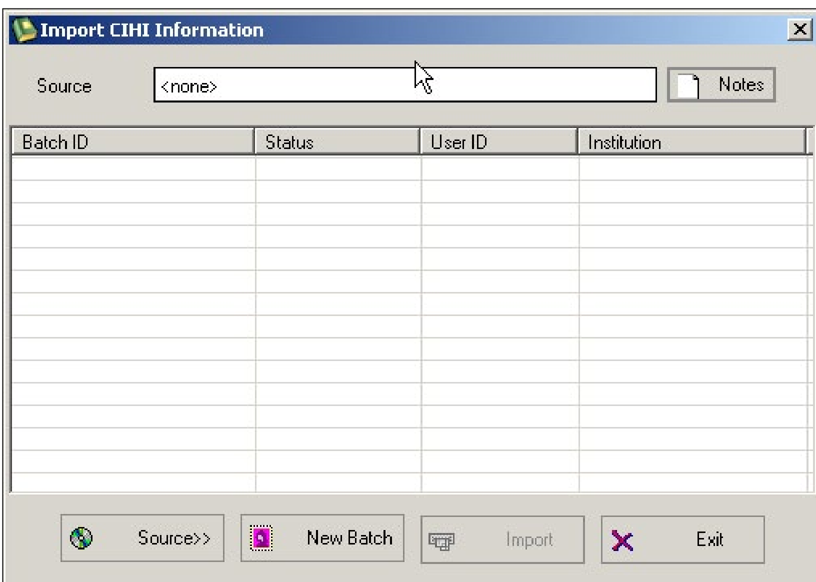
a) Select **Import** from the menu bar. Select **CIHI**.



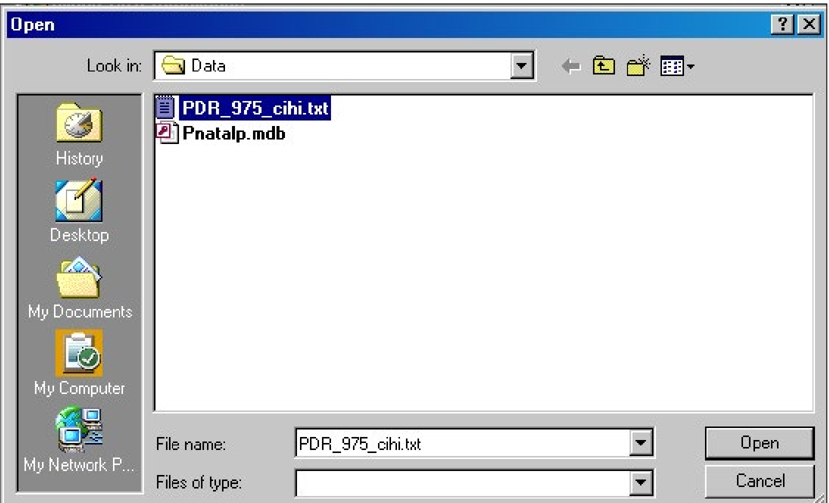
b) The Enter Institution ID screen will display. Enter the 3-digit institution number. The corresponding institution name will display. Select **OK** or <Tab> to **OK** and press <Enter>.



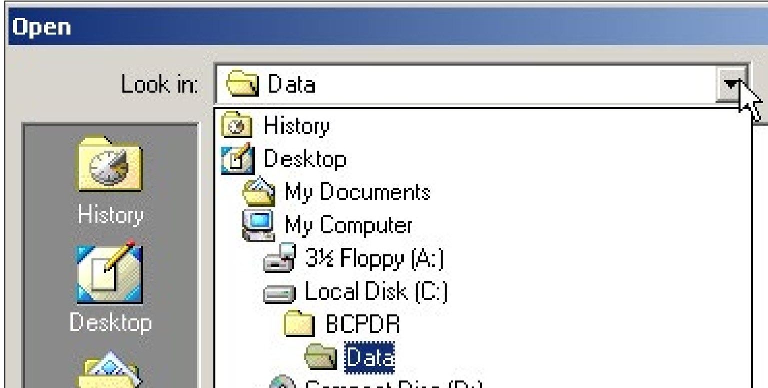
c) The Import CIHI Information screen will display. Select **Source** or press <Alt><S>.



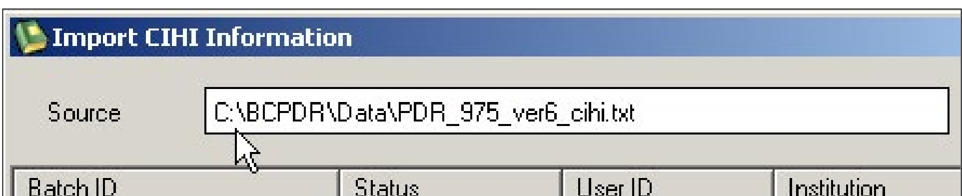
d) The Open screen will appear. This window should be displaying the default folder. If the CIHI text file is saved in the default folder, select the saved file.



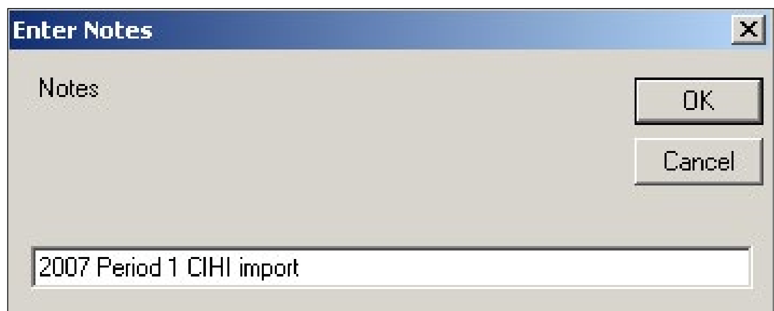
e) If the CIHI text file is in a different folder than the one showing, select from the down arrow to the right of the Look In field to display all available folders. Find and select the path and file name where the CIHI text file is located.



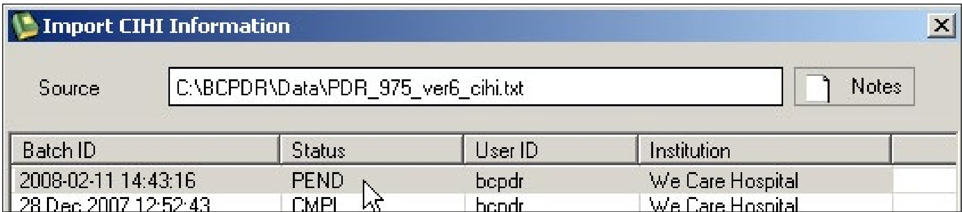
f) Once the correct CIHI text file has been selected, select **Open**. The Import CIHI Information screen returns. The selected path and filename will display in the Source field.



g) Select **New Batch** or press <Alt><N>. The Enter Notes screen will display. It is mandatory to enter information in this field (Eg: date range of what is being transferred). Select **OK** or <Tab> to **OK** and press <Enter>.



h) The Import CIHI Information screen will return. The **Batch ID**, **Status**, **User ID** and **Institution** will display on the top line. The **Status** will show as PEND (pending) until the Import is completed. To import select **Import** or press <ALT><I>.

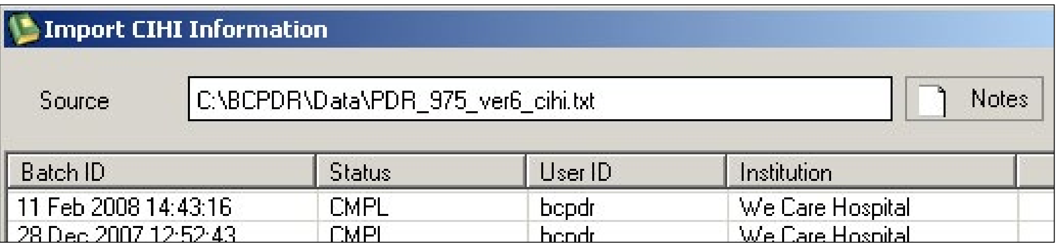


i) A progress bar will appear in the bottom left corner of the screen.

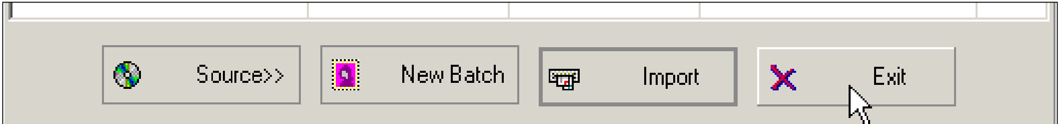
j) After the import is completed, the BCPDR Transfer Program screen displays the number of records imported successfully. After reading the BCPDR Transfer Program screen, select **OK** or press <Enter> to close the screen.

Note: This summary cannot be recalled once the screen is closed.

k) The Import CIHI Information screen will return. The **Status** will now show as CMPL (complete).



l) Select **Exit** or press <Alt><E> to exit.



The CIHI data has now been imported into the BCPDR's CIHI screen. Some cases may not have imported successfully. The following steps will outline how to view and correct these cases.

8.2.3.2 CIHI Import Rejections

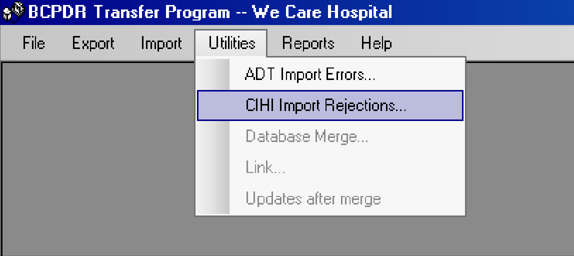
Step 4: Correct Unmatched Cases

The CIHI import only occurs when there is an exact match of six key fields:

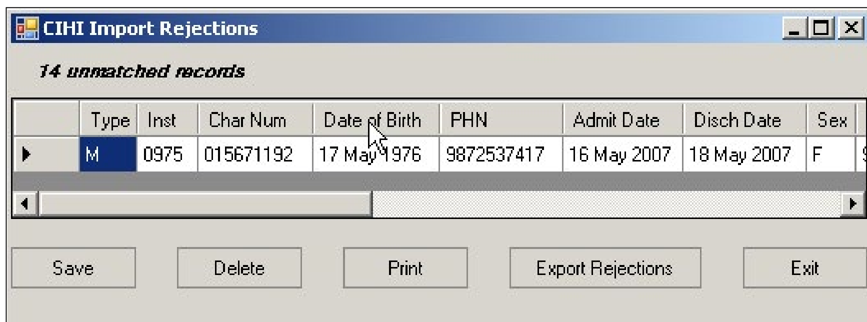
- Chart Number
- Date of Birth
- Discharge Date
- Personal Health #
- Sex (only for Baby Newborn or Baby Transfer/Readmission)
- Admission Date

The CIHI cases from your CIHI text file that did not match the key fields from the BCPDR will be displayed in the CIHI Import Rejections table.

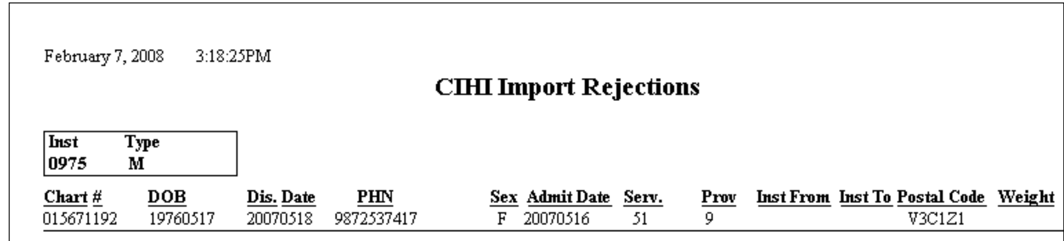
a) Select **Utilities** from the menu bar. Select **CIHI Import Rejections**.



b) The CIHI Import Rejections screen will appear. The screen window and columns are resizable.



c) Select **Print** or press <Alt><P> if a hard copy is preferred for checking the rejected records.



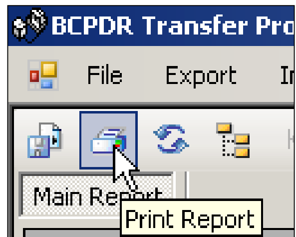
February 7, 2008 3:18:25PM

CIHI Import Rejections

Inst	Type
0975	M

Chart #	DOB	Dis. Date	PHN	Sex	Admit Date	Serv.	Prov	Inst From	Inst To	Postal Code	Weight
015671192	19760517	20070518	9872537417	F	20070516	51	9			V3C1Z1	

d) Select the printer icon on the menu bar.



Common examples of why records are rejected

Example 1:

- The cases selected from the abstracting system did not meet the BCPDR's scope. Patient Service 53 (Obstetric Aborted) and Gestational Age is 12 weeks.

How to correct:

Delete record from the CIHI Import Rejections table.

Example 2:

- The case is a valid record, but was not abstracted in the hospital's Health Record Abstracting system.

How to correct:

Find the chart and add this case. **Save** and **Validate** the record.

Example 3:

- There was not an exact match with the six key fields.

How to correct:

Review the record in the BCPDR. Compare and identify the six key fields from the Mother Screen, Baby Newborn Screen, Postpartum Screen or the Baby Transfer/Readmission Screen in the BCPDR with the six key fields from the rejected records in the CIHI Import Rejections table.

Correcting error in the BCPDR:

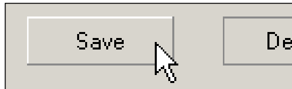
a) Correct the record in the BCPDR.

b) **Save** and **Validate** the data entry screen.

Editing error in the CIHI data:

a) Edit the CIHI Import Rejections table by clicking with the cursor within the field and editing as necessary. All fields in the CIHI Import Rejections table can be edited except Patient Type, Institution and LOS.

b) Select **Save** to save changes.

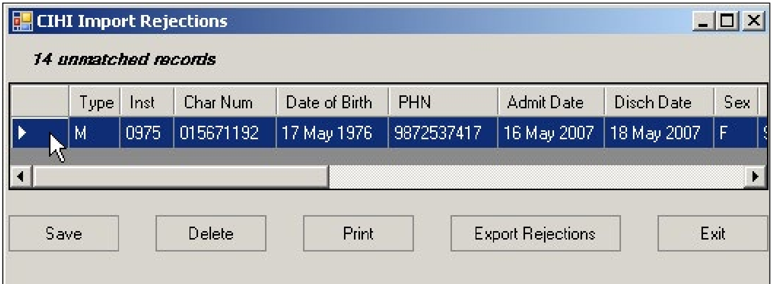


c) Make the correction in your hospital's Health Record Abstracting system.

Deleting CIHI Data

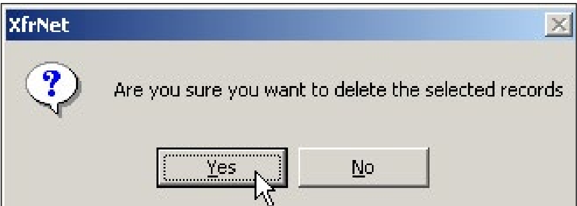
a) If the record is not valid for importing into the BCPDR, it should be deleted from the CIHI Import Rejections table.

b) Select the record by clicking in the record selector cell with your mouse. The entire row will be highlighted.



c) Select **Delete** or press <Alt><D>.

d) You will be asked to confirm the deletion. Select **Yes**.



Note: You can select multiple records for deletion by holding the <Ctrl> button while selecting records.

Exporting CIHI Rejection Table Corrections

a) When the corrections have been completed, select **Export Rejections** or press <Alt><X>:

b) A message box will display to indicate the above changes have been saved in your default folder. To ensure the changes are reflected after each update (deletion of record or amendment of data field(s)) of the CIHI text file, the same computer must be used for all repeated transfers of CIHI data to the BCPDR.

Select **OK** or press <Enter> to continue:

8.2.3.3 Complete CIHI Transfer

Step 5: Repeat Transfer CIHI Data

If cases are still being rejected, repeat Step 3: Transfer CIHI Data to BCPDR and Step 4: Correct Unmatched Cases as many times as necessary until there are 0 rejections.

a) Repeat Step 3: Transfer CIHI Data to BCPDR except:

- **Source** will now be found in the default folder.
- Within this folder, select the **Rejects.chi** file as the **Source**.

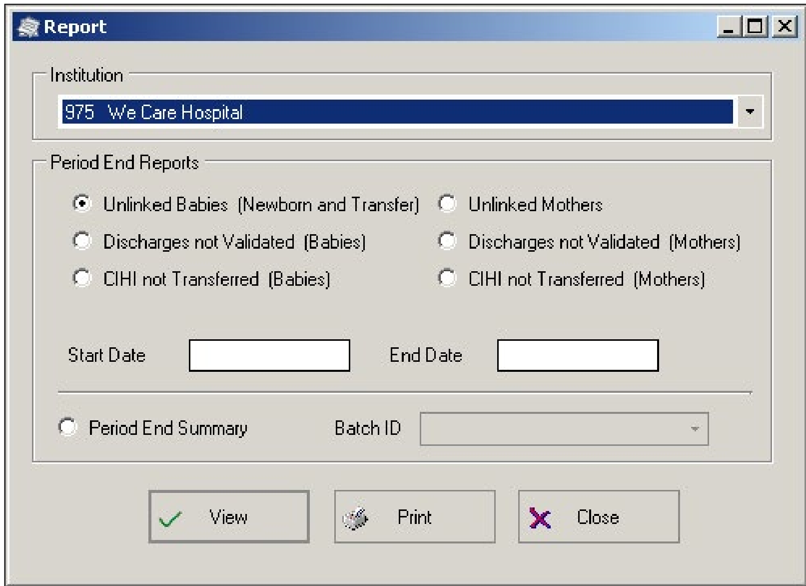
b) Each time **Export Rejections** is selected from the CIHI Import Rejections screen, the previous records in the Rejects.chi file will be overwritten by the updated records in the CIHI Import Rejection table.

Step 6: Check the BCPDR for Missing CIHI

These reports display Perinatal Database cases where the CIHI screen has not been populated.

a) Select **Reports** from the menu bar. Select **Period End Reports**.

The Report screen will display.



b) To run and view a report:

- Select the appropriate **Institution**
- Select a **Period End Report**

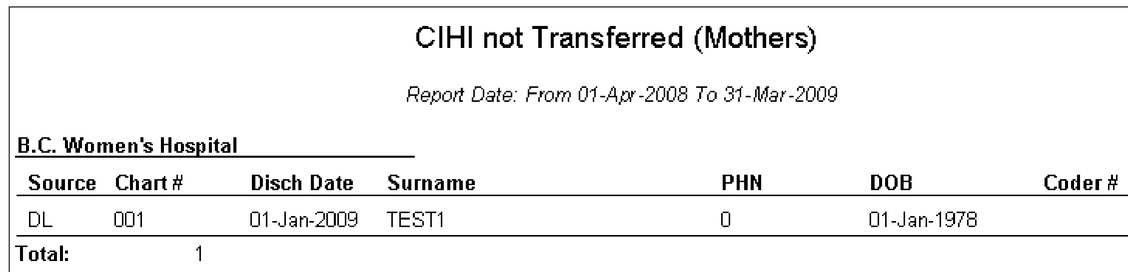
i) 'CIHI not Transferred (Babies)'

ii) 'CIHI not Transferred (Mothers)'

- Enter the **Start Date** and **End Date** (date range of your submission)
- Select **View**

The following message screens will appear if CIHI data is successfully imported from the CIHI text file:

If CIHI data is not successfully imported into a BCPDR record or records, a report is generated to identify which record(s) is/are missing the CIHI data from the CIHI text file.



CIHI not Transferred (Mothers)

Report Date: From 01-Apr-2008 To 31-Mar-2009

B.C. Women's Hospital

Source	Chart #	Disch Date	Surname	PHN	DOB	Coder #
DL	001	01-Jan-2009	TEST1	0	01-Jan-1978	
Total:	1					

Note: BCPDR records without CIHI data cannot be exported.

<u>Common examples of why the CIHI data did not populate the CIHI screen</u>

Example 1:

- The CIHI text file interface (from your vendor) selects Patient Services with 51, 53 or 59 for Mother records. The Mother records may have a different Patient Service; therefore, the CIHI data for that particular record would not appear in the CIHI text file.

How to correct:

Manually abstract the CIHI data, for the specific record, in the CIHI Data Screen from the Mother Suite, Postpartum Suite, Newborn Suite, or Baby Transfer/Readmission Suite.

Example 2:

- The record was entered twice in the BCPDR. The CIHI transfer populates the first record with the CIHI data. The second record will not have any CIHI information.

How to correct:

Delete the second record.

Example 3:

- The patient visit has not been completed in the hospital's Health Record Abstracting system.

How to correct:

Manually abstract the CIHI data, for the specific record, in the CIHI Data Screen from the Mother Suite, Postpartum Suite, Newborn Suite, or Baby Transfer/Readmission Suite.

When steps 1 to 6 are successfully completed, all the BCPDR's CIHI Data Screen from all the suites will be populated.

The CIHI flag, which is located on both the mother_admission and baby_admission tables, will be set to <u>Y</u> for each record.

Note: Records without the CIHI flag of <u>Y</u> will not be exported to the BCPDR.

8.2.3.4 Data Quality Checks

Data quality checks are performed to ensure that CIHI data matches data abstracted in BCPDR screens.

Run your facility specific data quality checks or other data quality initiatives (Eg: BCPDR Data Quality Tool) before proceeding to Step 7.

Step 7: Complete Data Quality Checks

a) Select **Reports** then **Period End Reports**

b) Select each of the following reports and select **View**.

REPORTS	CHECKS	HOW TO CORRECT
• Unlinked Babies (Newborn and Transfer) • Unlinked Mothers	That all records are linked. (These reports were run previously, prior to the transfer of CIHI data to the BCPDR.)	1) **Find** the record in the BCPDR. 2) **Link** the records. 3) **Save** and **Validate**.
• Discharges not Validated (Babies) • Discharges not Validated (Mothers)	That all records are validated. (These reports were run previously, prior to the transfer of CIHI data to the BCPDR.)	1) **Find** the record in the BCPDR. 2) **Save** and **Validate**.

8.2.3.5 Exporting Completed Records

The final step in the Period End Procedure includes the creation of a new batch file and the electronic submission of this file to PSBC.

Step 8: Export Completed Records to a File

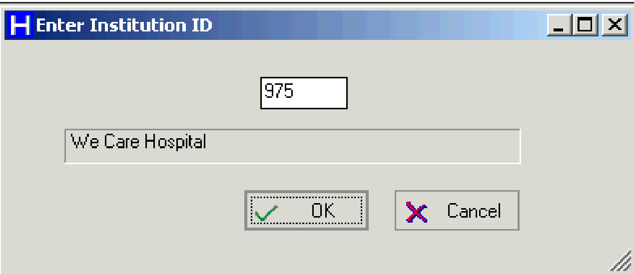
This step involves creating an MS Access batch file for submission to BCPDR.

a) Open the **Transfer Programs** application from the BCPDR.

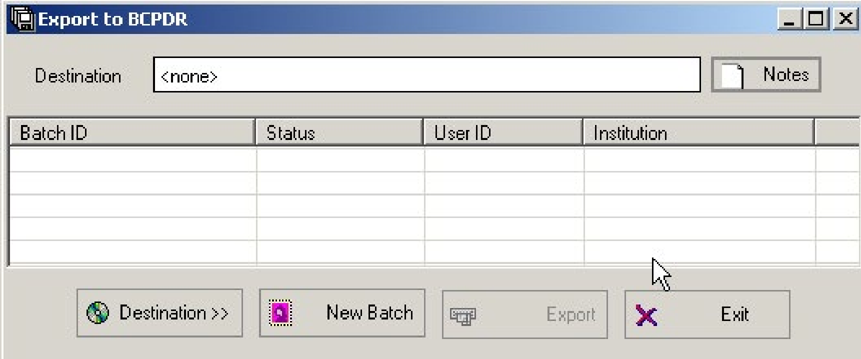
The user will be prompted to ensure that all other users have signed off the Perinatal Database system. Select **OK**.

Select **Export** from the menu bar. Select **Access Batch**.

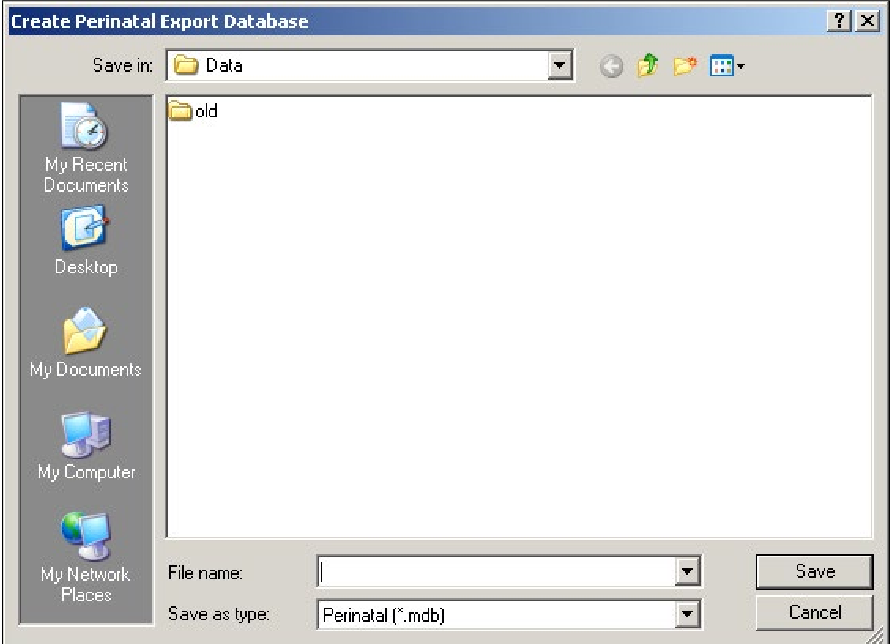
b) The Enter Institution ID screen will display. Abstract the 3-digit institution number. Select **OK** or <Tab> to **OK** and press <Enter>.



c) The Export to BCPDR screen will display. Select **Destination** or press <Alt><D>.



d) The Create Perinatal Export Database screen will display.



Save in:

From the **Save in:** field, at the top of the screen, identify which network drive and folder the exported data file will be saved in.

Note: The path is currently defaulted to the BCPDR data folder set in the PDR Setup Utility

File name:

The **File name:** is not automatically assigned and should be descriptive of the type of file being exported (Eg: period submission or data quality).

Here is an example of the recommended naming convention for exported data files:

Eg: H975.08p2-3.mdb

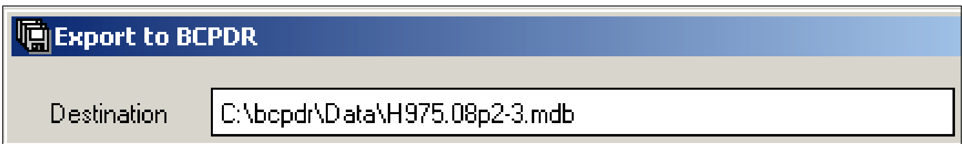
H	= hospital
975	= 3-digit institution number
08	= fiscal year
p2-3	= p plus submission period number (if there is more than one period being submitted, they should be separated by hyphens)
.mdb	= file name extension

Save as type:

Save as type: should be Perinatal (*.mdb).

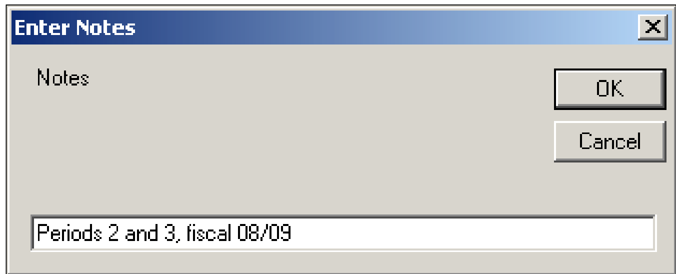
Select **Save** or press <Enter>.

e) The Export to BCPDR screen will return with the Destination field completed.



f) Select **New Batch** or press <Alt><N>:

g) The Enter Notes screen will display. It is mandatory to enter something in Enter Notes (Eg: submission period and fiscal year). This note is an internal label, which will be printed on the second page of the Period End Summary report. Select **OK** or <Tab> to **OK** and press <Enter>.

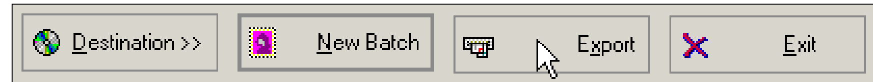


h) The Export to BCPDR screen will return.

Batch ID	Status	User ID	Institution
2009-03-31 14:30:07	PEND	bcpdr	We Care Hospital

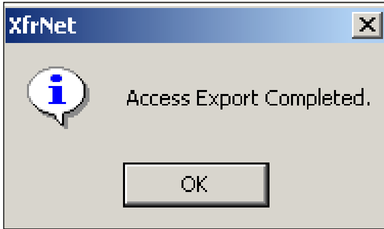
Note: The Batch ID, Status, User ID, and Institution will display on the top line. The Status will list as PEND (pending) until the Export is completed.

i) Select **Export** or press <Alt><X>.

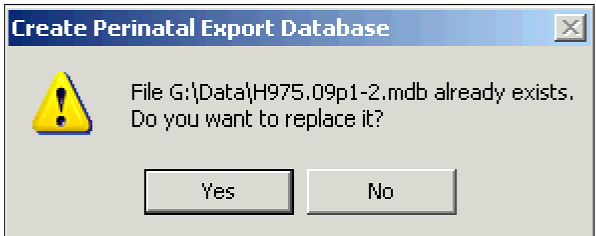


j) During Export, a progress bar will appear in the bottom left corner of the screen.

k) When the Export is complete, the following screen will display. Select **OK** or press <Tab> then <Enter>.

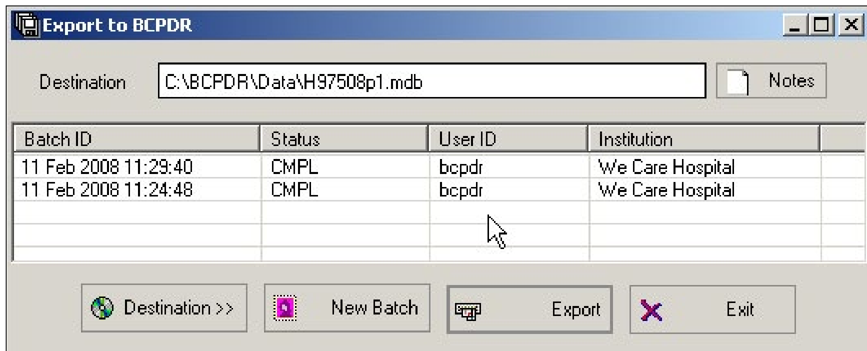


If a Batch had been previously exported with the same file name, this message screen will display.



- Do not overwrite the file. Select **No.**
- The Create Perinatal Export Database screen will display. Rename the file.
- Select **Save**.
- Select **New Batch** and enter text in Enter Notes.
- Select **OK**.
- Select **Export**.

l) After completing the Export, the Export to BCPDR screen will display.

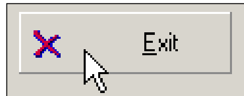


Note: The Status of the batch will now be CMPL (complete).

m) Upon completion of the export, the submission batch file is created. This file is a Microsoft Access file and will have the file extension of '.mdb'. The location of this '.mdb' file was determined at the time when creating the Perinatal export database (Eg: **Save in:**).

After Exporting, the transfer_batch_id field, located on both the mother_admission and baby_admission tables, will be populated with the current date/time for each record where the cts_flg and the cihi_flg are both set to Y (refer to *Section 8.2.3.8 How the BCPDR Recognizes Records for Export on page 176*). These records, which have successfully been exported, are ready to be sent to PSBC.

n) After creating the Export File, select **Exit** or press <Alt><E> to close the screen.



Note: Do not re-run another Export on the same data after an Export file had been created. Call the Helpline if you are encountering exporting problems.

Please retain this file for at least six to twelve months in an unzipped format. It may be necessary to re-send the file at a later date.

8.2.3.6 Period End Summary

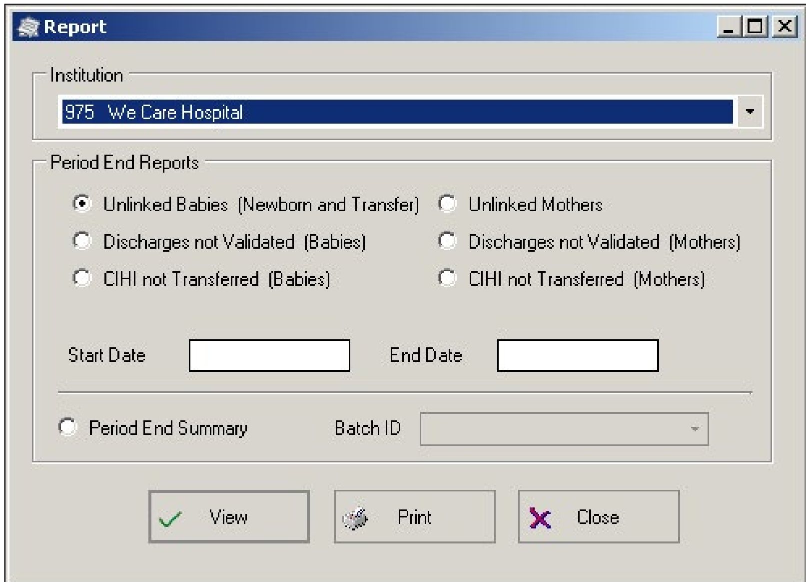
Step 9: Create Period End Summary File

Run the Period End Summary after Exporting is complete (Step 8: Export Completed Records to a File).

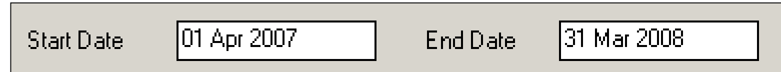
The Period End Summary is used for hospital reimbursement. Both the Period End Summary and the Exported file are to be sent to PSBC electronically through the eHealth Network Gateway (eNG). PSBC will add the account number to the Period End Summary for facilities currently manually entering this information. If your facility account number and/or billing information changes, please inform PSBC immediately.

a) Select **Reports** from the menu bar. Select **Period End Reports**.

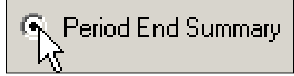
The Report screen will display.



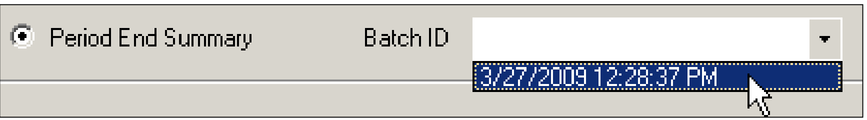
b) Enter the **Start Date** and **End Date**.



c) Select 'Period End Summary'.



d) Select the Batch ID for the Transfer Batch just exported. Make sure that the date and time match when the export was performed. Only Batch IDs for the selected Institution will appear in the list.



e) Select **View** to open the Period End Summary.

f) Review the Period End Summary to make sure the information is correct.

975 We Care Hospital

REQUEST FOR PAYMENT

Date: 27-Mar-2009

Invoice: BC PERINATAL DATABASE REGISTRY
F-502 - 4500 Oak Street, Vancouver, BC V6H 3N1

Institution: **975 We Care Hospital**
Health Records Department

Make Payment To:
(include cost centre if applicable)

Attention:

20 Baby Newborn Records	@	$10.00 =	$200.00	
1 Transfer/Readmission Records	@	$3.00 =	$3.00	
3 Postpartum Mother	@	$3.00 =	$9.00	
TOTAL			**$212.00**	**PAY THIS AMOUNT**

BCPDR USE ONLY

BUSINESS UNIT
FUND
SITE
DEPARTMENT
ACCOUNT #
AUTHORIZATION

Remit One Copy With Cheque To Health Authority

For Batch ID: 3/27/2009 12:28:37PM

Use the report navigation buttons at the top of the screen to switch pages:

975 We Care Hospital

REQUEST FOR PAYMENT

PERIOD END SUMMARY REPORT

Batch ID: 3/27/2009 12:28:37PM

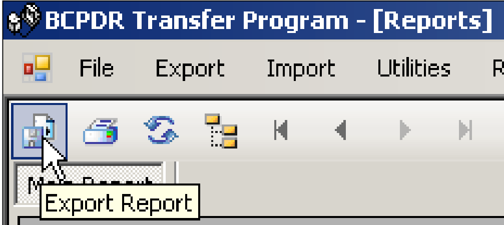
Batch Notes: klsd;klde

	1st SEND	RE-SEND	TOTAL
MOTHER	7	0	7
PP MOTHER	3	0	3
BABY NEWBORN	20	0	20
BABY TRANSFER/READMISSION	1	0	1

DISCHARGE DATE RANGE: from 01-Apr-2007 to 31-Mar-2008

Title	Service Code	# Of Cases
BABY SERVICES:	20	1
BABY SERVICES:	54	18
Total		**19**
MOTHER SERVICES:	51	5
MOTHER SERVICES:	59	2
Total		**7**

g) To save an electronic copy of the Period End Summary report, select **Export Report** on the toolbar from the top left corner of the screen:

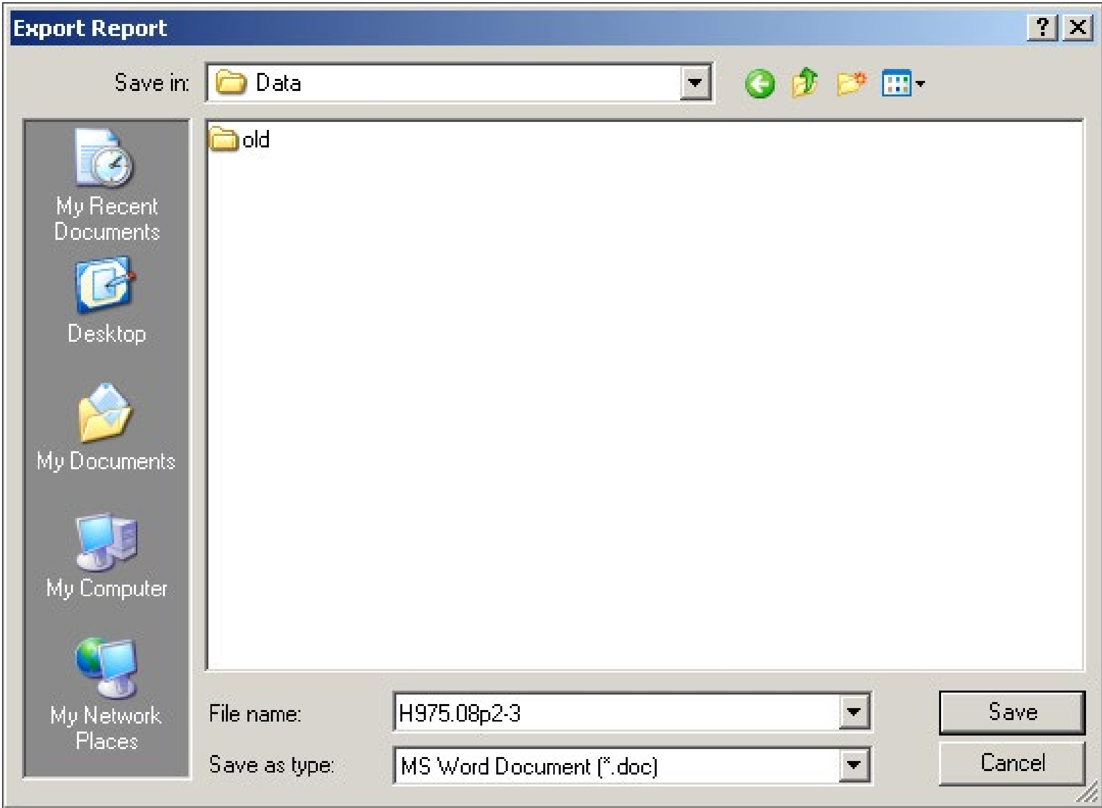


The Export Report screen will display.

Save in:

From the **Save in:** field, at the top of the screen, identify which folder the electronic copy of the Period End Summary report will be saved in.

Note: The path is currently defaulted to the BCPDR data folder set in the PDR Setup Utility but if another folder is preferred, change the folder setting.



File name:

The **File name:** is not automatically assigned and should be descriptive of the type of file being exported (Eg: period submission or data quality).

Here is an example of the recommended naming convention for exported data files:

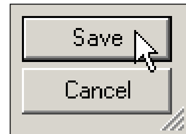
Eg: H975.08p2-3.doc

H	= hospital
975	= 3-digit institution number
08	= fiscal year
p2-3	= p plus submission period number (if there is more than one period being submitted, they should be separated by hyphens)
.doc	= file name extension

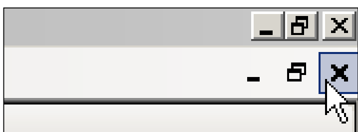
Save as type:

Save as type: should be MS Word Document (*.doc)

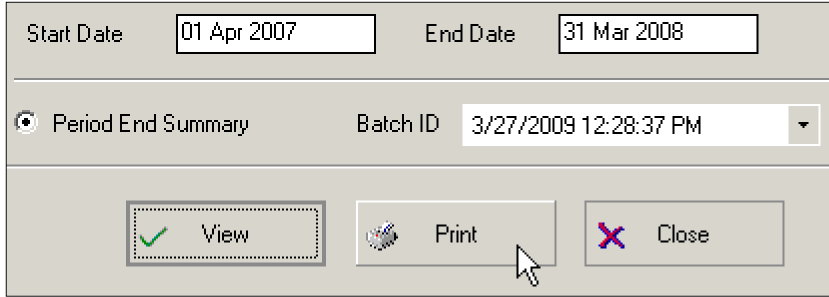
Select **Save** to complete the **Export**.



h) To return to the Data Transfer application, select the lower ‘x’ button. If you select the upper ‘x’ button, the Data Transfer application will close completely.



i) A hard copy of the Period End Summary may be printed from either the Report Viewer at the top left corner toolbar or from the Report screen (select Print):



8.2.3.7 Electronic Data Submission

After exporting, the submission batch file and Period End Summary are ready to be submitted to PSBC on the eHealth Network Gateway (eNG) FTP server.

Step 10: Send Export and Period End Summary Files

Detailed instructions for Electronic Data Submission are available as a separate document.

Electronic File Transmission

Login to the eNG FTP server and navigate to the folder designated for your hospital.

Please send an email to ***psbc@phsa.ca*** to notify PSBC that a submission file is waiting to be picked up from the eNG.

Post Transmission

A PSBC Product Support Analyst will return an email to notify you that the file had been retrieved and is free of errors. Please keep a copy of the unzipped submission batch files for at least six to twelve months as a backup.

8.2.3.8 How the BCPDR Recognizes Records for Export

Completed records are exported to PSBC at Period End. The system recognizes completed records if the record meets the following three criteria:

- The CTS flag must be set to Y
- The CIHI flag must be set to Y
- The transfer_batch_id must be blank.

These criteria fields are located in the mother_admission table and the baby_admission table.

	How field is activated to meet criteria:	Other Details:
CTS flag (clear to send flag)	Is blank until record is Saved and Validated. The flag is then set at Y.	If the record is Saved, and not Validated, the flag is set at N.
CIHI flag	Is blank until the Doctors Service and Diagnoses fields are populated in the CIHI screen. The flag is set at Y.	Doctor Service and Diagnoses fields are populated after the transfer of CIHI data to the BCPDR (refer to the Period End Procedure, Steps 3, 4 and 5). If these fields cannot be imported, Doctor Service and Diagnoses fields can be manually abstracted.
Transfer_batch_id	Is blank until the Transfer Program that exports records to the BCPDR is run. The transfer_batch_id is then populated with the date/time the export was run.	The date/time in the transfer_batch_id is the batch date and time that displays when the export is run. Edits to the record: If the record is edited in the entry screens, then Saved and Validated, the date/time is removed from the transfer_batch_id field. This signals the system that there has been a change to this record. The transfer_batch_id will again be populated with the next export. Transfer count: When the transfer_batch_id is populated, the system will add 1 to the transfer_count field. *Eg: If the record is exported for the first time, the transfer_count is updated from the value of null to 1. If the record is exported a second time, the transfer_count is updated from 1 to 2.*

8.2.3.9 Period End Flowchart

HOSPITAL PERINATAL DATABASE

1. Enter period data into the BCPDR Data Collection suites
2. Complete Mother/Baby linkages.
3. Run Period End Reports:
   - Unlinked Baby (Newborn and Transfer)
   - Unlinked Mothers
4. Ensure all Records are Validated.
5. Run Period End Reports:
   - Discharges not Validated (Babies)
   - Discharges not Validated (Mothers)
6. Make corrections/updates to Data.

HOSPITAL CIHI ABSTRACTING SYSTEM

1. Complete CIHI abstracting.
2. Correct CIHI data (based on CIHI default reports).
3. Create CIHI text file from hospital's Health Record Abstracting system.

↓

CIHI DATA

1. Transfer data from the CIHI abstracting system.
   - Run CIHI Import
   - Run CIHI Import Rejections utility
   - Export CIHI rejections (if required)
   - Re-Run CIHI Import (if required)
2. Ensure all CIHI records are imported.
3. Run Period End Reports:
   - CIHI not Transferred (Babies)
   - CIHI not Transferred (Mothers)

↓

DATA QUALITY

1. Run facility specific DQ or other DQ checks if applicable.
2. Re-run Period End Reports:
   - Unlinked Baby (Newborn and Transfer)
   - Unlinked Mothers
   - Discharges not Validated (Babies)
   - Discharges not Validated (Mothers)

↓

EXPORT DATA TO BCPDR

1. Run Export Access Batch.
2. Run Period End Summary report.
3. Electronically submit encrypted files to PSBC via the eNG.

↓

Notify Perinatal Services BC via e-mail

8.2.3.10 Period End Checklist

☐ **CIHI Default Errors have been corrected**

☐ **Step 1: Ensure records are validated and mother/baby linkages are complete**

- Run Period End Report – Unlinked Babies (Newborn and Transfer)
- Run Period End Report – Unlinked Mothers
- Run Period End Report – Discharges not Validated (Babies)
- Run Period End Report – Discharges not Validated (Mothers)

☐ **Step 2: Obtain CIHI Data from abstracting system**

☐ **Step 3: Transfer CIHI Data to BCPDR**

- Run Import CIHI from BCPDR Transfer Program application.

☐ **Step 4: Correct Unmatched Cases**

- Run Export Rejections

☐ **Step 5: Repeat Transfer CIHI Data**

☐ **Step 6: Check the BCPDR for Missing CIHI:**

- Run Period End Report – CIHI not Transferred (Babies)
- Run Period End Report – CIHI not Transferred (Mothers)

☐ **Step 7: Complete Data Quality Checks:**

- Re-Run Period End Report – Unlinked Babies (Newborn and Transfer)
- Re-Run Period End Report – Unlinked Mothers
- Re-Run Period End Report – Discharges not Validated (Babies)
- Re-Run Period End Report – Discharges not Validated (Mothers)

☐ **Step 8: Export Completed Records to a File**

☐ **Step 9: Create Period End Summary File**

☐ **Step 10: Send Exported Data and Period End Summary Files to PSBC**

- Encrypt and upload the Exported Data and Period End Summary files via the eNG
- E-mail PSBC for submission notification of files

THIS PAGE INTENTIONALLY LEFT BLANK

9. REPORTS

PSBC's mandate is directly supported by the operation and maintenance of the BC Perinatal Data Registry (BCPDR), a provincial database that captures critical individual-level obstetrical and neonatal data for virtually all births occurring in BC. The Surveillance team provides ongoing systematic analysis and interpretation of perinatal data in order to describe and monitor trends in perinatal health in BC. Working closely with the Information Systems team, we provide health care providers, policy makers, planners, administrators, and researchers with timely, relevant and quality data to improve maternal-fetal and newborn outcomes, as well as to facilitate systems planning, guide decision making, and enhance knowledge generation and translation.

9.1 Provincial Reports

A number of provincial reports have been developed that monitor trends in perinatal health in BC. These reports can be found in the Data & Surveillance section of PSBC's website ***www.perinatalservicesbc.ca*** and are regularly updated. Specific reports are described below.

9.1.1 Annual Indicators for BC Residents and for Place of Delivery

The Perinatal Surveillance Indicators Report includes data for BC by place of residence and place of delivery for ten fiscal years. Reports are available for BC and for each Health Authority in BC.

9.1.2 Core Surveillance Quarterly Report

The Perinatal Surveillance Quarterly Report includes data for BC residents for the most recent five years. The focus of this report is to provide BC-level data on selected indicators of maternal and neonatal morbidity.

9.1.3 PSBC Perinatal Health Report

This report describes the current state of perinatal health in BC, and serves as the baseline to monitor future trends and changes for a larger set of maternal/newborn indicators than are presented in the Annual or Quarterly Indicator reports. This report includes indicators with clinical and public health importance. These indicators may change in response to changing patterns of care or a changing profile of women and newborns in British Columbia.

9.1.4 Special Reports

Special reports are produced to explore selected topics in greater detail. Annual Robson Ten Group Classification tables for British Columbia are included in this section.

9.1.5 Facility-level maternity and neonatal indicators

Labour and birth information for each hospital in British Columbia with planned obstetrical services is available on a searchable website to expectant mothers, their families, the general public, and healthcare providers. The information is being provided to help maternity care providers continue to improve care and support the best outcomes for mothers and babies. The information can also help women have informed conversations with their doctors, midwives, or nurse practitioners about their labour and delivery options. This initiative was launched in October 2013.

Any questions please contact Perinatal Services BC at ***psbc@phsa.ca***.

9.2 Hospital Reports

A standard set of hospital-specific reports can be run by selecting the Hospital Reports button from the Perinatal Data Registry application.

9.2.1 Standard Hospital Reports

** Indicates the report is a Fiscal Year report. It provides a Summary of data for a selected fiscal year as well as current year-to-date and previous years.*

HOSPITAL REPORT	DETAILS	SCREENS USED	FIELDS USED
Anesthetic/ Analgesic*	Summarizes the occurrence of each type of anesthetic/analgesic given to the mother.	Birth Summary	• Anesthetic/Analgesic
		Antenatal	• Term • Preterm • Prev C/S • Prev Vag
		Mother	• Discharge Date
Cesarean Section Summary Tables	Summarizes the occurrence of each type of Cesarean section. VBAC information is also provided.	Birth Summary	• Primary Indic. For Operative Delivery • C/S Type • VBAC Attempted • Baby Sequence
		Antenatal	• Prev C/S • Term • Preterm • Prev Vag
		Mother	• Discharge Date
Detail – Baby Transfer/ Readmissions	Provides selected information for each baby transfer/ readmission. Provides one page for each case. Will generate a cover sheet indicating total number of cases for the date range.	Selected screens	Selected fields
Detail – Mother Discharges	Provides selected information for each mother. Provides two pages for each case. Will generate a cover sheet indicating total number of cases for the date range.	Selected screens	Selected fields

HOSPITAL REPORT	DETAILS	SCREENS USED	FIELDS USED
Detail – Newborn Discharges	Provides selected information for each baby newborn. Provides one page for each case. Will generate a cover sheet indicating total number of cases for the date range.	Selected screens	Selected fields
Episiotomy/Tear*	Summarizes the occurrence of each type of episiotomy or tear experienced by the mother during delivery.	Birth Summary	• Perineum/Vagina/Cervix • C/S Type
		Mother	• Discharge Date
		Antenatal	• Term • Preterm • Prev C/S • Prev Vag
Gestational Age at Birth	Summarizes the gestational age of babies and provides subtotals for live births and stillbirths.	Calculated final gestational age	
		Newborn Record	• Stillbirth • Discharge Date • Baby Sequence
Hospital readmissions due to breastfeeding problems	Identifies the number of babies who were born at the hospital and subsequently readmitted for breastfeeding and dehydration problems.	Baby Transfer/ Readmission in CIHI	• Breastfeeding problems (diagnosis codes P920 – P929, R633) • Dehydration (diagnosis codes E860, E868, P718, P719, P7420 – P7444)
Indication for Induction*	Summarizes the occurrence of each type of primary indication for induction for the mother.	Birth Summary	• Indication for Induction • C/S Type • Baby Sequence
		Antenatal	• Term • Preterm • Prev C/S • Prev Vag
		Mother	• Discharge Date

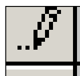
HOSPITAL REPORT	DETAILS	SCREENS USED	FIELDS USED
Labour Initiation*	Summarizes the categories of labour initiation for the mother.	Birth Summary	• Labour Initiation
		Antenatal	• Term • Preterm • Prev C/S • Prev Vag
		Mother	• Discharge Date
Live births by birth weight*	Summarizes the birth weight categories of babies and provides subtotals by period.	CIHI Screen	• Admission Weight
		Newborn Record	• Stillbirth
		Baby Newborn	• Discharge Date • Baby Sequence
Maternal age at EDC vs. newborn size	Summarizes the estimated age of mother at the date of confinement and provides comparisons with the newborn's birth weight.	Final gestational age calculation	
		Baby Newborn	• Discharge Date • Baby Sequence
		Baby CIHI	• Admission Weight
		Mother	• Date of Birth
		Birth Summary	• Delivery Date
Summary statistics – baby newborn	Provides statistical information. Eg: total births, live births (singleton etc), stillbirths (when death occurred) and LOS.	Baby Newborn	• Admission Date • Discharge Date • Baby Sequence
		Newborn Record	• Stillbirth • Discharge To
Summary statistics – baby transfer & readmission	Provides statistical information. Eg: total baby transfer/ readmission, LOS, babies transferred in.	Baby Transfer/ Readmission	• Admission Date • Discharge Date
Summary statistics – mother	Provides statistical information. Eg: total mother discharges, C/S and type, VBAC's (failed and successful) and LOS (antepartum, postpartum).	Mother	• Admission Date • Discharge Date
		Birth Summary	• CS Type • VBAC Attempted
		Baby Newborn	• Admission Date

PARAMETERS FOR HOSPITAL REPORTS

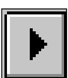
PARAMETER	DETAILS
Discharge Date Range	All records with discharge dates greater than or equal to the Start Date and less than or equal to the End Date will be included in the report.
Fiscal Year	All records with discharge dates greater than or equal to the Start Date of period 1 and less than or equal to End Date of Period 13 of selected year will be included in the report.
Last Period	The last period reported on reports providing year-to-date information. Defaults to the current period (as determined by the current date).
Parity	Nulliparous – Only mothers who have had one delivery will be included in the report. Multiparous – Only mothers with two or more deliveries will be included in the report. Total – All mothers will be included in the report.
Baby Outcome	Singleton – Only single births will be included in the report. Multiple – Only multiple births (Eg: twins, triplets, etc) will be included in the report. Total – All babies will be included in the report.
All Institutions	Will select all hospitals that have records in the database (Eg: database contains more than one hospital).
Single (Institution)	Will report on specified hospital. Select from drop down list (all Institution button must be turned off).

9.2.2 Change Fiscal Year For Hospital Reports

Database Symbols



Indicates an inactive row that is currently being populated with manually entered data in the fields in the row. This symbol will disappear, after tabbing to the next row, once all entry is complete for the fields in the row.

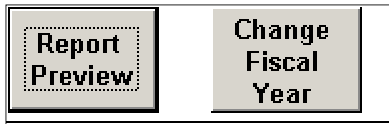


Indicates the row that user is presently in.

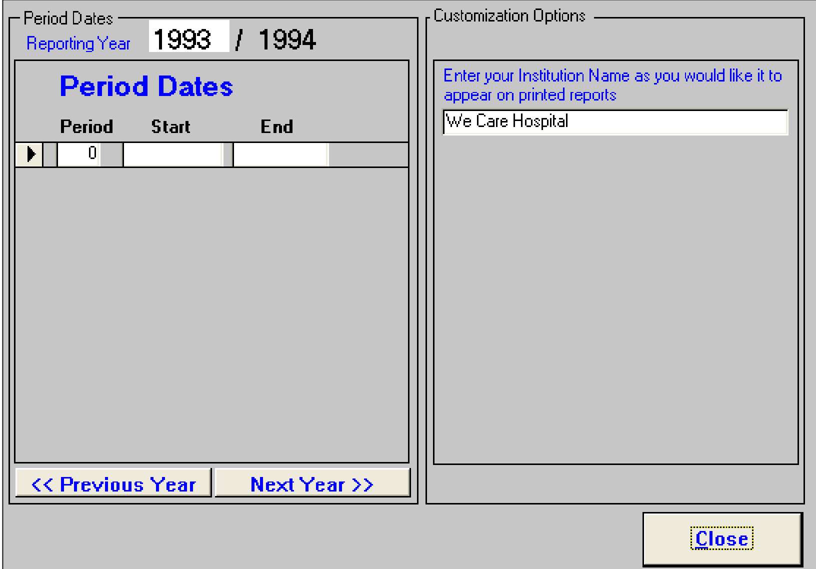
Indicates the last row that has not been activated.

The **Reporting Year** and **Period Dates** for the Hospital Reports application should be updated every fiscal year.

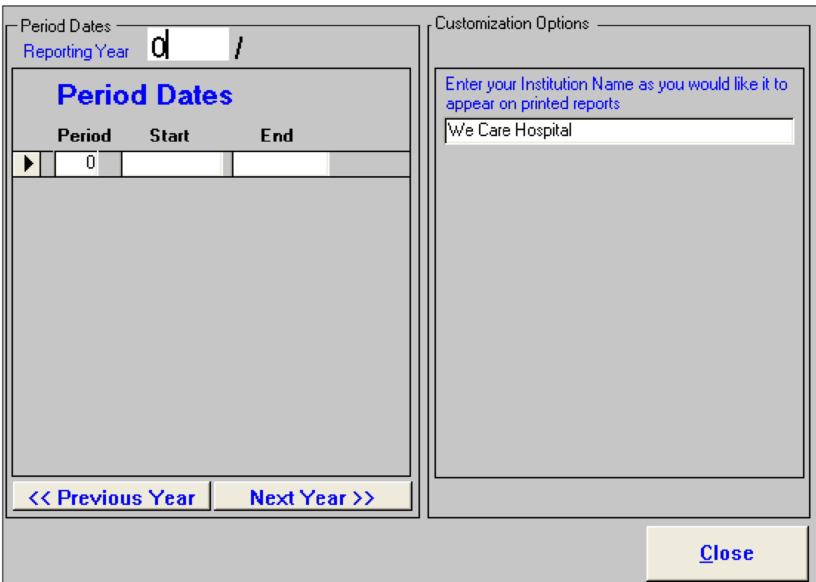
a) Select **Change Fiscal Year** on the bottom of Hospital Reports screen.



The Period Dates screen will display.



b) Select **Next Year>>**. Continue clicking until the Report Year is 0. This is the year that requires updating.

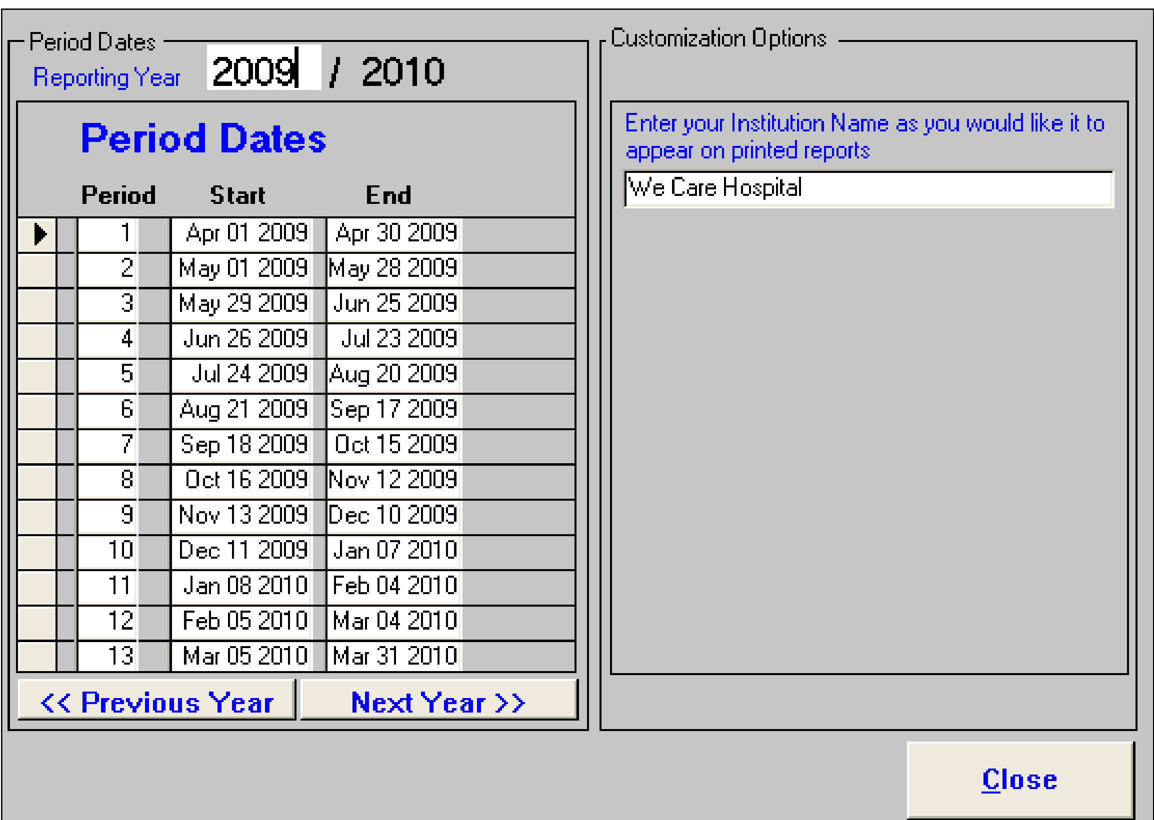


c) Entering Fiscal Year and Period Ranges.

- The new fiscal year in the **Reporting Year** field should always be entered first before the **Period Dates.**
- Click and place your cursor in the **Reporting Year** field that is currently defaulted to 0. Enter the new fiscal year and then press <Tab>.

  The system will automatically fill in the corresponding year in the **Reporting Year** field.

  Eg: When 2009 is entered, the system will automatically fill in 2010.
- The cursor will move to the first **Period** field in the **Period Dates** section that is defaulted to 0. Enter 1 and then press <Tab>.
- The cursor will move across the row to the **Start** and **End** fields. Enter the **Start** date and **End** date for the corresponding period for the fiscal year.
- Enter corresponding dates for all 13 periods in the fiscal year.



d) Select **Close** to exit the screen.

9.3 Ad Hoc Reports

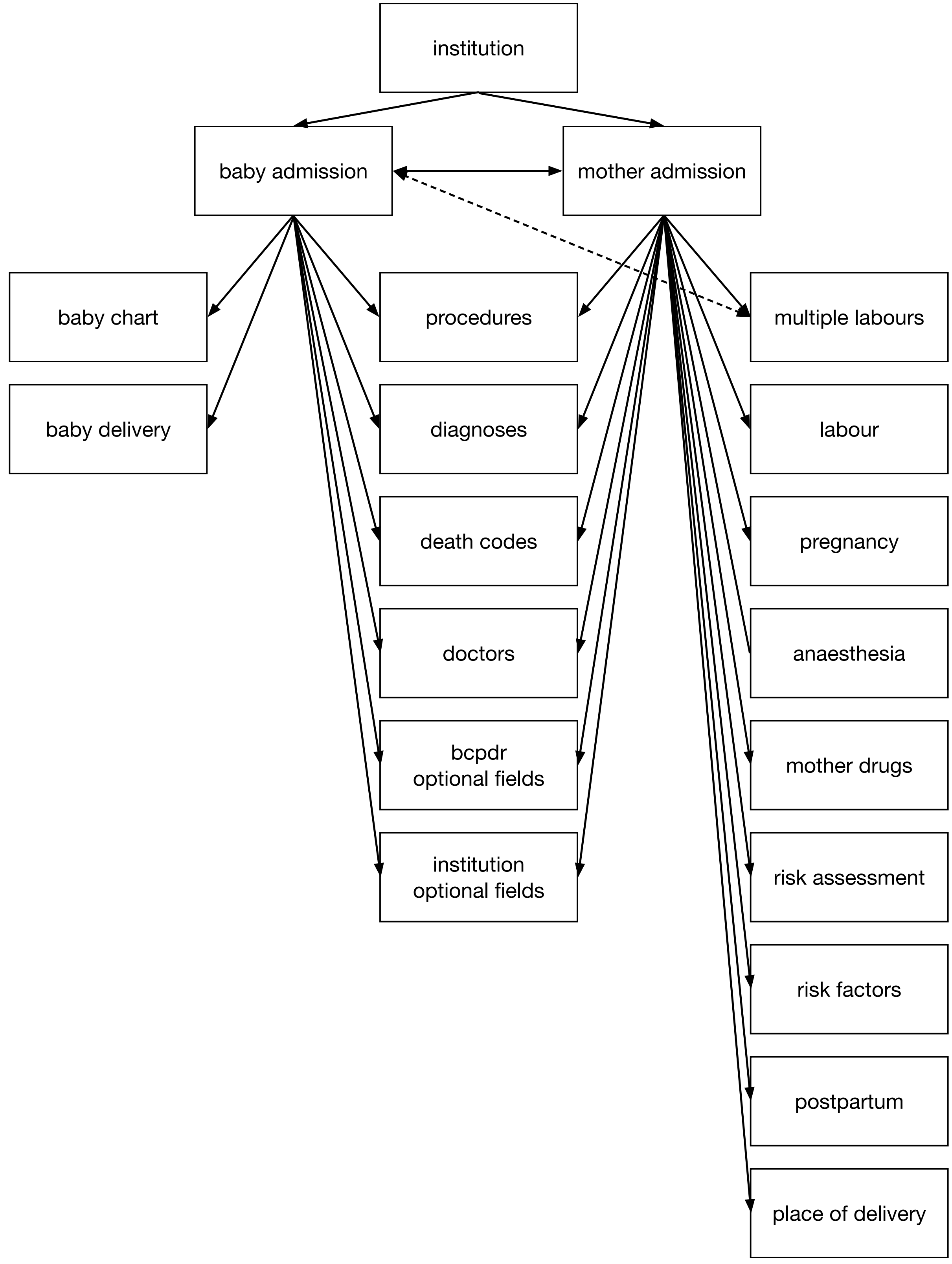
9.3.1 Ad Hoc Reporting

PSBC no longer provides technical assistance for the use of MS Access for the purpose of ad hoc reporting from the BCPDR. Please see your local reporting, surveillance or decision support department for assistance with your reporting needs.

Any questions please contact PSBC at ***psbc@phsa.ca***.

9.4 Database Structure

9.4.1 Table Relationship Diagram



9.4.2 Alphabetic List of Fields

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
1st Temperature 1st hour after birth	Baby Chart	Numeric	temperature_first	baby_chart
3rd Trimester Hemoglobin	Antenatal	Numeric	hemoglob_third_ trimester	pregnancy
Actual Place of Delivery	Birth Summary	Coded	actual_place_of_delivery	place_of_delivery
Acute Fatty Liver	Pregnancy/PP	Y/N/[blank]	pp_fatty_liver	postpartum
Admission Date (Baby)	Baby Newborn	Date	admission_date	baby_admission
Admission Date (Baby)	Baby Transfer/Readmission	Date	admission_date	baby_admission
Admission Date (Mother Postpartum)	Postpartum Mother	Date	admission_date	mother_admission
Admission Date (Mother)	Mother	Date	admission_date	mother_admission
Admission Time (Baby)	Baby Newborn	Numeric	admission_hour	baby_admission
Admission Time (Baby)	Baby Transfer/Readmission	Numeric	admission_hour	baby_admission
Admission Time (Mother Postpartum)	Postpartum Mother	Numeric	admission_hour	mother_admission
Admission Time (Mother)	Mother	Numeric	admission_hour	mother_admission
Admission Weight (Baby)	CIHI Data	Numeric	admission_weight	baby_admission
Admission Wt. (Kg) (Mother)	Chart Data	Numeric	admission_weight	pregnancy
Alcohol	Risks	Y/N/[blank]	r_alc_flg	risk_factors
Anesthetic/Analgesic – Entonox	Birth Summary	Y/N/[blank]	entonox_flg	anaesthesia
Anesthetic/Analgesic – Epidural	Birth Summary	Y/N/[blank]	epidural_flg	anaesthesia
Anesthetic/Analgesic – General	Birth Summary	Y/N/[blank]	general_flg	anaesthesia
Anesthetic/Analgesic – Local	Birth Summary	Y/N/[blank]	local_flg	anaesthesia
Anesthetic/Analgesic – Narcotics	Birth Summary	Y/N/[blank]	narcotic_flg	anaesthesia
Anesthetic/Analgesic – None	Birth Summary	Y/N/[blank]	none_flg	anaesthesia
Anesthetic/Analgesic – Other	Birth Summary	Y/N/[blank]	other_flg	anaesthesia
Anesthetic/Analgesic – Pudendal	Birth Summary	Y/N/[blank]	pudendal_flg	anaesthesia
Anesthetic/Analgesic – Spinal	Birth Summary	Y/N/[blank]	spinal_flg	anaesthesia
Anesthetic/Analgesic – Unknown	Birth Summary	Y/N/[blank]	unknown_flg	anaesthesia
Antibiotics	Baby Chart	Y/N/[blank]	antibiotics	baby_chart
Antihypertensive Drugs	Risks	Coded	risk_code	risk_assessment
Apgar Score – 1 Min	Newborn Record	Numeric	apgar_1_minute	baby_delivery
Apgar Score – 10 Min	Newborn Record	Numeric	apgar_10_minutes	baby_delivery
Apgar Score – 5 Min	Newborn Record	Numeric	apgar_5_minutes	baby_delivery
Augmented – ARM	Birth Summary	Y/N/[blank]	labour_aug_arm_flg	multiple_labours
Augmented – Other	Birth Summary	Y/N/[blank]	labour _aug_other_flg	multiple_labours
Augmented – Oxytocin	Birth Summary	Y/N/[blank]	labour_aug_oxy_flg	multiple_labours
Average Number of Drinks/WK	Risks	Numeric	alcohol_per_wk	risk_factors

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Baby Seq (Mother) (first number)	Birth Summary	Numeric	baby_sequence	multiple_labours
Baby Sequence (first number)	Baby Newborn	Numeric	baby_sequence	baby_admission
Baby Sequence (first number)	Baby Transfer/Readmission	Numeric	baby_sequence	baby_admission
Baby Sequence (second number)	Baby Newborn	Numeric	multiple_birth_count	baby_admission
Baby Sequence (second number)	Baby Transfer/Readmission	Numeric	multiple_birth_count	baby_admission
BCPDR Fields – Item 1	Supplementary	Coded	option_1	bcpdr_optional_fields
BCPDR Fields – Item 10	Supplementary	Coded	option_10	bcpdr_optional_fields
BCPDR Fields – Item 2	Supplementary	Coded	option_2	bcpdr_optional_fields
BCPDR Fields – Item 3	Supplementary	Coded	option_3	bcpdr_optional_fields
BCPDR Fields – Item 4	Supplementary	Coded	option_4	bcpdr_optional_fields
BCPDR Fields – Item 5	Supplementary	Coded	option_5	bcpdr_optional_fields
BCPDR Fields – Item 6	Supplementary	Coded	option_6	bcpdr_optional_fields
BCPDR Fields – Item 7	Supplementary	Coded	option_7	bcpdr_optional_fields
BCPDR Fields – Item 8	Supplementary	Coded	option_8	bcpdr_optional_fields
BCPDR Fields – Item 9	Supplementary	Coded	option_9	bcpdr_optional_fields
Binge Drinking	Risks	Y/N/U	binge_drinking	risk_factors
Birth Hospital	Baby Transfer/Readmission	Text	birth_institution	baby_admission
Blood Transfusion – Antepartum	Chart Data	Numeric	units_antepartum	pregnancy
Blood Transfusion – Intrapartum	Chart Data	Numeric	units_intrapartum	pregnancy
Blood Transfusion – Postpartum	Chart Data & Pregnancy/PP	Numeric	units_postpartum	pregnancy
Blood Transfusion Given	Chart Data & Pregnancy/PP	Y/N/[blank]	blood_transfusion_flg	pregnancy
Blood Type	Antenatal	Coded	blood_abo_and_rh	pregnancy
Breastfeeding Initiation	Newborn Record	Coded	breast_feeding_initiation	baby_admission
Cervical Dilation on Admission	Chart Data	Numeric	cervical_dilation_on_ admis	pregnancy
Cervical Dilation Prior to CS	Birth Summary	Numeric	cervical_dilation_prior_cs	labour
Cesarean Incision	Birth Summary	Coded	cesarean_incision	multiple_labours
Cesarean Section Type	Birth Summary	Coded	csection_type	multiple_labours
Chart Number (Baby Transfer)	Baby Transfer/Readmission	Text	chart_num	baby_admission
Chart Number (Baby)	Baby Newborn	Text	chart_num	baby_admission
Chart Number (Mother Postpartum)	Postpartum Mother	Text	chart_num	mother_admission
Chart Number (Mother)	Mother	Text	chart_num	mother_admission
Chest Compression	Newborn Record	Y/N/[blank]	chest_compress_flg	baby_delivery
Chest Compression – Start Age	Newborn Record	Numeric	age_start_chest_ compress	baby_delivery
Chest Compression – Stop Age	Newborn Record	Numeric	age_stop_chest_ compress	baby_delivery
Cigarettes	Risks	Coded	smoker_type_cd	risk_factors
Cigarettes – Current #/day	Risks	Numeric	cigs_per_day	risk_factors

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Coder # (Baby)	CIHI Data	Text	coder_number	baby_admission
Coder # (Mother)	CIHI Data	Text	coder_number	mother_admission
Cord Arterial Gases – Base E/D	Newborn Record	Numeric	cord_arterial_gases_base	baby_delivery
Cord Arterial Gases – pH	Newborn Record	Numeric	cord_arterial_gases_ph	baby_delivery
CPAP days	Baby Chart	Numeric	cpap_days	baby_chart
Current Pregnancy – APH (> 20 weeks)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Bleeding (< 20 weeks)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – IUGR Identified	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Other Antibodies	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Preg. Induced Hypertension	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Proteinuria (> + 1)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Rh Antibodies	Risks	Coded	risk_code	risk_assessment
Date of Birth (Baby)	Baby Newborn	Date	date_of_birth	baby_admission
Date of Birth (Baby)	Baby Transfer/Readmission	Date	date_of_birth	baby_admission
Date of Birth (Mother Postpartum)	Postpartum Mother	Date	date_of_birth	mother_admission
Date of Birth (Mother)	Baby Transfer/Readmission	Date	mother_DOB	baby_admission
Date of Birth (Mother)	Mother	Date	date_of_birth	mother_admission
Death Codes	CIHI Data	Coded	death_code	death codes
Delivered By	Birth Summary	Coded	delivered_by	multiple_labours
Delivery Date	Birth Summary	Date	baby_delivered_date	multiple_labours
Delivery Date (Mother Postpartum)	Postpartum Mother	Date	pp_delivery_date	postpartum
Delivery Position	Birth Summary	Coded	baby_position_delivery	multiple_labours
Delivery Presentation	Birth Summary	Coded	baby_presentation_ delivery	multiple_labours
Delivery Time	Birth Summary	Time	baby_delivered_hour	multiple_labours
Demographics Codes – Postal (Baby)	CIHI Data	Text	postal_code	baby_admission
Demographics Codes – Postal (Mother)	CIHI Data	Text	postal_code	mother_admission
Demographics Codes – Prov (Baby)	CIHI Data	Coded	province_code	baby_admission
Demographics Codes – Prov (Mother)	CIHI Data	Coded	province_code	mother_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Demographics Codes – Residence (Baby)	CIHI Data	Coded	residence_code	baby_admission
Demographics Codes – Residence (Mother)	CIHI Data	Coded	residence_code	mother_admission
Diagnoses – Code	CIHI Data	Text	diagnosis_cd	diagnoses
Diagnoses – Prefix	CIHI Data	Text	diagnosis_prefix	diagnoses
Diagnoses – Seq	CIHI Data	Numeric	sequence	diagnoses
Diagnoses – Type	CIHI Data	Coded	diagnosis_type	diagnoses
Discharge Date (Baby)	Baby Newborn	Date	discharge_date	baby_admission
Discharge Date (Baby)	Baby Transfer/Readmission	Date	discharge_date	baby_admission
Discharge Date (Mother Postpartum)	Postpartum Mother	Date	discharge_date	mother_admission
Discharge Date (Mother)	Mother	Date	discharge_date	mother_admission
Discharge Time (Baby)	Baby Newborn	Numeric	discharge_hour	baby_admission
Discharge Time (Baby)	Baby Transfer/Readmission	Numeric	discharge_hour	baby_admission
Discharge Time (Mother Postpartum)	Postpartum Mother	Numeric	discharge_hour	mother_admission
Discharge Time (Mother)	Mother	Numeric	discharge_hour	mother_admission
Discharge To	Baby Chart	Coded	discharge_to	baby_admission
Discharge Weight (grams)	Baby Chart	Numeric	discharge_weight	baby_admission
Doctor – Service	CIHI Data	Coded	doctor_service	doctors
Doctor – Type	CIHI Data	Coded	doctor_type	doctors
Drugs – Antibiotics	Chart Data	Y/N/[blank]	antibiotics	mother_drugs
Drugs – Antihypertensives	Chart Data	Y/N/[blank]	antihypertensive	mother_drugs
Drugs – CS Prophylactic Antibiotics	Chart Data	Y/N/[blank]	cs_prophylactic_ antibiotics	mother_drugs
Drugs – Other for Lung Maturation	Chart Data	Y/N/[blank]	other_for_lung_ maturation	mother_drugs
Drugs – Steroids for Lung Maturation	Chart Data	Y/N/[blank]	steroids_for_lung_ maturation	mother_drugs
Drugs – Tocolytics	Chart Data	Y/N/[blank]	tocolytic	mother_drugs
Drugs For Resuscitation/ Stabilization	Newborn Record	Y/N/U	drugs	baby_delivery
Episiotomy (median or mediolateral)	Birth Summary	Coded	episiotomy_type	labour
Evaluation of Development – Head Circ	Newborn Record	Numeric	birth_head_ circumference	baby_delivery
Evaluation of Development – Length	Newborn Record	Numeric	birth_length	baby_delivery
Exposure to Second Hand Smoke	Risks	Y/N/[blank]	second_hand_smoke	risk_factors
Fetal Surveillance During Labour – Auscultation	Chart Data	Y/N/[blank]	auscultation	labour

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Fetal Surveillance During Labour – External Monitor	Chart Data	Y/N/[blank]	elec_fetal_monitor_external	labour
Fetal Surveillance During Labour – Internal Monitor	Chart Data	Y/N/[blank]	elec_fetal_monitor_internal	labour
Fetal Surveillance During Labour – Not Monitored	Chart Data	Y/N/[blank]	no_fetal_monitoring	labour
First Contact with Physician/Midwife Date	Antenatal	Date	first_contact_phys_date	pregnancy
First Stage Date	Birth Summary	Date	first_stage_date	multiple_labours
First Stage Time	Birth Summary	Numeric	first_stage_hour	multiple_labours
First U/S Date (4-19 wks)	Antenatal	Date	first_us_date	pregnancy
G.A. From First U/S Days	Antenatal	Numeric	first_us_g_age_days	pregnancy
G.A. From First U/S Weeks	Antenatal	Numeric	first_us_g_age	pregnancy
Gestational Age – By Exam	Newborn Record	Numeric	gest_age_by_exam	baby_delivery
Gestational Age – From Mat Record	Newborn Record	Numeric	gest_age_from_document	baby_delivery
Given Name (Baby)	Baby Newborn	Text	given_name	baby_admission
Given Name (Baby)	Baby Transfer/Readmission	Text	given_name	baby_admission
Given Name (Mother Postpartum)	Postpartum Mother	Text	given_name	mother_admission
Given Name (Mother)	Baby Transfer/Readmission	Text	mother_first_name	baby_admission
Given Name (Mother)	Mother	Text	given_name	mother_admission
Given Name Alias (Mother Postpartum)	Postpartum Mother	Text	given_name_alias	mother_admission
Given Name Alias (Mother)	Mother	Text	given_name_alias	mother_admission
Gravida	Antenatal	Numeric	gravida	pregnancy
Group B Strep	Antenatal	Y/N/U	b_strep	pregnancy
Group B Strep – Results	Antenatal	Coded	b_strep_result	pregnancy
HBsAg Results	Antenatal	Coded	hbsag_result	pregnancy
HBsAg Testing	Antenatal	Y/N/U	hbsag_test	pregnancy
Height (cm)	Chart Data	Numeric	height	pregnancy
HELLP Syndrome	Pregnancy/PP	Y/N/[blank]	pp_hellp_syndrome	postpartum
History of Mental Illness – Anxiety	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Bipolar	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Depression	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Other	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – PP Depression	Risks	Coded	risk_code	risk_assessment

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
History of Mental Illness – Unknown	Risks	Coded	risk_code	risk_assessment
HIV Testing	Antenatal	Y/N/U	hiv_test	pregnancy
Indication for Induction	Birth Summary	Coded	indication_for_induction	multiple_labours
Induced – ARM	Birth Summary	Y/N/[blank]	labour_ind_arm_flg	multiple_labours
Induced – Other	Birth Summary	Y/N/[blank]	labour_ind_other_flg	multiple_labours
Induced – Oxytocin	Birth Summary	Y/N/[blank]	labour_ind_oxy_flg	multiple_labours
Induced – Prost	Birth Summary	Y/N/[blank]	labour_ind_prost_flg	multiple_labours
Induced [Therap] Abort	Antenatal	Numeric	therap_abortions	pregnancy
Infectious Agent #1 – Positive Blood Culture	Baby Chart	Coded	baby_blood_infect_ agent_1	baby_chart
Infectious Agent #1 – Positive Other Culture	Baby Chart	Coded	baby_other_infect_ agent_1	baby_chart
Infectious Agent #1 – Positive Urine Culture	Baby Chart	Coded	baby_urine_infect_ agent_1	baby_chart
Infectious Agent #1 – Postpartum Positive Blood Culture	Pregnancy/PP	Coded	pp_blood_agent_1	postpartum
Infectious Agent #1 – Postpartum Positive Other Culture	Pregnancy/PP	Coded	pp_other_infect_agent_1	postpartum
Infectious Agent #1 – Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_urine_agent_1	postpartum
Infectious Agent #2 – Positive Blood Culture	Baby Chart	Coded	baby_blood_infect_ agent_2	baby_chart
Infectious Agent #2 – Positive Other Culture	Baby Chart	Coded	baby_other_infect_ agent_2	baby_chart
Infectious Agent #2 – Positive Urine Culture	Baby Chart	Coded	baby_urine_infect_ agent_2	baby_chart
Infectious Agent #2 – Postpartum Positive Blood Culture	Pregnancy/PP	Coded	pp_blood_agent_2	postpartum
Infectious Agent #2 – Postpartum Positive Other Culture	Pregnancy/PP	Coded	pp_other_infect_agent_2	postpartum
Infectious Agent #2 – Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_urine_agent_2	postpartum
Inpatient Number (Baby)	Baby Newborn	Text	inpatient_num	baby_admission
Inpatient Number (Baby)	Baby Transfer/Readmission	Text	inpatient_num	baby_admission
Inpatient Number (Mother Postpartum)	Postpartum Mother	Text	inpatient_num	mother_admission
Inpatient Number (Mother)	Mother	Text	inpatient_num	mother_admission
Institution Fields – Item 1	Supplementary	Text	option_1	inst_optional_fields
Institution Fields – Item 10	Supplementary	Text	option_10	inst_optional_fields
Institution Fields – Item 2	Supplementary	Text	option_2	inst_optional_fields
Institution Fields – Item 3	Supplementary	Text	option_3	inst_optional_fields

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Institution Fields – Item 4	Supplementary	Text	option_4	inst_optional_fields
Institution Fields – Item 5	Supplementary	Text	option_5	inst_optional_fields
Institution Fields – Item 6	Supplementary	Text	option_6	inst_optional_fields
Institution Fields – Item 7	Supplementary	Text	option_7	inst_optional_fields
Institution Fields – Item 8	Supplementary	Text	option_8	inst_optional_fields
Institution Fields – Item 9	Supplementary	Text	option_9	inst_optional_fields
Institution From (Baby)	CIHI Data	Numeric	institution_from	baby_admission
Institution From (Mother)	CIHI Data	Numeric	institution_from	mother_admission
Institution Number (Baby)	CIHI Data	Numeric	institution_id	baby_admission
Institution Number (Mother)	CIHI Data	Numeric	institution_id	mother_admission
Institution To (Baby)	CIHI Data	Numeric	institution_to	baby_admission
Institution To (Mother)	CIHI Data	Numeric	institution_to	mother_admission
Intended Place of Delivery	Birth Summary	Coded	intended_place_of_ delivery	place_of_delivery
IPPV ETT	Newborn Record	Y/N/[blank]	ippv_ett_flg	baby_delivery
IPPV ETT – Start Age	Newborn Record	Numeric	age_start_ippv_ett	baby_delivery
IPPV ETT – Stop Age	Newborn Record	Numeric	age_stop_ippv_ett	baby_delivery
IPPV Mask	Newborn Record	Y/N/[blank]	ippv_mask_flg	baby_delivery
IPPV Mask – Start Age	Newborn Record	Numeric	age_start_ippv_mask	baby_delivery
IPPV Mask – Stop Age	Newborn Record	Numeric	age_stop_ippv_mask	baby_delivery
IVF	Antenatal	Y/N/U	ivf	pregnancy
Labour Initiation – Augmented	Birth Summary	Y/N/[blank]	labour_aug_flg	multiple_labours
Labour Initiation – Induced	Birth Summary	Y/N/[blank]	labour_ind_flg	multiple_labours
Labour Initiation – No Labour	Birth Summary	Y/N/[blank]	labour_none_flg	multiple_labours
Labour Initiation – Spontaneous	Birth Summary	Y/N/[blank]	labour_spont_flg	multiple_labours
Labour Initiation – Unknown	Birth Summary	Y/N/[blank]	labour_unknown_flg	multiple_labours
Labour Position	Birth Summary	Coded	baby_position_labour	multiple_labours
Labour Presentation	Birth Summary	Coded	baby_presentation_ labour	multiple_labours
Laceration (Degree)	Birth Summary	Coded	laceration_degree	labour
Last Menstrual Period Date	Antenatal	Date	last_menstrual_period	pregnancy
Liver Hematoma	Pregnancy/PP	Y/N/[blank]	pp_liver_hematoma	postpartum
Living	Antenatal	Numeric	living	pregnancy
Main Patient Service (Baby)	CIHI Data	Coded	main_patient_service	baby_admission
Main Patient Service (Mother)	CIHI Data	Coded	main_patient_service	mother_admission
Maternal Serum Screen Offered	Antenatal	Y/N/U	mat_serum_screen	pregnancy
Meconium Present	Newborn Record	Y/N/[blank]	meconium	baby_delivery
Medical History – Diabetes/Other Abnormal Glucose Factor	Risks	Coded	risk_code	risk_assessment

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Medical History – Hypertension > 140/90	Risks	Coded	risk_code	risk_assessment
Medical History – Hypertensive Chronic Renal Disease	Risks	Coded	risk_code	risk_assessment
Medical History – Other Cause of Hypertension	Risks	Coded	risk_code	risk_assessment
Midwife Case	Birth Summary	Y/N/[blank]	midwife_case	labour
Newborn Feeding	Newborn Record	Coded	newborn_feeding	baby_admission
NICU days – Level II (Baby)	CIHI data	Numeric	NICU_II	baby_admission
NICU days – Level III (Baby)	CIHI data	Numeric	NICU_III	baby_admission
No Selected Risks	Risks	Coded	risk_code	risk_assessment
Number (#) Antenatal Visits	Antenatal	Numeric	num_antenatal_visits	pregnancy
Oxygen	Newborn Record	Y/N/[blank]	oxygen_flg	baby_delivery
Oxygen – Start Age	Newborn Record	Numeric	age_start_oxygen	baby_delivery
Oxygen – Stop Age	Newborn Record	Numeric	age_stop_oxygen	baby_delivery
Oxygen Days	Baby Chart	Numeric	oxygen_days	baby_admission
Past Obstetrical History – Major Congenital Anomalies	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Low Birth Weight	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Macrosomic Baby	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Neonatal Death	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Rh Isoimmuinization	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Stillbirth	Risks	Coded	risk_code	risk_assessment
Perineum/Vaginal/Cervix – Cervical Tear	Birth Summary	Y/N/[blank]	cervical_tear_flg	labour
Perineum/Vaginal/Cervix – Episiotomy	Birth Summary	Y/N/[blank]	episiotomy_flg	labour
Perineum/Vaginal/Cervix – Intact	Birth Summary	Y/N/[blank]	intact_flg	labour
Perineum/Vaginal/Cervix – Laceration	Birth Summary	Y/N/[blank]	laceration_flg	labour
Perineum/Vaginal/Cervix – Other Tear	Birth Summary	Y/N/[blank]	other_tear_flg	labour
Perineum/Vaginal/Cervix – Unknown	Birth Summary	Y/N/[blank]	condition_unknown_flg	labour
Personal Health # (Baby)	Baby Newborn	Text	personal_health_number	baby_admission
Personal Health # (Baby)	Baby Transfer/Readmission	Text	personal_health_number	baby_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Personal Health # (Mother Postpartum)	Postpartum Mother	Text	personal_health_number	mother_admission
Personal Health # (Mother)	Baby Transfer/Readmission	Text	mother_PHN	baby_admission
Personal Health # (Mother)	Mother	Text	personal_health_number	mother_admission
Place of Delivery (Mother Postpartum)	Postpartum Mother	Numeric	pp_delivery_inst_no	postpartum
Placenta Delivered Date	Birth Summary	Date	placenta_delivered_date	multiple_labours
Placenta Delivered Time	Birth Summary	Numeric	placenta_delivered_hour	multiple_labours
Positive Blood Culture	Baby Chart	Y/N/[blank]	baby_pos_blood_culture	baby_chart
Positive Other Culture	Baby Chart	Y/N/[blank]	baby_pos_other_culture	baby_chart
Positive Urine Culture	Baby Chart	Y/N/[blank]	baby_pos_urine_culture	baby_chart
Postpartum Hemoglobin Date	Pregnancy/PP	Date	pp_hemoglobin_date	postpartum
Postpartum Hemoglobin Value	Pregnancy/PP	Numeric	pp_hemoglobin_value	postpartum
Postpartum Infection	Pregnancy/PP	Y/N/U	pp_infection	postpartum
Postpartum Positive Blood Culture	Pregnancy/PP	Y/N/[blank]	pp_pos_blood_culture	postpartum
Postpartum Positive Other Culture	Pregnancy/PP	Y/N/[blank]	pp_pos_other_culture	postpartum
Postpartum Special Care Units Days	Pregnancy/PP	Numeric	pp_scu_days	postpartum
Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_uti	postpartum
Postpartum Wound Infection	Pregnancy/PP	Y/N/[blank]	pp_wound_infection	postpartum
Postpartum Wound Infection – Severity	Pregnancy/PP	Coded	pp_wound_severity	postpartum
Postpartum Wound Infection – Type	Pregnancy/PP	Coded	pp_wound_type	postpartum
Prepreg Wt. (Kg)	Chart Data	Numeric	pre_pregnancy_weight	pregnancy
Preterm	Antenatal	Numeric	premature	pregnancy
Prev. C/S	Antenatal	Numeric	prev_cesarian_deliv	pregnancy
Prev. Vag	Antenatal	Numeric	prev_vaginal_deliv	pregnancy
Primary Indic. Operative Delivery	Birth Summary	Coded	primary_ind_operative_ delivery	multiple_labours
Procedures – Anaes Agent	CIHI Data	Coded	anesthetic_agent	procedures_ performed
Procedures – Code	CIHI Data	Text	procedure_code	procedures_ performed
Procedures – Date	CIHI Data	Date	procedure_date	procedures_ performed
Procedures – Dr. Serv	CIHI Data	Coded	procedure_doctor_ service	procedures_ performed

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Procedures – Ext	CIHI Data	Text	extent	procedures_ performed
Procedures – Loc	CIHI Data	Text	location	procedures_ performed
Procedures – Seq	CIHI Data	Numeric	sequence	procedures_ performed
Procedures – Stat	CIHI Data	Text	status	procedures_ performed
Rh Immunglobulin Postpartum – Eligible	Chart Data	Y/N/U	rh_immun_postpart_ eligble	pregnancy
Rh Immunoglobulin Given Earliest Date Antepartum	Antenatal	Date	rh_immun_antepartum_ date	pregnancy
Rh Immunoglobulin Postpartum – Date Given	Chart Data	Date	rh_immun_postpart_date	pregnancy
Rupture of Membranes (R.O.M.) Date	Birth Summary	Date	mem_rupture_date	multiple_labours
Rupture of Membranes (R.O.M.) Time	Birth Summary	Numeric	mem_rupture_hour	multiple_labours
School Years Completed	Antenatal	Numeric	school_years	mother_admission
Second Stage Date	Birth Summary	Date	second_stage_date	multiple_labours
Second Stage Time	Birth Summary	Numeric	second_stage_hour	multiple_labours
Sex	Baby Newborn	Coded	sex	baby_admission
Sex	Baby Transfer/Readmission	Coded	sex	baby_admission
Spont Abort	Antenatal	Numeric	spont_abortions	pregnancy
Stillbirth	Newborn Record	P/A/U/N	stillbirth	baby_delivery
Substance Use – Cocaine	Risks	Coded	risk_code	risk_assessment
Substance Use – Heroin	Risks	Coded	risk_code	risk_assessment
Substance Use – Marijuana	Risks	Coded	risk_code	risk_assessment
Substance Use – Methadone	Risks	Coded	risk_code	risk_assessment
Substance Use – Other	Risks	Coded	risk_code	risk_assessment
Substance Use – Prescription	Risks	Coded	risk_code	risk_assessment
Substance Use – Solvents	Risks	Coded	risk_code	risk_assessment
Substance Use – Unknown	Risks	Coded	risk_code	risk_assessment
Suction – Oropharynx	Newborn Record	Y/N/[blank]	suction_oropharynx	baby_delivery
Suction – Trachea	Newborn Record	Y/N/[blank]	suction_trachea	baby_delivery
Suction – Unspecified	Newborn Record	Y/N/[blank]	suction_unspecified	baby_delivery
Surfactant Given	Baby Chart	Y/N/[blank]	surfactant	baby_chart
Surname (Baby)	Baby Newborn	Text	surname	baby_admission
Surname (Baby)	Baby Transfer/Readmission	Text	surname	baby_admission
Surname (Mother Postpartum)	Postpartum Mother	Text	surname	mother_admission
Surname (Mother)	Baby Transfer/Readmission	Text	mother_last_name	baby_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Surname (Mother)	Mother	Text	surname	mother_admission
Surname Alias (Mother Postpartum)	Postpartum Mother	Text	surname_alias	mother_admission
Surname Alias (Mother)	Mother	Text	surname_alias	mother_admission
Surname Birth (Baby)	Baby Newborn	Text	surname_birth	baby_admission
Surname Birth (Baby)	Baby Transfer/Readmission	Text	surname_birth	baby_admission
Surname Birth (Mother Postpartum)	Postpartum Mother	Text	surname_birth	mother_admission
Surname Birth (Mother)	Mother	Text	surname_birth	mother_admission
Term	Antenatal	Numeric	term	pregnancy
Total Prior Admissions This Pregnancy	Chart Data	Numeric	total_prior_admiss	pregnancy
TPN Days	Baby Chart	Numeric	tpn_days	baby_admission
TWEAK Score	Risks	Numeric	tweak_score	risk_factors
VBAC Attempted	Birth Summary	Y/N/U/A	vbac_attempted	labour
VBAC Eligible	Birth Summary	Y/N/U	vbac_eligible	labour
Ventilator Days	Baby Chart	Numeric	ventilator_days	baby_admission

9.4.3 Sorted by Entry Screen

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
3rd Trimester Hemoglobin	Antenatal	Numeric	hemoglob_third_trimester	pregnancy
Blood Type	Antenatal	Coded	blood_abo_and_rh	pregnancy
First Contact with Physician/Midwife Date	Antenatal	Date	first_contact_phys_date	pregnancy
First U/S Date (4-19 wks)	Antenatal	Date	first_us_date	pregnancy
G.A. From First U/S Weeks	Antenatal	Numeric	first_us_g_age	pregnancy
G.A. From First U/S Days	Antenatal	Numeric	first_us_g_age_days	pregnancy
Gravida	Antenatal	Numeric	gravida	pregnancy
Group B Strep	Antenatal	Y/N/U	b_strep	pregnancy
Group B Strep – Results	Antenatal	Coded	b_strep_result	pregnancy
HBsAg Results	Antenatal	Coded	hbsag_result	pregnancy
HBsAg Testing	Antenatal	Y/N/U	hbsag_test	pregnancy
HIV Testing	Antenatal	Y/N/U	hiv_test	pregnancy
Induced [Therap] Abort	Antenatal	Numeric	therap_abortions	pregnancy
IVF	Antenatal	Y/N/U	ivf	pregnancy
Last Menstrual Period Date	Antenatal	Date	last_menstrual_period	pregnancy
Living	Antenatal	Numeric	living	pregnancy
Maternal Serum Screen Offered	Antenatal	Y/N/U	mat_serum_screen	pregnancy
Number (#) Antenatal Visits	Antenatal	Numeric	num_antenatal_visits	pregnancy
Preterm	Antenatal	Numeric	premature	pregnancy
Prev. C/S	Antenatal	Numeric	prev_cesarian_deliv	pregnancy
Prev. Vag	Antenatal	Numeric	prev_vaginal_deliv	pregnancy
Rh Immunoglobulin Given Earliest Date Antepartum	Antenatal	Date	rh_immun_antepartum_date	pregnancy
School Years Completed	Antenatal	Numeric	school_years	mother_admission
Spont Abort	Antenatal	Numeric	spont_abortions	pregnancy
Term	Antenatal	Numeric	term	pregnancy
1st Temperature 1st hour after birth	Baby Chart	Numeric	temperature_first	baby_chart
Antibiotics	Baby Chart	Y/N/[blank]	antibiotics	baby_chart
CPAP days	Baby Chart	Numeric	cpap_days	baby_chart
Discharge To	Baby Chart	Coded	discharge_to	baby_admission
Discharge Weight (grams)	Baby Chart	Numeric	discharge_weight	baby_admission
Infectious Agent #1 – Positive Blood Culture	Baby Chart	Coded	baby_blood_infect_agent_1	baby_chart
Infectious Agent #1 – Positive Other Culture	Baby Chart	Coded	baby_other_infect_agent_1	baby_chart

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Infectious Agent #1 – Positive Urine Culture	Baby Chart	Coded	baby_urine_infect_agent_1	baby_chart
Infectious Agent #2 – Positive Blood Culture	Baby Chart	Coded	baby_blood_infect_agent_2	baby_chart
Infectious Agent #2 – Positive Other Culture	Baby Chart	Coded	baby_other_infect_agent_2	baby_chart
Infectious Agent #2 – Positive Urine Culture	Baby Chart	Coded	baby_urine_infect_agent_2	baby_chart
Oxygen Days	Baby Chart	Numeric	oxygen_days	baby_admission
Positive Blood Culture	Baby Chart	Y/N/[blank]	baby_pos_blood_culture	baby_chart
Positive Other Culture	Baby Chart	Y/N/[blank]	baby_pos_other_culture	baby_chart
Positive Urine Culture	Baby Chart	Y/N/[blank]	baby_pos_urine_culture	baby_chart
Surfactant Given	Baby Chart	Y/N/[blank]	surfactant	baby_chart
TPN Days	Baby Chart	Numeric	tpn_days	baby_admission
Ventilator Days	Baby Chart	Numeric	ventilator_days	baby_admission
Admission Date (Baby)	Baby Newborn	Date	admission_date	baby_admission
Admission Time (Baby)	Baby Newborn	Numeric	admission_hour	baby_admission
Baby Sequence (first number)	Baby Newborn	Numeric	baby_sequence	baby_admission
Baby Sequence (second number)	Baby Newborn	Numeric	multiple_birth_count	baby_admission
Chart Number (Baby)	Baby Newborn	Text	chart_num	baby_admission
Date of Birth (Baby)	Baby Newborn	Date	date_of_birth	baby_admission
Discharge Date (Baby)	Baby Newborn	Date	discharge_date	baby_admission
Discharge Time (Baby)	Baby Newborn	Numeric	discharge_hour	baby_admission
Given Name (Baby)	Baby Newborn	Text	given_name	baby_admission
Inpatient Number (Baby)	Baby Newborn	Text	inpatient_num	baby_admission
Personal Health # (Baby)	Baby Newborn	Text	personal_health_number	baby_admission
Sex	Baby Newborn	Coded	sex	baby_admission
Surname (Baby)	Baby Newborn	Text	surname	baby_admission
Surname Birth (Baby)	Baby Newborn	Text	surname_birth	baby_admission
Surname (Mother)	Baby Transfer/Readmission	Text	mother_last_name	baby_admission
Surname (Baby)	Baby Transfer/Readmission	Text	surname	baby_admission
Surname Birth (Baby)	Baby Transfer/Readmission	Text	surname_birth	baby_admission
Given Name (Baby)	Baby Transfer/Readmission	Text	given_name	baby_admission
Given Name (Mother)	Baby Transfer/Readmission	Text	mother_first_name	baby_admission
Inpatient Number (Baby)	Baby Transfer/Readmission	Text	inpatient_num	baby_admission
Personal Health # (Baby)	Baby Transfer/Readmission	Text	personal_health_number	baby_admission
Personal Health # (Mother)	Baby Transfer/Readmission	Text	mother_PHN	baby_admission
Sex	Baby Transfer/Readmission	Coded	sex	baby_admission
Admission Date (Baby)	Baby Transfer/Readmission	Date	admission_date	baby_admission
Admission Time (Baby)	Baby Transfer/Readmission	Numeric	admission_hour	baby_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Baby Sequence (first number)	Baby Transfer/Readmission	Numeric	baby_sequence	baby_admission
Baby Sequence (second number)	Baby Transfer/Readmission	Numeric	multiple_birth_count	baby_admission
Birth Hospital	Baby Transfer/Readmission	Text	birth_institution	baby_admission
Chart Number (Baby Transfer)	Baby Transfer/Readmission	Text	chart_num	baby_admission
Date of Birth (Baby)	Baby Transfer/Readmission	Date	date_of_birth	baby_admission
Date of Birth (Mother)	Baby Transfer/Readmission	Date	mother_DOB	baby_admission
Discharge Date (Baby)	Baby Transfer/Readmission	Date	discharge_date	baby_admission
Discharge Time (Baby)	Baby Transfer/Readmission	Numeric	discharge_hour	baby_admission
Actual Place of Delivery	Birth Summary	Coded	actual_place_of_delivery	place_of_delivery
Anesthetic/Analgesic – Entonox	Birth Summary	Y/N/[blank]	entonox_flg	anaesthesia
Anesthetic/Analgesic – Epidural	Birth Summary	Y/N/[blank]	epidural_flg	anaesthesia
Anesthetic/Analgesic – General	Birth Summary	Y/N/[blank]	general_flg	anaesthesia
Anesthetic/Analgesic – Local	Birth Summary	Y/N/[blank]	local_flg	anaesthesia
Anesthetic/Analgesic – Narcotics	Birth Summary	Y/N/[blank]	narcotic_flg	anaesthesia
Anesthetic/Analgesic – None	Birth Summary	Y/N/[blank]	none_flg	anaesthesia
Anesthetic/Analgesic – Other	Birth Summary	Y/N/[blank]	other_flg	anaesthesia
Anesthetic/Analgesic – Pudendal	Birth Summary	Y/N/[blank]	pudendal_flg	anaesthesia
Anesthetic/Analgesic – Spinal	Birth Summary	Y/N/[blank]	spinal_flg	anaesthesia
Anesthetic/Analgesic – Unknown	Birth Summary	Y/N/[blank]	unknown_flg	anaesthesia
Augmented – ARM	Birth Summary	Y/N/[blank]	labour_aug_arm_flg	multiple_labours
Augmented – Other	Birth Summary	Y/N/[blank]	labour _aug_other_flg	multiple_labours
Augmented – Oxytocin	Birth Summary	Y/N/[blank]	labour_aug_oxy_flg	multiple_labours
Baby Seq (Mother) (first number)	Birth Summary	Numeric	baby_sequence	multiple_labours
Cervical Dilation Prior to CS	Birth Summary	Numeric	cervical_dilation_prior_cs	labour
Cesarean Incision	Birth Summary	Coded	cesarean_incision	multiple_labours
Cesarean Section Type	Birth Summary	Coded	csection_type	multiple_labours
Delivered By	Birth Summary	Coded	delivered_by	multiple_labours
Delivery Date	Birth Summary	Date	baby_delivered_date	multiple_labours
Delivery Position	Birth Summary	Coded	baby_position_delivery	multiple_labours
Delivery Presentation	Birth Summary	Coded	baby_presentation_ delivery	multiple_labours
Delivery Time	Birth Summary	Time	baby_delivered_hour	multiple_labours
Episiotomy (median or mediolateral)	Birth Summary	Coded	episiotomy_type	labour
First Stage Date	Birth Summary	Date	first_stage_date	multiple_labours
First Stage Time	Birth Summary	Numeric	first_stage_hour	multiple_labours
Indication for Induction	Birth Summary	Coded	indication_for_induction	multiple_labours
Induced – ARM	Birth Summary	Y/N/[blank]	labour_ind_arm_flg	multiple_labours
Induced – Other	Birth Summary	Y/N/[blank]	labour_ind_other_flg	multiple_labours

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Induced – Oxytocin	Birth Summary	Y/N/[blank]	labour_ind_oxy_flg	multiple_labours
Induced – Prost	Birth Summary	Y/N/[blank]	labour_ind_prost_flg	multiple_labours
Intended Place of Delivery	Birth Summary	Coded	intended_place_of_ delivery	place_of_delivery
Labour Initiation – Augmented	Birth Summary	Y/N/[blank]	labour_aug_flg	multiple_labours
Labour Initiation – Induced	Birth Summary	Y/N/[blank]	labour_ind_flg	multiple_labours
Labour Initiation – No Labour	Birth Summary	Y/N/[blank]	labour_none_flg	multiple_labours
Labour Initiation – Spontaneous	Birth Summary	Y/N/[blank]	labour_spont_flg	multiple_labours
Labour Initiation – Unknown	Birth Summary	Y/N/[blank]	labour_unknown_flg	multiple_labours
Labour Position	Birth Summary	Coded	baby_position_labour	multiple_labours
Labour Presentation	Birth Summary	Coded	baby_presentation_ labour	multiple_labours
Laceration (Degree)	Birth Summary	Coded	laceration_degree	labour
Midwife Case	Birth Summary	Y/N/[blank]	midwife_case	labour
Perineum/Vaginal/Cervix – Cervical Tear	Birth Summary	Y/N/[blank]	cervical_tear_flg	labour
Perineum/Vaginal/Cervix – Episiotomy	Birth Summary	Y/N/[blank]	episiotomy_flg	labour
Perineum/Vaginal/Cervix – Intact	Birth Summary	Y/N/[blank]	intact_flg	labour
Perineum/Vaginal/Cervix – Laceration	Birth Summary	Y/N/[blank]	laceration_flg	labour
Perineum/Vaginal/Cervix – Other Tear	Birth Summary	Y/N/[blank]	other_tear_flg	labour
Perineum/Vaginal/Cervix – Unknown	Birth Summary	Y/N/[blank]	condition_unknown_flg	labour
Placenta Delivered Date	Birth Summary	Date	placenta_delivered_date	multiple_labours
Placenta Delivered Time	Birth Summary	Numeric	placenta_delivered_hour	multiple_labours
Primary Indic. Operative Delivery	Birth Summary	Coded	primary_ind_operative_ delivery	multiple_labours
Rupture of Membranes (R.O.M.) Date	Birth Summary	Date	mem_rupture_date	multiple_labours
Rupture of Membranes (R.O.M.) Time	Birth Summary	Numeric	mem_rupture_hour	multiple_labours
Second Stage Date	Birth Summary	Date	second_stage_date	multiple_labours
Second Stage Time	Birth Summary	Numeric	second_stage_hour	multiple_labours
VBAC Attempted	Birth Summary	Y/N/U/A	vbac_attempted	labour
VBAC Eligible	Birth Summary	Y/N/U	vbac_eligible	labour
Admission Wt. (Kg) (Mother)	Chart Data	Numeric	admission_weight	pregnancy
Blood Transfusion – Antepartum	Chart Data	Numeric	units_antepartum	pregnancy
Blood Transfusion – Intrapartum	Chart Data	Numeric	units_intrapartum	pregnancy

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Cervical Dilation on Admission	Chart Data	Numeric	cervical_dilation_on_admis	pregnancy
Drugs – Antibiotics	Chart Data	Y/N/[blank]	antibiotics	mother_drugs
Drugs – Antihypertensives	Chart Data	Y/N/[blank]	antihypertensive	mother_drugs
Drugs – CS Prophylactic Antibiotics	Chart Data	Y/N/[blank]	cs_prophylactic_antibiotics	mother_drugs
Drugs – Other for Lung Maturation	Chart Data	Y/N/[blank]	other_for_lung_maturation	mother_drugs
Drugs – Steroids for Lung Maturation	Chart Data	Y/N/[blank]	steroids_for_lung_maturation	mother_drugs
Drugs – Tocolytics	Chart Data	Y/N/[blank]	tocolytic	mother_drugs
Fetal Surveillance During Labour – Auscultation	Chart Data	Y/N/[blank]	auscultation	labour
Fetal Surveillance During Labour – External Monitor	Chart Data	Y/N/[blank]	elec_fetal_monitor_external	labour
Fetal Surveillance During Labour – Internal Monitor	Chart Data	Y/N/[blank]	elec_fetal_monitor_internal	labour
Fetal Surveillance During Labour – Not Monitored	Chart Data	Y/N/[blank]	no_fetal_monitoring	labour
Height (cm)	Chart Data	Numeric	height	pregnancy
Prepreg Wt. (Kg)	Chart Data	Numeric	pre_pregnancy_weight	pregnancy
Rh Immunglobulin Postpartum – Eligible	Chart Data	Y/N/U	rh_immun_postpart_eligble	pregnancy
Rh Immunoglobulin Postpartum – Date Given	Chart Data	Date	rh_immun_postpart_date	pregnancy
Total Prior Admissions This Pregnancy	Chart Data	Numeric	total_prior_admiss	pregnancy
Blood Transfusion – Postpartum	Chart Data & Pregnancy/PP	Numeric	units_postpartum	pregnancy
Blood Transfusion Given	Chart Data & Pregnancy/PP	Y/N/[blank]	blood_transfusion_flg	pregnancy
Admission Weight (Baby)	CIHI Data	Numeric	admission_weight	baby_admission
Coder # (Baby)	CIHI Data	Text	coder_number	baby_admission
Coder # (Mother)	CIHI Data	Text	coder_number	mother_admission
Death Codes	CIHI Data	Coded	death_code	death codes
Demographics Codes – Postal (Baby)	CIHI Data	Text	postal_code	baby_admission
Demographics Codes – Postal (Mother)	CIHI Data	Text	postal_code	mother_admission
Demographics Codes – Prov (Baby)	CIHI Data	Coded	province_code	baby_admission
Demographics Codes – Prov (Mother)	CIHI Data	Coded	province_code	mother_admission
Demographics Codes – Residence (Baby)	CIHI Data	Coded	residence_code	baby_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Demographics Codes – Residence (Mother)	CIHI Data	Coded	residence_code	mother_admission
Diagnoses – Prefix	CIHI Data	Text	diagnosis_prefix	diagnoses
Diagnoses – Code	CIHI Data	Text	diagnosis_cd	diagnoses
Diagnoses – Seq	CIHI Data	Numeric	sequence	diagnoses
Diagnoses – Type	CIHI Data	Coded	diagnosis_type	diagnoses
Doctor – Service	CIHI Data	Coded	doctor_service	doctors
Doctor – Type	CIHI Data	Coded	doctor_type	doctors
Institution From (Baby)	CIHI Data	Numeric	institution_from	baby_admission
Institution From (Mother)	CIHI Data	Numeric	institution_from	mother_admission
Institution Number (Baby)	CIHI Data	Numeric	institution_id	baby_admission
Institution Number (Mother)	CIHI Data	Numeric	institution_id	mother_admission
Institution To (Baby)	CIHI Data	Numeric	institution_to	baby_admission
Institution To (Mother)	CIHI Data	Numeric	institution_to	mother_admission
Main Patient Service (Baby)	CIHI Data	Coded	main_patient_service	baby_admission
Main Patient Service (Mother)	CIHI Data	Coded	main_patient_service	mother_admission
NICU days – Level II (Baby)	CIHI data	Numeric	NICU_II	baby_admission
NICU days – Level III (Baby)	CIHI data	Numeric	NICU_III	baby_admission
Procedures – Anaes Agent	CIHI Data	Coded	anesthetic_agent	procedures_ performed
Procedures – Code	CIHI Data	Text	procedure_code	procedures_ performed
Procedures – Date	CIHI Data	Date	procedure_date	procedures_ performed
Procedures – Dr. Serv	CIHI Data	Coded	procedure_doctor_ service	procedures_ performed
Procedures – Ext	CIHI Data	Text	extent	procedures_ performed
Procedures – Loc	CIHI Data	Text	location	procedures_ performed
Procedures – Seq	CIHI Data	Numeric	sequence	procedures_ performed
Procedures – Stat	CIHI Data	Text	status	procedures_ performed
Admission Date (Mother)	Mother	Date	admission_date	mother_admission
Admission Time (Mother)	Mother	Numeric	admission_hour	mother_admission
Chart Number (Mother)	Mother	Text	chart_num	mother_admission
Date of Birth (Mother)	Mother	Date	date_of_birth	mother_admission
Discharge Date (Mother)	Mother	Date	discharge_date	mother_admission
Discharge Time (Mother)	Mother	Numeric	discharge_hour	mother_admission
Given Name (Mother)	Mother	Text	given_name	mother_admission

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Given Name Alias (Mother)	Mother	Text	given_name_alias	mother_admission
Inpatient Number (Mother)	Mother	Text	inpatient_num	mother_admission
Personal Health # (Mother)	Mother	Text	personal_health_number	mother_admission
Surname (Mother)	Mother	Text	surname	mother_admission
Surname Alias (Mother)	Mother	Text	surname_alias	mother_admission
Surname Birth (Mother)	Mother	Text	surname_birth	mother_admission
Apgar Score – 1 Min	Newborn Record	Numeric	apgar_1_minute	baby_delivery
Apgar Score – 10 Min	Newborn Record	Numeric	apgar_10_minutes	baby_delivery
Apgar Score – 5 Min	Newborn Record	Numeric	apgar_5_minutes	baby_delivery
Breastfeeding Initiation	Newborn Record	Coded	breast_feeding_initiation	baby_admission
Chest Compression	Newborn Record	Y/N/[blank]	chest_compress_flg	baby_delivery
Chest Compression – Start Age	Newborn Record	Numeric	age_start_chest_compress	baby_delivery
Chest Compression – Stop Age	Newborn Record	Numeric	age_stop_chest_compress	baby_delivery
Cord Arterial Gases – Base E/D	Newborn Record	Numeric	cord_arterial_gases_base	baby_delivery
Cord Arterial Gases – pH	Newborn Record	Numeric	cord_arterial_gases_ph	baby_delivery
Drugs For Resuscitation/ Stabilization	Newborn Record	Y/N/U	drugs	baby_delivery
Evaluation of Development – Head Circ	Newborn Record	Numeric	birth_head_circumference	baby_delivery
Evaluation of Development – Length	Newborn Record	Numeric	birth_length	baby_delivery
Gestational Age–By Exam	Newborn Record	Numeric	gest_age_by_exam	baby_delivery
Gestational Age -From Mat Record	Newborn Record	Numeric	gest_age_from_document	baby_delivery
IPPV ETT	Newborn Record	Y/N/[blank]	ippv_ett_flg	baby_delivery
IPPV ETT – Start Age	Newborn Record	Numeric	age_start_ippv_ett	baby_delivery
IPPV ETT – Stop Age	Newborn Record	Numeric	age_stop_ippv_ett	baby_delivery
IPPV Mask	Newborn Record	Y/N/[blank]	ippv_mask_flg	baby_delivery
IPPV Mask – Start Age	Newborn Record	Numeric	age_start_ippv_mask	baby_delivery
IPPV Mask – Stop Age	Newborn Record	Numeric	age_stop_ippv_mask	baby_delivery
Meconium Present	Newborn Record	Y/N/[blank]	meconium	baby_delivery
Newborn Feeding	Newborn Record	Coded	newborn_feeding	baby_admission
Oxygen	Newborn Record	Y/N/[blank]	oxygen_flg	baby_delivery
Oxygen – Start Age	Newborn Record	Numeric	age_start_oxygen	baby_delivery
Oxygen – Stop Age	Newborn Record	Numeric	age_stop_oxygen	baby_delivery
Stillbirth	Newborn Record	P/A/U/N	stillbirth	baby_delivery
Suction – Oropharynx	Newborn Record	Y/N/[blank]	suction_oropharynx	baby_delivery
Suction – Trachea	Newborn Record	Y/N/[blank]	suction_trachea	baby_delivery

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Suction – Unspecified	Newborn Record	Y/N/[blank]	suction_unspecified	baby_delivery
Admission Date (Mother Postpartum)	Postpartum Mother	Date	admission_date	mother_admission
Admission Time (Mother Postpartum)	Postpartum Mother	Numeric	admission_hour	mother_admission
Chart Number (Mother Postpartum)	Postpartum Mother	Text	chart_num	mother_admission
Date of Birth (Mother Postpartum)	Postpartum Mother	Date	date_of_birth	mother_admission
Delivery Date (Mother Postpartum)	Postpartum Mother	Date	pp_delivery_date	postpartum
Discharge Date (Mother Postpartum)	Postpartum Mother	Date	discharge_date	mother_admission
Discharge Time (Mother Postpartum)	Postpartum Mother	Numeric	discharge_hour	mother_admission
Given Name (Mother Postpartum)	Postpartum Mother	Text	given_name	mother_admission
Given Name Alias (Mother Postpartum)	Postpartum Mother	Text	given_name_alias	mother_admission
Inpatient Number (Mother Postpartum)	Postpartum Mother	Text	inpatient_num	mother_admission
Personal Health # (Mother Postpartum)	Postpartum Mother	Text	personal_health_number	mother_admission
Place of Delivery (Mother Postpartum)	Postpartum Mother	Numeric	pp_delivery_inst_no	postpartum
Surname (Mother Postpartum)	Postpartum Mother	Text	surname	mother_admission
Surname Alias (Mother Postpartum)	Postpartum Mother	Text	surname_alias	mother_admission
Surname Birth (Mother Postpartum)	Postpartum Mother	Text	surname_birth	mother_admission
Acute Fatty Liver	Pregnancy/PP	Y/N/[blank]	pp_fatty_liver	postpartum
HELLP Syndrome	Pregnancy/PP	Y/N/[blank]	pp_hellp_syndrome	postpartum
Infectious Agent #1 – Postpartum Positive Blood Culture	Pregnancy/PP	Coded	pp_blood_agent_1	postpartum
Infectious Agent #1 – Postpartum Positive Other Culture	Pregnancy/PP	Coded	pp_other_infect_agent_1	postpartum
Infectious Agent #1 – Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_urine_agent_1	postpartum
Infectious Agent #2 – Postpartum Positive Blood Culture	Pregnancy/PP	Coded	pp_blood_agent_2	postpartum
Infectious Agent #2 – Postpartum Positive Other Culture	Pregnancy/PP	Coded	pp_other_infect_agent_2	postpartum
Infectious Agent #2 – Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_urine_agent_2	postpartum

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
Liver Hematoma	Pregnancy/PP	Y/N/[blank]	pp_liver_hematoma	postpartum
Postpartum Hemoglobin Date	Pregnancy/PP	Date	pp_hemoglobin_date	postpartum
Postpartum Hemoglobin Value	Pregnancy/PP	Numeric	pp_hemoglobin_value	postpartum
Postpartum Infection	Pregnancy/PP	Y/N/U	pp_infection	postpartum
Postpartum Positive Blood Culture	Pregnancy/PP	Y/N/[blank]	pp_pos_blood_culture	postpartum
Postpartum Positive Other Culture	Pregnancy/PP	Y/N/[blank]	pp_pos_other_culture	postpartum
Postpartum Special Care Units Days	Pregnancy/PP	Numeric	pp_scu_days	postpartum
Postpartum Urinary Tract Infection	Pregnancy/PP	Coded	pp_uti	postpartum
Postpartum Wound Infection	Pregnancy/PP	Y/N/[blank]	pp_wound_infection	postpartum
Postpartum Wound Infection – Severity	Pregnancy/PP	Coded	pp_wound_severity	postpartum
Postpartum Wound Infection – Type	Pregnancy/PP	Coded	pp_wound_type	postpartum
Alcohol	Risks	Y/N/[blank]	r_alc_flg	risk_factors
Antihypertensive Drugs	Risks	Coded	risk_code	risk_assessment
Average Number of Drinks/WK	Risks	Numeric	alcohol_per_wk	risk_factors
Binge Drinking	Risks	Y/N/U	binge_drinking	risk_factors
Cigarettes	Risks	Coded	smoker_type_cd	risk_factors
Cigarettes – Current #/day	Risks	Numeric	cigs_per_day	risk_factors
Current Pregnancy – APH (> 20 weeks)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Bleeding (< 20 weeks)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – IUGR Identified	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Other Antibodies	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Preg. Induced Hypertension	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Proteinuria (> + 1)	Risks	Coded	risk_code	risk_assessment
Current Pregnancy – Rh Antibodies	Risks	Coded	risk_code	risk_assessment
Exposure to Second Hand Smoke	Risks	Y/N/[blank]	second_hand_smoke	risk_factors
History of Mental Illness – Anxiety	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Bipolar	Risks	Coded	risk_code	risk_assessment

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
History of Mental Illness – Depression	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Other	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – PP Depression	Risks	Coded	risk_code	risk_assessment
History of Mental Illness – Unknown	Risks	Coded	risk_code	risk_assessment
Medical History – Diabetes/Other Abnormal Glucose Factor	Risks	Coded	risk_code	risk_assessment
Medical History – Hypertension > 140/90	Risks	Coded	risk_code	risk_assessment
Medical History – Hypertensive Chronic Renal Disease	Risks	Coded	risk_code	risk_assessment
Medical History – Other Cause of Hypertension	Risks	Coded	risk_code	risk_assessment
No Selected Risks	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Major Congenital Anomalies	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Low Birth Weight	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Macrosomic Baby	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Neonatal Death	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Rh Isoimmuinization	Risks	Coded	risk_code	risk_assessment
Past Obstetrical History – Prior Stillbirth	Risks	Coded	risk_code	risk_assessment
Substance Use – Cocaine	Risks	Coded	risk_code	risk_assessment
Substance Use – Heroin	Risks	Coded	risk_code	risk_assessment
Substance Use – Marijuana	Risks	Coded	risk_code	risk_assessment
Substance Use – Methadone	Risks	Coded	risk_code	risk_assessment
Substance Use – Other	Risks	Coded	risk_code	risk_assessment
Substance Use – Prescription	Risks	Coded	risk_code	risk_assessment
Substance Use – Solvents	Risks	Coded	risk_code	risk_assessment
Substance Use – Unknown	Risks	Coded	risk_code	risk_assessment
TWEAK Score	Risks	Numeric	tweak_score	risk_factors
BCPDR Fields – Item 1	Supplementary	Coded	option_1	bcpdr_optional_fields
BCPDR Fields – Item 10	Supplementary	Coded	option_10	bcpdr_optional_fields
BCPDR Fields – Item 2	Supplementary	Coded	option_2	bcpdr_optional_fields
BCPDR Fields – Item 3	Supplementary	Coded	option_3	bcpdr_optional_fields
BCPDR Fields – Item 4	Supplementary	Coded	option_4	bcpdr_optional_fields

FIELD NAME	SCREEN	VALUES	TABLE FIELD	TABLE
BCPDR Fields – Item 5	Supplementary	Coded	option_5	bcpdr_optional_fields
BCPDR Fields – Item 6	Supplementary	Coded	option_6	bcpdr_optional_fields
BCPDR Fields – Item 7	Supplementary	Coded	option_7	bcpdr_optional_fields
BCPDR Fields – Item 8	Supplementary	Coded	option_8	bcpdr_optional_fields
BCPDR Fields – Item 9	Supplementary	Coded	option_9	bcpdr_optional_fields
Institution Fields – Item 1	Supplementary	Text	option_1	inst_optional_fields
Institution Fields – Item 10	Supplementary	Text	option_10	inst_optional_fields
Institution Fields – Item 2	Supplementary	Text	option_2	inst_optional_fields
Institution Fields – Item 3	Supplementary	Text	option_3	inst_optional_fields
Institution Fields – Item 4	Supplementary	Text	option_4	inst_optional_fields
Institution Fields – Item 5	Supplementary	Text	option_5	inst_optional_fields
Institution Fields – Item 6	Supplementary	Text	option_6	inst_optional_fields
Institution Fields – Item 7	Supplementary	Text	option_7	inst_optional_fields
Institution Fields – Item 8	Supplementary	Text	option_8	inst_optional_fields
Institution Fields – Item 9	Supplementary	Text	option_9	inst_optional_fields

9.5 Field Values

9.5.1 Coded Field Values

All Coded Field Values pertaining to the CIHI Data Screen have been removed from this table. Please refer to DAD and Classifications resources from CIHI.

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.1				
Actual Place of Delivery	Birth Summary	place_of_delivery	1	Hospital
			2	Home
			3	Other
			4	Unknown
9.5.1.2				
Blood Type	Antenatal	pregnancy	A+	A+
			A-	A-
			AB+	AB+
			AB-	AB-
			B+	B+
			B-	B-
			O+	O+
			O-	O-
			U	Unknown
9.5.1.3				
Breastfeeding Initiation	Newborn Record	baby_admission	1	<= 1 hour
			2	> 1 hour and <= 24 hours
			3	> 24 hours
			4	Unknown
			5	Not Applicable
9.5.1.4				
Cesarean Section Incision	Birth Summary	multiple_labours	0	Not Applicable
			1	Low Segment Transverse
			2	Low Segment Vertical
			3	Classical
			4	Other
			5	Unknown

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.5				
Cesarean Section Type	Birth Summary	multiple_labours	0	Not Applicable
			1	Primary Elective
			2	Primary Emergency
			3	Repeat Elective
			4	Repeat Emergency
9.5.1.6				
Cigarettes	Risks	risk_factors	C	Current
			F	Former
			N	Never
9.5.1.7				
Delivered By	Birth Summary	multiple_labours	1	Family Physician
			2	Obstetrician (or Fellow)
			3	Midwife
			4	Nurse
			5	Medical Student Intern
			6	Obstetrical Resident
			7	Midwife Trainee
			8	Family Practice Resident
			9	Other
			10	No Attendant
			11	Unknown
			12	Surgeon
9.5.1.8				
Delivery Position	Birth Summary	multiple_labours	1	Anterior
			2	Posterior
			3	Transverse
			4	Other
			5	Unknown
9.5.1.9				
Delivery Presentation	Birth Summary	multiple_labours	1	Breech, NOS
			2	Frank Breech
			3	Footling Breech
			4	Complete Breech
			5	Incomplete Breech
			6	Vertex
			7	Transverse
			8	Other
			9	Unknown
			10	Not Applicable

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.10				
Discharged To	Baby Chart	baby_admission	H	Home
			A	Adoption
			F	Foster Home
			O	Other Hospital
			D	Death/S.B.
			U	Unknown
9.5.1.11				
Episiotomy Type	Birth Summary	labour	1	Median
			2	Mediolateral
9.5.1.12				
Group B Strep Results	Antenatal	pregnancy	Pos	Positive
			Neg	Negative
			Unk	Unknown
9.5.1.13				
Indication for Induction	Birth Summary	multiple_labours	0	Not Applicable
			1	Post Dates
			2	Prelabour R.O.M.
			3	Fetal Compromise
			4	Other Maternal Condition
			5	Logistics
			6	Fetal Demise
			7	Other
			8	Unknown
			9	Hypertension in Pregnancy
			10	APH (Antepartum Hemorrhage)
			11	Chorioamnionitis
			12	Diabetes
9.5.1.14				
Infectious Agents	Baby Chart Pregnancy/PP	baby_chart postpartum	B970	Adenovirus
			B966	Bacillus fragilis
			Cdiff	Clostridium difficile
			B967	Clostridium perfrigens
			B972	Coronavirus
			B9681	Enterococcus
			B971	Enterovirus
			B962	Eschericia coli

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
			B963	Haemophilus influenzae
			B9680	Helicobacter pylori
			B961	Klebsiella penumoniae
			B960	Mycoplasma pneumoniae
			B9688	Other specified bacterial
			Othor	Other specified organism
			B957	Other staphylococcus
			B9548	Other streptococcus
			B9788	Other viral agents
			B977	Papillomavirus
			B9780	Parainfluenzae virus
			B976	Parvovirus
			B964	Proteus
			B965	Pseudomonas
			B975	Reovirus
			B974	Respiratory synctial virus
			B973	Retrovirus
			B956	Staphylococcus aureus
			B958	Staphylococcus, unspecified
			B953	Streptococcus pneumoniae
			B950	Streptococcus, group A
			B951	Streptococcus, group B
			B952	Streptococcus, group D
			B9540	Streptococcus, group G
			B955	Streptococcus, unspecified
			Unk	Unknown organism

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.15				
Labour Position	Birth Summary	multiple_labours	1	Anterior
			2	Posterior
			3	Transverse
			4	Other
			5	Unknown
			6	Not Applicable
9.5.1.16				
Labour Presentation	Birth Summary	multiple_labours	1	Breech, NOS
			2	Frank Breech
			3	Footling Breech
			4	Complete Breech
			5	Incomplete Breech
			6	Vertex
			7	Transverse
			8	Other
			9	Unknown
			10	Not Applicable
9.5.1.17				
Laceration Degree	Birth Summary	labour	1	First
			2	Second
			3	Third
			4	Fourth
9.5.1.18				
Newborn Feeding	Newborn Record	baby_admission	BR	Breast Milk
			FR	Formula
			BF	Breast Milk & Formula
			UN	Unknown
			NA	Not Applicable
9.5.1.19				
Postpartum Urinary Tract Infection	Pregnancy/PP	postpartum	BO	Both cystitis and pyelonephritis
			CY	Cystitis
			OT	Other Urinary Tract Infection
			PY	Pyelonephritis
			UN	Unknown
9.5.1.20				
Postpartum Wound Infection - Severity	Pregnancy/PP	postpartum	DE	Deep
			SU	Superficial
			UN	Unknown

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.21				
Postpartum Wound Infection - Type	Pregnancy/PP	postpartum	CS	Caesarean Section
			PE	Perineum
9.5.1.22				
Primary Indic. Operative Delivery	Birth Summary	multiple_labours	1	Breech
			2	Dystocia / CPD
			3	Nonreassuring Fetal Heart Rate
			4	Repeat C-Section
			5	Abruptio Placenta
			6	Placenta Previa
			7	Other
			8	Not Applicable
			9	Unknown
			10	Malposition / Malpresentation
			11	Active Herpes
			12	VBAC Declined/ Maternal Request
9.5.1.23				
Risk Code	Risks	risk_assessment	01	Prior Neonatal Death
			02	Prior Stillbirth
			03	Prior Low Birthweight Baby
			04	Prior Macrosomic Baby
			05	Prior Rh Immunization
			06	Major Congenital Anomalies
			07	Bleeding (< 20 Weeks)
			08	APH (> 20 Weeks)
			09	Pregnancy Induced Hypertension
			10	Proteinuria > + 1
			11	Blood Antibodies – Rh
			12	Blood Antibodies – Other
			13	Gestational Diabetes, Insulin Dependent
			14	Gestational Diabetes, Non-Insulin Dep.

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
			15	Diabetes Mellitus, Insulin Dependent
			16	Diabetes Mellitus, Non-Insulin Dependent
			17	Other Abnormal Glucose Factors
			18	Heart Disease–Class I
			19	Heart Disease–Class II
			20	Heart Disease–Class III
			21	Heart Disease–Class IV
			22	Heart Disease–Class Unknown
			23	Hypertension > 140/90
			24	Antihypertensive Drugs
			25	Hypertensive Chronic Renal Disease
			26	Hypertension – Other Causes
			27	No Specified Risks
			28	IUGR Identified
			29	Prescription
			30	Heroin
			31	Methadone
			32	Marijuana
			33	Cocaine
			34	Solvents
			35	Other Drug
			36	Unknown Drug
			37	General Depression
			38	Previous PP Depression
			39	Anxiety
			40	Bipolar
			41	Mental Illness – Other
			42	Mental Illness – Unknown

FIELD NAME	SCREEN	TABLE	CODE	DESCRIPTION
9.5.1.24				
Sex	Baby Newborn Baby Transfer/ Readmission	baby_admission	F	Female
			M	Male
			O	Other
			U	Undifferentiated

9.5.2 Non-coded Field Values

NB/XF
- This field will contain one of two selections:
  NB = Baby Newborn record
  XF = Baby Transfer / Readmission record.
- This is used only for the Screen Source field on the baby_admission table.

DL/PP
- This field will contain one of two selections:
  DL = Mother Record
  PP = Mother Postpartum Record
- This is used only for the Screen Source Field on the mother_admission table.

P/A/U/N
- This field will contain one of four selections:
  P = prior to onset of labour
  A = during labour (after onset of first stage of labour)
  U = unknown if prior to or during labour
  N = not applicable.
- This is used only for the Stillbirth field on the baby_delivery table.

Y/[blank]
- This field will contain one of two selections:
  Y = yes (yes has been chosen for this field)
  [blank] = no value has been chosen for this field.

Y/N/[blank]
- This field will contain one of three selections:
  Y = yes (yes has been chosen for this field)
  N = no (yes was chosen, but it was then unselected)
  [blank] = no value has been chosen for this field.
- To query on this type of field, always ask for "Y" or "not Y".

Y/N/U
- This field will contain one of three selections:
  Y = yes
  N = no
  U = unknown.

Y/N/U/[blank]
- This field will contain one of three selections:
  Y = yes
  N = no
  U = unknown.
  [blank] = no value has been chosen for this field

Y/N/U/A
- This field will contain one of four selections:
  Y = yes
  N = no
  U = unknown
  A = not applicable

9.6 Supplementary Screens

9.6.1 Institution Fields

The Institution Fields are located in the Supplementary Screen of all Suites and are for Health Authority/Hospital use. These fields can be used by Health Authorities/Hospitals to collect data not currently collected in the BCPDR. Although maintenance and management of these fields is the responsibility of the Health Authority/Hospital, BCPDR would like to track and provide assistance in the development of these fields.

BCPDR will provide no data quality on these fields; however, these fields will be exported to PSBC.

Eg: A Hospital may wish to collect the Bishop Score. The Mother Suite Supplementary Screen – Institution Fields – Item 1 could be designated as the field to collect this data. Values between 0 and 10 would be entered in this field.

It is the responsibility of the Health Authorities/Hospital to document the use of these fields for historical purposes.

Field Attributes

The ten boxes are text boxes that are 50 characters in length. These boxes may be used for hospital, Health Service Delivery Areas or even Health Authority comparisons. Data quality for these fields may be performed via the creation of queries in the Adhoc Section of the BCPDR.

The data is stored in the inst_optional_fields table:

Screen Name	Field Name
Item 1	option_1
Item 2	option_2
Item 3	option_3
Item 4	option_4
Item 5	option_5
Item 6	option_6
Item 7	option_7
Item 8	option_8
Item 9	option_9
Item 10	option_10

See Appendix 10.9 Supplementary Institution Fields on page 255.

9.6.2 BCPDR Fields

The BCPDR Fields will be assigned and activated by PSBC. These fields will be used to collect data elements not currently in the BCPDR. Usage of these fields may be for guideline assessment, Ministry of Health or program evaluation etc. Once a request for a new field has been formally approved by PSBC, these fields will be activated as required and will be mandatory to complete once activated.

10. APPENDICES

10.1 PSBC Provincial Perinatal Forms Documentation Hierarchy

For those hospitals that utilize our PSBC forms, the PSBC Provincial Perinatal Forms Documentation Hierarchy will help determine the Recommended Source (usually indicative of the first time information is documented in the chart) as well as Alternative Source(s) (other locations in the chart to find the information) for data field collection.

Eg: for field name Blood Type, the Recommended Source is Antenatal Record Part 2, Section 13.

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Mother	Admission Date (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Admission Time (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Chart Number (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Date of Birth (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Discharge Date (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Discharge Time (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Given Name (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Given Name Alias (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Inpatient Number (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Personal Health # (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Surname (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Mother	Surname Alias (Mother)	Admission/Discharge Form or Downloaded Information	Antenatal Record 1 (1)	
Mother	Mother	Surname Birth (Mother)	Admission/Discharge Form or Downloaded Information		
Mother	Antenatal	3rd Trimester Hemoglobin	Antenatal Record 2 (13) Laboratory report(s)		Abstract lowest hemoglobin level taken in 3rd trimester
Mother	Antenatal	Blood Type	Antenatal Record 2 (13)	Triage & Assessment 1 (3) Labour Partogram 1 (1)	
Mother	Antenatal	First Contact with Physician/ Midwife Date	Antenatal Record 1 (9) Antenatal Record 2 (16)		Indicate earliest documented date
Mother	Antenatal	First U/S Date (4-19 wks)	Antenatal Record 1 (4) Antenatal Record 2 (18)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Antenatal	G.A. From First U/S Weeks	Antenatal Record 1 (4) Antenatal Record 2 (18)		
Mother	Antenatal	G.A. From First U/S Days	Antenatal Record 1 (4) Antenatal Record 2 (18)		
Mother	Antenatal	Gravida	Antenatal Record 1 (3)	Labour & Birth Summary (1) Labour Partogram 1 (1) Triage & Assessment 1 (1)	
Mother	Antenatal	Group B Strep	Antenatal Record 2 (13)	Triage & Assessment 1 (3) Labour Partogram 1 (1)	
Mother	Antenatal	Group B Strep – Results	Antenatal Record 2 (13)	Triage & Assessment 1 (3) Labour Partogram 1 (1)	
Mother	Antenatal	HBsAg Results	Antenatal Record 2 (13)		
Mother	Antenatal	HBsAg Testing	Antenatal Record 2 (13)		
Mother	Antenatal	HIV Testing	Antenatal Record 2 (13)		
Mother	Antenatal	Induced [Therap] Abort	Antenatal Record 1 (3)		
Mother	Antenatal	IVF	Antenatal Record 1 (5)		
Mother	Antenatal	Last Menstrual Period Date	Antenatal Record 1 (4) Antenatal Record 2 (14)	Triage & Assessment 1 (1)	Menses cycle in Antenatal Record 1 (4) indicates whether periods are regular
Mother	Antenatal	Living	Antenatal Record 1 (3)	Labour & Birth Summary (1) Labour Partogram 1 (1) Triage & Assessment 1 (1)	
Mother	Antenatal	Maternal Serum Screen Offered	Antenatal Record 1 (10) Antenatal Record 2 (13) Antenatal Record 2 (16) Antenatal Record 2 (18)		Forms refer to Prenatal Genetic Screening
Mother	Antenatal	Number (#) Antenatal Visits	Antenatal Record 2 (16)		Count # visits
Mother	Antenatal	Preterm	Antenatal Record 1 (3)	Labour & Birth Summary (1) Labour Partogram 1 (1) Triage & Assessment 1 (1)	
Mother	Antenatal	Prev. C/S	Antenatal Record 1 (3)		
Mother	Antenatal	Prev. Vag	Antenatal Record 1 (3)		
Mother	Antenatal	Rh Immunoglobulin Given Earliest Date Antepartum	Antenatal Record 2 (13) Antenatal Record 2 (16)		
Mother	Antenatal	School Years Completed	Antenatal Record 1 (1)		
Mother	Antenatal	Spont Abort	Antenatal Record 1 (3)		
Mother	Antenatal	Term	Antenatal Record 1 (3)	Labour & Birth Summary (1) Labour Partogram 1 (1) Triage & Assessment 1 (1)	
Mother	Birth Summary	Actual Place of Delivery	Labour & Birth Summary (5)		Midwife-involved cases only
Mother	Birth Summary	Anesthetic/Analgesic – Entonox	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Birth Summary	Anesthetic/Analgesic – Epidural	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – General	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Local	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Narcotics	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – None	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Other	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Pudendal	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Spinal	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Anesthetic/Analgesic – Unknown	Labour & Birth Summary (3) Labour Partogram 2,3 (5,7)		
Mother	Birth Summary	Baby Seq (Mother) (first number)	Labour & Birth Summary (1)		
Mother	Birth Summary	Cervical Dilation Prior to CS	Labour & Birth Summary (4)	Labour Partogram 1 (2)	
Mother	Birth Summary	Cesarean Incision	OR Report		This information is not captured on PSBC Forms
Mother	Birth Summary	Cesarean Section Type	Labour & Birth Summary (4)		
Mother	Birth Summary	Delivered By	Labour & Birth Summary (5)		
Mother	Birth Summary	Delivery Date	Labour & Birth Summary (5)	Labour Partogram 6 (12)	
Mother	Birth Summary	Delivery Position	Labour & Birth Summary (4)	Labour Partogram 1 (2)	
Mother	Birth Summary	Delivery Presentation	Labour & Birth Summary (3) & (4)	Labour Partogram 1 (2)	
Mother	Birth Summary	Delivery Time	Labour & Birth Summary (5)	Labour Partogram 6 (12)	
Mother	Birth Summary	Episiotomy (median or mediolateral)	Labour & Birth Summary (4)		
Mother	Birth Summary	First Stage Date	Labour & Birth Summary (5)		
Mother	Birth Summary	First Stage Time	Labour & Birth Summary (5)		
Mother	Birth Summary	Indication for Induction	Labour & Birth Summary (2)		
Mother	Birth Summary	Intended Place of Delivery	Antenatal Record 2 (12,16)		Comments section in Antenatal Record 2 (16) will likely indicate if planned place of delivery changed over course of pregnancy. Midwife-involved cases only
Mother	Birth Summary	Labour Initiation - Augmented – ARM	Labour & Birth Summary (2) Labour Partogram 1 (2)	Labour Partogram 1 (1) Labour Partogram 2,3 (5)	
Mother	Birth Summary	Labour Initiation - Augmented – Other	Labour & Birth Summary (2)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Birth Summary	Labour Initiation - Augmented – Oxytocin	Labour & Birth Summary (2) Labour Partogram 2,3 (4)		
Mother	Birth Summary	Labour Initiation - Induced – ARM	Labour & Birth Summary (2) Labour Partogram 1 (2)	Labour Partogram 1 (1) Labour Partogram 2,3 (5)	
Mother	Birth Summary	Labour Initiation - Induced – Other	Labour & Birth Summary (2)		
Mother	Birth Summary	Labour Initiation - Induced – Oxytocin	Labour & Birth Summary (2) Labour Partogram 2,3 (4)		
Mother	Birth Summary	Labour Initiation - Induced – Prost	Labour & Birth Summary (2)		
Mother	Birth Summary	Labour Initiation – No Labour	Labour & Birth Summary (2)	Labour Partogram	
Mother	Birth Summary	Labour Initiation – Spontaneous	Labour & Birth Summary (2)		
Mother	Birth Summary	Labour Initiation – Unknown			Will be used very rarely
Mother	Birth Summary	Labour Position	Labour & Birth Summary (4)	Triage & Assessment 1 (4) Labour Partogram 1 (2)	If using Triage & Assessment ensure that the patient is in labour
Mother	Birth Summary	Labour Presentation	Labour & Birth Summary (3,4)	Triage & Assessment 1 (4) Labour Partogram 1 (2)	If using Triage & Assessment ensure that the patient is in labour
Mother	Birth Summary	Laceration (Degree)	Labour & Birth Summary (4)		
Mother	Birth Summary	Midwife Case	Labour & Birth Summary (5)	Antenatal Record 1 (11) Antenatal Record 2 (18)	Having a list of all midwives that practise in your area will assist with identification based on names and signatures.
Mother	Birth Summary	Perineum/Vaginal/Cervix – Cervical Tear	Labour & Birth Summary (4)		
Mother	Birth Summary	Perineum/Vaginal/Cervix – Episiotomy	Labour & Birth Summary (4)		
Mother	Birth Summary	Perineum/Vaginal/Cervix – Intact	Labour & Birth Summary (4)		
Mother	Birth Summary	Perineum/Vaginal/Cervix – Laceration	Labour & Birth Summary (4)		
Mother	Birth Summary	Perineum/Vaginal/Cervix – Other Tear	Labour & Birth Summary (4)		
Mother	Birth Summary	Perineum/Vaginal/Cervix – Unknown	Labour & Birth Summary (4)		
Mother	Birth Summary	Placenta Delivered Date	Labour & Birth Summary (5)	Labour Partogram 6 (14)	
Mother	Birth Summary	Placenta Delivered Time	Labour & Birth Summary (5)	Labour Partogram 6 (14)	
Mother	Birth Summary	Primary Indic. Operative Delivery	Labour & Birth Summary (4)		Repeat C/S & VBAC Declined/Maternal Request can be found on Antental Record 1(3)

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Birth Summary	Rupture of Membranes (R.O.M.) Date	Labour & Birth Summary (5)	Triage & Assessment 1 (2) Labour Partogram 1 (1)	
Mother	Birth Summary	Rupture of Membranes (R.O.M.) Time	Labour & Birth Summary (5)	Triage & Assessment 1 (2) Labour Partogram 1 (1)	
Mother	Birth Summary	Second Stage Date	Labour & Birth Summary (5)	Labour Partogram 6 (12)	
Mother	Birth Summary	Second Stage Time	Labour & Birth Summary (5)	Labour Partogram 6 (12)	
Mother	Birth Summary	VBAC Attempted	Labour & Birth Summary (4)		Noted as Trial of Labour
Mother	Birth Summary	VBAC Eligible	Labour & Birth Summary (4)		Noted as VBAC Candidate
Mother	Chart Data	Admission Wt. (Kg) (Mother)	Triage & Assessment 1 (3) Antenatal Record 2 (16)	Labour Partogram 1 (1)	Info can be taken from Antenatal Record if visit was within 7 days of delivery
Mother	Chart Data	Blood Transfusion – Antepartum	Canadian Blood Services Form		
Mother	Chart Data	Blood Transfusion – Intrapartum	Canadian Blood Services Form		
Mother	Chart Data	Blood Transfusion – Postpartum	Canadian Blood Services Form		
Mother	Chart Data	Cervical Dilation on Admission	Triage & Assessment 1 (4)	Labour Partogram 1 (2)	
Mother	Chart Data	Drugs – Antibiotics	Labour & Birth Summary (3)		
Mother	Chart Data	Drugs – Antihypertensives	Medication Forms		
Mother	Chart Data	Drugs – CS Prophylactic Antibiotics	Labour & Birth Summary (3)		
Mother	Chart Data	Drugs – Other for Lung Maturation	Medication Forms		
Mother	Chart Data	Drugs – Steroids for Lung Maturation	Medication Forms		
Mother	Chart Data	Drugs – Tocolytics	Medication Forms		
Mother	Chart Data	Fetal Surveillance During Labour – Auscultation	Labour Partogram 2 & 3 (3)	Triage & Assessment 1 (4) Labour & Birth Summary (3)	If using Triage & Assessment ensure that the patient is in labour
Mother	Chart Data	Fetal Surveillance During Labour – External Monitor	Labour Partogram 2 & 3 (3)	Triage & Assessment 1 (4) Labour & Birth Summary (3)	If using Triage & Assessment ensure that the patient is in labour
Mother	Chart Data	Fetal Surveillance During Labour – Internal Monitor	Labour Partogram 2 & 3 (3)	Labour & Birth Summary (3)	
Mother	Chart Data	Fetal Surveillance During Labour – Not Monitored	Labour Partogram 2 & 3 (3)	Labour & Birth Summary (3)	
Mother	Chart Data	Height (cm)	Antenatal Record 1 (9) Antenatal Record 2 (14)	Triage & Assessment 1(3)	

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Chart Data	Prepreg Wt. (Kg)	Antenatal Record 1 (9) Antenatal Record 2 (14,16)	Triage & Assessment 1(3)	If using Antenatal Record 2 (16) weight must be <12 weeks gestation
Mother	Chart Data	Rh Immunglobulin Postpartum – Eligible	Maternal Postpartum Care Path		
Mother	Chart Data	Rh Immunoglobulin Postpartum – Date Given	Maternal Postpartum Care Path		
Mother	Chart Data	Total Prior Admissions This Pregnancy	Count inpatient visits in ADT Count inpatient visits in chart	Triage & Assessment 1 (3) Antenatal Record 2 (16)	
Mother	Pregnancy/PP	Acute Fatty Liver	Clinician's notes		
Mother	Pregnancy/PP	HELLP Syndrome	Clinician's notes		
Mother	Pregnancy/PP	Infectious Agent #1 – Postpartum Positive Blood Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Infectious Agent #1 – Postpartum Positive Other Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Infectious Agent #1 – Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Infectious Agent #2 – Postpartum Positive Blood Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Infectious Agent #2 – Postpartum Positive Other Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Infectious Agent #2 – Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Liver Hematoma	Clinician's notes		
Mother	Pregnancy/PP	Postpartum Hemoglobin Date	Lab reports		
Mother	Pregnancy/PP	Postpartum Hemoglobin Value	Lab reports		
Mother	Pregnancy/PP	Postpartum Infection	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Positive Blood Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Positive Other Culture	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Special Care Units Days	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Wound Infection	Clinician's notes Lab reports		
Mother	Pregnancy/PP	Postpartum Wound Infection – Severity	Clinician's notes Lab reports		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Pregnancy/PP	Postpartum Wound Infection – Type	Clinician's notes Lab reports		
Mother	Risks	Alcohol	Antenatal Record 1 (8)		
Mother	Risks	Average Number of Drinks/WK	Antenatal Record 1 (8)		
Mother	Risks	Binge Drinking	Antenatal Record 1 (8)		
Mother	Risks	Cigarettes	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Cigarettes – Current #/ day	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Current Pregnancy – APH (> 20 weeks)	Antenatal Record 1 (5) Antenatal Record 2 (16)		
Mother	Risks	Current Pregnancy – Bleeding (< 20 weeks)	Antenatal Record 1 (5) Antenatal Record 2 (16)		
Mother	Risks	Current Pregnancy – IUGR Identified	Antenatal Record 2 (16)		
Mother	Risks	Current Pregnancy – Other Antibodies	Canadian Blood Services Report		
Mother	Risks	Current Pregnancy – Preg. Induced Hypertension	Antenatal Record 1 (7) Antenatal Record 2 (16)		
Mother	Risks	Current Pregnancy – Proteinuria (> + 1)	Antenatal Record 2 (16)		
Mother	Risks	Current Pregnancy – Rh Antibodies	Antenatal Record 2 (13) Canadian Blood Services Report		Use Antibody titre 1 located on Antenatal Record 2 (13) where available
Mother	Risks	Exposure to Second Hand Smoke	Antenatal Record 1 (8)		
Mother	Risks	History of Mental Illness – Anxiety	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	History of Mental Illness – Bipolar	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	History of Mental Illness – Depression	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	History of Mental Illness – Other	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	History of Mental Illness – PP Depression	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	History of Mental Illness – Unknown	Antenatal Record 1 (7)	Triage & Assessment 1 (3)	
Mother	Risks	Medical History – Diabetes/Other Abnormal Glucose Factor	Antenatal Record 1 (7) Antenatal Record 2 (13) & (16)		
Mother	Risks	Medical History - Antihypertensive Drugs	Antenatal Record 1 (7) Antenatal Record 2 (16)		
Mother	Risks	Medical History – Hypertension > 140/90	Antenatal Record 2 (16)		
Mother	Risks	Medical History – Hypertensive Chronic Renal Disease	Antenatal Record 1 (7) Antenatal Record 2 (16)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Mother	Risks	Medical History – Other Cause of Hypertension	Antenatal Record 1 (7) Antenatal Record 2 (16)		
Mother	Risks	No Selected Risks	Review of Antenatal Record 1 & 2		
Mother	Risks	Past Obstetrical History – Major Congenital Anomalies	Antenatal Record 1 (3)		
Mother	Risks	Past Obstetrical History – Prior Low Birth Weight	Antenatal Record 1 (3)		
Mother	Risks	Past Obstetrical History – Prior Macrosomic Baby	Antenatal Record 1 (3)		
Mother	Risks	Past Obstetrical History – Prior Neonatal Death	Antenatal Record 1 (3)		
Mother	Risks	Past Obstetrical History – Prior Rh Isoimmuinization	Antenatal Record 1 (3)		
Mother	Risks	Past Obstetrical History – Prior Stillbirth	Antenatal Record 1 (3)		
Mother	Risks	Substance Use – Cocaine	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Heroin	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Marijuana	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Methadone	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Other	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Prescription	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Solvents	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	Substance Use – Unknown	Antenatal Record 1 (8)	Triage & Assessment 1 (3)	
Mother	Risks	TWEAK Score	Antenatal Record 1 (8)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
All Suites	CIHI Data	Admission Weight (Baby)	Downloaded from CIHI		Some episodes of care - including but not limited to stillbirths and PP episodes that are not on an obstetric service - may need to have CIHI information entered manually. ***See 8.2.3.1 Performing a CIHI Import, Step 2: Obtain CIHI Data from the Health Record Abstracting System, on page 156***
All Suites	CIHI Data	Coder # (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Coder # (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Death Codes	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Postal (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Postal (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Prov (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Prov (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Residence (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Demographics Codes – Residence (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Diagnoses – Prefix	Downloaded from CIHI		
All Suites	CIHI Data	Diagnoses – Code	Downloaded from CIHI		
All Suites	CIHI Data	Diagnoses – Seq	Downloaded from CIHI		
All Suites	CIHI Data	Diagnoses – Type	Downloaded from CIHI		
All Suites	CIHI Data	Doctor – Service	Downloaded from CIHI		
All Suites	CIHI Data	Doctor – Type	Downloaded from CIHI		
All Suites	CIHI Data	Institution From (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Institution From (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Institution Number (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Institution Number (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Institution To (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Institution To (Mother)	Downloaded from CIHI		
All Suites	CIHI Data	Main Patient Service (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Main Patient Service (Mother)	Downloaded from CIHI		
All Suites	CIHI data	NICU days – Level II (Baby)	Downloaded from CIHI		
All Suites	CIHI data	NICU days – Level III (Baby)	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Anaes Agent	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Code	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Date	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Dr. Serv	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Ext	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Loc	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Seq	Downloaded from CIHI		
All Suites	CIHI Data	Procedures – Stat	Downloaded from CIHI		
All Suites	Supplementary	BCPDR Fields – Item 1	N/A		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
All Suites	Supplementary	BCPDR Fields – Item 2	N/A		
All Suites	Supplementary	BCPDR Fields – Item 3	N/A		
All Suites	Supplementary	BCPDR Fields – Item 4	N/A		
All Suites	Supplementary	BCPDR Fields – Item 5	N/A		
All Suites	Supplementary	BCPDR Fields – Item 6	N/A		
All Suites	Supplementary	BCPDR Fields – Item 7	Maternal and Fetal Levels of Service Tool (2.0)		
All Suites	Supplementary	BCPDR Fields – Item 8	N/A		
All Suites	Supplementary	BCPDR Fields – Item 9	N/A		
All Suites	Supplementary	BCPDR Fields - Item 10	N/A		
All Suites	Supplementary	Institution Fields – Item 1	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 2	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 3	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 4	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 5	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 6	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 7	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 8	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 9	N/A		At facility's discretion
All Suites	Supplementary	Institution Fields – Item 10	N/A		At facility's discretion
Newborn	Baby Newborn	Admission Date (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Admission Time (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Baby Sequence (first number)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Baby Sequence (second number)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Chart Number (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Date of Birth (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Discharge Date (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Discharge Time (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Given Name (Baby)	Admission/Discharge Form or Downloaded Information		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Newborn	Baby Newborn	Inpatient Number (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Personal Health # (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Sex	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Surname (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Baby Newborn	Surname Birth (Baby)	Admission/Discharge Form or Downloaded Information		
Newborn	Newborn Record	Apgar Score – 1 Min	Newborn Record 1 (2)	Labour & Birth Summary (5)	
Newborn	Newborn Record	Apgar Score – 5 Min	Newborn Record 1 (2)	Labour & Birth Summary (5)	
Newborn	Newborn Record	Apgar Score – 10 Min	Newborn Record 1 (2)	Labour & Birth Summary (5)	
Newborn	Newborn Record	Breastfeeding Initiation	Newborn Clinical Path 1 (4)	Newborn Record 2 (12) & (14) Labour Partogram (14)	
Newborn	Newborn Record	Chest Compression	Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Chest Compression – Start Age	Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Chest Compression – Stop Age	Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Cord Arterial Gases – Base E/D	Lab reports		Newborn Record 1 (3) Labour & Birth Summary (4) Indicate that Cord Gases were taken
Newborn	Newborn Record	Cord Arterial Gases – pH	Lab reports		Newborn Record 1 (3) Labour & Birth Summary (4) Indicate that Cord Gases were taken
Newborn	Newborn Record	Drugs For Resuscitation/ Stabilization	Newborn Resuscitation Record (4)		
Newborn	Newborn Record	Evaluation of Development – Head Circ	Newborn Record 1 (6)		
Newborn	Newborn Record	Evaluation of Development – Length	Newborn Record 1 (6)		
Newborn	Newborn Record	Gestational Age - By Exam	Newborn Record 1 (8)		
Newborn	Newborn Record	Gestational Age - From Mat Record	Labour & Birth Summary (1)	Newborn Record 1 (8) Labour Partogram 1(1) Triage & Assessment (1)	
Newborn	Newborn Record	IPPV ETT	Newborn Resuscitation Record (3)		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Newborn	Newborn Record	IPPV ETT – Start Age	Newborn Resuscitation Record (3)		
Newborn	Newborn Record	IPPV ETT – Stop Age	Newborn Resuscitation Record (3)		
Newborn	Newborn Record	IPPV Mask	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	IPPV Mask – Start Age	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	IPPV Mask – Stop Age	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Meconium Present	Newborn Record 1 (3)	Labour & Birth Summary (3) Newborn Clinical Path 1 (1)	
Newborn	Newborn Record	Newborn Feeding	Newborn Clinical Path 1 (3) & (4)	Newborn Record 2 (12)	
Newborn	Newborn Record	Oxygen	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Oxygen – Start Age	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Oxygen – Stop Age	Newborn Record 1 (3) Newborn Resuscitation Record (3)		
Newborn	Newborn Record	Stillbirth	Newborn Record 1 (7)	Labour & Birth Summary (5)	
Newborn	Newborn Record	Suction – Oropharynx	Newborn Record 1 (3) Newborn Resuscitation Record (4)		
Newborn	Newborn Record	Suction – Trachea	Newborn Record 1 (3) Newborn Resuscitation Record (4)		
Newborn	Newborn Record	Suction – Unspecified	Newborn Record 1 (3) Newborn Resuscitation Record (4)		
Newborn	Baby Chart	1st Temperature 1st hour after birth	Newborn Record 1 (3)	Newborn Clinicial Path 1 (2) Newborn Resuscitation Record (2)	
Newborn	Baby Chart	Antibiotics	Medication Record	Newborn Resuscitation Record (4)	
Newborn	Baby Chart	CPAP days	NICU (Nnursing or Respiratory therapy) Flowsheets	Newborn Resuscitation Record (3)	
Newborn	Baby Chart	Discharge To	Newborn Record 2 (17)	Newborn Clinical Path 3 (7)	
Newborn	Baby Chart	Discharge Weight (grams)	Newborn Record 2 (15)	Newborn Clinical Path 3 (7)	
Newborn	Baby Chart	Infectious Agent #1 – Positive Blood Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Infectious Agent #1 – Positive Other Culture	Clinician's notes Lab reports		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Newborn	Baby Chart	Infectious Agent #1 – Positive Urine Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Infectious Agent #2 – Positive Blood Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Infectious Agent #2 – Positive Other Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Infectious Agent #2 – Positive Urine Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Oxygen Days	NICU (Nursing or Respiratory therapy) Flowsheets		Newborn Resuscitation Record 1 (3) - count only if baby >60 min old
Newborn	Baby Chart	Positive Blood Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Positive Other Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Positive Urine Culture	Clinician's notes Lab reports		
Newborn	Baby Chart	Surfactant Given	Medication Record	NICU (Nursing or Respiratory therapy) Flowsheets Newborn Resuscitation Record (4)	
Newborn	Baby Chart	TPN Days	NICU Flowsheets	TPN Order sheet	
Newborn	Baby Chart	Ventilator Days	NICU (Nursing or Respiratory therapy) Flowsheets		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Surname (Mother)	Mother chart		Completes automatically if Baby Transfer/ Readmission episode can be linked with Mother Delivery episode
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Surname (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Surname Birth (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Given Name (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Given Name (Mother)	Baby chart	Mother chart	Completes automatically if Baby Transfer/ Readmission episode can be linked with Mother Delivery episode

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Inpatient Number (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Personal Health # (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Personal Health # (Mother)	Baby chart	Mother chart	Completes automatically if Baby Transfer/ Readmission episode can be linked with Mother Delivery episode
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Sex	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Admission Date (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Admission Time (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Baby Sequence (first number)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Baby Sequence (second number)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Birth Hospital	Baby chart	Mother chart	Completes automatically if Baby Transfer/ Readmission episode can be linked with Mother Delivery episode
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Chart Number (Baby Transfer)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Date of Birth (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Date of Birth (Mother)	Baby chart	Mother chart	Completes automatically if Baby Transfer/ Readmission episode can be linked with Mother Delivery episode
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Discharge Date (Baby)	Admission/Discharge Form or Downloaded Information		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Baby Transfer/ Readmission	Baby Transfer - Transfer/ Readmission	Discharge Time (Baby)	Admission/Discharge Form or Downloaded Information		
Baby Transfer/ Readmission	Baby Chart	1st Temperature 1st hour after birth	Baby chart		Only collect if baby is transferred within one hour of birth
Baby Transfer/ Readmission	Baby Chart	Antibiotics	Medication Record		
Baby Transfer/ Readmission	Baby Chart	CPAP days	NICU (Nursing or Respiratory therapy) Flowsheets		
Baby Transfer/ Readmission	Baby Chart	Discharge To	Baby chart		
Baby Transfer/ Readmission	Baby Chart	Discharge Weight (grams)	Baby chart		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #1 – Positive Blood Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #1 – Positive Other Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #1 – Positive Urine Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #2 – Positive Blood Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #2 – Positive Other Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Infectious Agent #2 – Positive Urine Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Oxygen Days	NICU (Nursing or Respiratory therapy) Flowsheets		
Baby Transfer/ Readmission	Baby Chart	Positive Blood Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Positive Other Culture	Clinician's notes Lab reports		
Baby Transfer/ Readmission	Baby Chart	Positive Urine Culture	Clinician's notes Lab reports		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Baby Transfer/ Readmission	Baby Chart	Surfactant Given	Medication Record	NICU (Nursing or Respiratory therapy) Flowsheets Newborn Resuscitation Record (4)	
Baby Transfer/ Readmission	Baby Chart	TPN Days	NICU Flowsheets	TPN Order sheet	
Baby Transfer/ Readmission	Baby Chart	Ventilator Days	NICU (Nursing or Respiratory therapy) Flowsheets		
Postpartum	Postpartum Mother	Admission Date (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Admission Time (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Chart Number (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Date of Birth (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Delivery Date (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Discharge Date (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Discharge Time (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Given Name (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Given Name Alias (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Inpatient Number (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Personal Health # (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Place of Delivery (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Surname (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Surname Alias (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Postpartum Mother	Surname Birth (Mother Postpartum)	Admission/Discharge Form		
Postpartum	Pregnancy/PP	Acute Fatty Liver	Clinician’s notes		
Postpartum	Pregnancy/PP	HELLP Syndrome	Clinician’s notes		
Postpartum	Pregnancy/PP	Infectious Agent #1 – Postpartum Positive Blood Culture	Clinician’s notes Lab reports		
Postpartum	Pregnancy/PP	Infectious Agent #1 – Postpartum Positive Other Culture	Clinician’s notes Lab reports		

SUITE	SCREEN	FIELD NAME	RECOMMENDED SOURCE	ALTERNATIVE SOURCE(S)	ADDITIONAL NOTES
Postpartum	Pregnancy/PP	Infectious Agent #1 – Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Infectious Agent #2 – Postpartum Positive Blood Culture	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Infectious Agent #2 – Postpartum Positive Other Culture	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Infectious Agent #2 – Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Liver Hematoma	Clinician's notes		
Postpartum	Pregnancy/PP	Blood Transfusion – Postpartum - # Units	Canadian Blood Services Form		
Postpartum	Pregnancy/PP	Postpartum Hemoglobin Date	Lab reports		
Postpartum	Pregnancy/PP	Postpartum Hemoglobin Value	Lab reports		
Postpartum	Pregnancy/PP	Postpartum Infection	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Positive Blood Culture	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Positive Other Culture	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Special Care Units Days	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Urinary Tract Infection	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Wound Infection	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Wound Infection – Severity	Clinician's notes Lab reports		
Postpartum	Pregnancy/PP	Postpartum Wound Infection – Type	Clinician's notes Lab reports		

10.2 Height Conversion Table

HEIGHT TABLE	
Ft / Inch	**Centimetres**
4'8"	142
4'9"	145
4'10"	147
4'11"	150
5'0"	152
5'1"	155
5'2"	157
5'3"	160
5'4"	163
5'5"	165
5'6"	168
5'7"	170
5'8"	173
5'9"	175
5'10"	178
5'11"	180
6'0"	183
6'1"	185
6'2"	188

Note: 1 inch = 2.54 cm

10.3 Weight Conversion Table – Pounds to Kilograms

Pounds	Kg	Pounds	Kg	Pounds	Kg	Pounds	Kg	Pounds	Kg	Pounds	Kg	Pounds	Kg
75	34.0	109	49.4	143	64.9	177	80.3	211	95.7	245	111.1	279	126.6
76	34.5	110	49.9	144	65.3	178	80.7	212	96.2	246	111.6	280	127.0
77	34.9	111	50.3	145	65.8	179	81.2	213	96.6	247	112.0	281	127.5
78	35.4	112	50.8	146	66.2	180	81.6	214	97.1	248	112.5	282	127.9
79	35.8	113	51.3	147	66.7	181	82.1	215	97.5	249	112.9	283	128.4
80	36.3	114	51.7	148	67.1	182	82.6	216	98.0	250	113.4	284	128.8
81	36.7	115	52.2	149	67.6	183	83.0	217	98.4	251	113.9	285	129.3
82	37.2	116	52.6	150	68.0	184	83.5	218	98.9	252	114.3	286	129.7
83	37.6	117	53.1	151	68.5	185	83.9	219	99.3	253	114.8	287	130.2
84	38.1	118	53.5	152	68.9	186	84.4	220	99.8	254	115.2	288	130.6
85	38.6	119	54.0	153	69.4	187	84.8	221	100.2	255	115.7	289	131.1
86	39.0	120	54.4	154	69.9	188	85.3	222	100.7	256	116.1	290	131.5
87	39.5	121	54.9	155	70.3	189	85.7	223	101.2	257	116.6	291	132.0
88	39.9	122	55.3	156	70.8	190	86.2	224	101.6	258	117.0	292	132.4
89	40.4	123	55.8	157	71.2	191	86.6	225	102.1	259	117.5	293	132.9
90	40.8	124	56.2	158	71.7	192	87.1	226	102.5	260	117.9	294	133.4
91	41.3	125	56.7	159	72.1	193	87.5	227	103.0	261	118.4	295	133.8
92	41.7	126	57.2	160	72.6	194	88.0	228	103.4	262	118.8	296	134.3
93	42.2	127	57.6	161	73.0	195	88.5	229	103.9	263	119.3	297	134.7
94	42.6	128	58.1	162	73.5	196	88.9	230	104.3	264	119.7	298	135.2
95	43.1	129	58.5	163	73.9	197	89.4	231	104.8	265	120.2	299	135.6
96	43.5	130	59.0	164	74.4	198	89.8	232	105.2	266	120.7	300	136.1
97	44.0	131	59.4	165	74.8	199	90.3	233	105.7	267	121.1	301	136.5
98	44.5	132	59.9	166	75.3	200	90.7	234	106.1	268	121.6	302	137.0
99	44.9	133	60.3	167	75.7	201	91.2	235	106.6	269	122.0	303	137.4
100	45.4	134	60.8	168	76.2	202	91.6	236	107.0	270	122.5	304	137.9
101	45.8	135	61.2	169	76.7	203	92.1	237	107.5	271	122.9	305	138.3
102	46.3	136	61.7	170	77.1	204	92.5	238	108.0	272	123.4	306	138.8
103	46.7	137	62.1	171	77.6	205	93.0	239	108.4	273	123.8	307	139.3
104	47.2	138	62.6	172	78.0	206	93.4	240	108.9	274	124.3	308	139.7
105	47.6	139	63.0	173	78.5	207	93.9	241	109.3	275	124.7	309	140.2
106	48.1	140	63.5	174	78.9	208	94.3	242	109.8	276	125.2	310	140.6
107	48.5	141	64.0	175	79.4	209	94.8	243	110.2	277	125.6	311	141.1
108	49.0	142	64.4	176	79.8	210	95.3	244	110.7	278	126.1	312	141.5

Note: 1 pound = 453.6 grams

Updated April 2014

10.4 Weight Conversion Table – Pounds / Ounces to Grams

	0 lb	1 lb	2 lb	3 lb	4 lb	5 lb	6 lb	7 lb	8 lb	9 lb	10 lb	11 lb	12 lb	13 lb	14 lb
0 oz	00	454	907	1361	1814	2268	2722	3175	3629	4082	4536	4990	5443	5897	6350
1 oz	28	482	936	1389	1843	2296	2750	3203	3657	4111	4564	5018	5471	5925	6379
2 oz	57	510	964	1417	1871	2325	2778	3232	3685	4139	4593	5046	5500	5953	6407
3 oz	85	539	992	1446	1899	2353	2807	3260	3714	4167	4621	5075	5528	5982	6435
4 oz	113	567	1021	1474	1928	2381	2835	3289	3742	4196	4649	5103	5557	6010	6464
5 oz	142	595	1049	1503	1956	2410	2863	3317	3770	4224	4678	5131	5585	6038	6492
6 oz	170	624	1077	1531	1984	2438	2892	3345	3799	4252	4706	5160	5613	6067	6520
7 oz	198	652	1106	1559	2013	2466	2920	3374	3827	4281	4734	5188	5642	6095	6549
8 oz	227	680	1134	1588	2041	2495	2948	3402	3856	4309	4763	5216	5670	6123	6577
9 oz	255	709	1162	1616	2070	2523	2977	3430	3884	4337	4791	5245	5698	6152	6605
10 oz	283	737	1191	1644	2098	2551	3005	3459	3912	4366	4819	5273	5727	6180	6634
11 oz	312	765	1219	1673	2126	2580	3033	3487	3941	4394	4848	5301	5755	6209	6662
12 oz	340	794	1247	1701	2155	2608	3062	3515	3969	4423	4876	5330	5783	6237	6690
13 oz	369	822	1276	1729	2183	2637	3090	3544	3997	4451	4904	5358	5812	6265	6719
14 oz	397	850	1304	1758	2211	2665	3118	3572	4026	4479	4933	5386	5840	6294	6747
15 oz	425	879	1332	1786	2240	2693	3147	3600	4054	4508	4961	5415	5868	6322	6776

Note: 1 ounce = 28.35 grams

10.5 Gestational Age Calculation

10.5.1 Gestational Age Calculation Used by BCPDR Application

GESTATIONAL AGE FIELDS

Information regarding gestational age is abstracted in four separate database fields.

DATABASE FIELD	GESTATIONAL AGE FROM THE FIELDS
Last menstrual period date	The system does an internal calculation from delivery date and last menstrual period date to determine the gestational age.
First ultrasound date **Gestational Age from first U/S**	The system does an internal calculation from delivery date and first ultrasound date and age to determine the gestational age. *Note: both first ultrasound date and age must be present before this calculation can be done.*
Gestational age by exam	This is the newborn gestational age as recorded by physician, following newborn examination. It is abstracted into the Newborn Record Screen.
Gestational age by documentation	This is the gestational age as recorded on the maternal chart. Is abstracted on Newborn Record Screen.

FINAL GESTATIONAL AGE

The field chosen to be the final gestational age is determined by:

DETERMINING FACTOR	WILL CHOOSE THIS FIELD FOR FINAL GESTATIONAL AGE
If calculated GA by Last menstrual period date and calculated GA by First ultrasound date differs by ***<7 days***	**Last menstrual period date**
If calculated GA by Last menstrual period date and calculated GA by First ultrasound date differs by ***>1 week and <2 week*** AND age at first U/S ***>12 wk***	**Last menstrual period date**
If calculated GA by Last menstrual period date and calculated GA by First ultrasound date differs by ***>1 week and <2 week*** AND age at first U/S ***<12 wk***	**First ultrasound date**
If calculated GA by Last menstrual period date and calculated GA by First ultrasound date differs by ≥***2 wk***	**First ultrasound date**
If Last menstrual period date is ***blank***	**First ultrasound date**
If Last menstrual period date and First ultrasound date are ***blank***	**Gestational age by exam**
If Last menstrual period date, First ultrasound date and Gestational age by exam are ***blank***	**Gestational age by documentation**

Hospital Report Application

The Hospital Report called "Gestational Age at Birth" uses the above final gestational age calculation.

Ad hoc Report Application

From Ad hoc Report Application, there is a standard query called Gestational_Age. This will list the four gestational age choices (ie: GA by LMP, GA by US, GA by exam, GA by documentation) and the chosen final gestational for each newborn. To be included in this listing, both mother and newborn suites must be completed and linked.

10.5.2 Gestational Age Calculation Used by PSBC Surveillance

If desired, the specifications for this calculation can be obtained from PSBC.

GESTATIONAL AGE FIELDS

Information regarding gestational age is abstracted into five separate database fields.

DATABASE FIELDS	GESTATIONAL AGE FROM THE FIELDS	Shorthand for the Calculation
Last Menstrual Period Date	The system does an internal calculation from delivery date and last menstrual period date to determine the gestational age.	GA by dates
First U/S Date **G.A. From First U/S – Weeks**	The system does an internal calculation from delivery date and first ultrasound date and age to determine the gestational age. *Note: both First U/S Date and G.A. From First U/S – Weeks must be present for this calculation to occur.*	GA by us
Gestational Age By Exam	This is the newborn gestational age as recorded by the health care provider, following newborn examination. This field is abstracted into the Newborn Record Screen.	GA by exam
Gestational Age From Maternal Chart	This is the gestational age as recorded on the maternal chart. This field is abstracted into the Newborn Record Screen.	GA from document

GESTATIONAL AGE IN COMPLETED WEEKS

The field used to assign the final estimate of gestational age, in completed weeks, is determined by the following rules:

DETERMINING FACTOR	Shorthand for the Calculation
If Last Menstrual Period is recorded and there is no ultrasound	GA by dates
If Last Menstrual Period is recorded and there is no ultrasound, but Gestational Age by Exam is at least 3 weeks different than Last Menstrual Period	GA by exam
If Last Menstrual Period is recorded and equal to Gestational Age in weeks, taken from ultrasound at < 14 weeks	GA by dates
If Last Menstrual Period is recorded and not equal to Gestational Age in weeks, taken from ultrasound at < 14 weeks	GA by us
If Last Menstrual Period is recorded and within 1 week of Gestational Age in weeks, taken from ultrasound at 14 – 20 weeks	GA by dates
If Last Menstrual Period is recorded and difference is 2+ weeks different from Gestational Age in weeks, taken from ultrasound at 14 – 20 weeks	GA by us
If Last Menstrual Period is not recorded but Gestational Age can be calculated from an ultrasound <20 weeks	GA by us
If Last Menstrual Period and first ultrasound (date and weeks gestation) are not recorded	GA by exam
If Last Menstrual Period, first ultrasound (date and weeks gestation), and Gestational Age by Exam are not recorded	GA from document
If Last Menstrual Period, first ultrasound (date and weeks gestation), Gestational Age by Exam and Gestational Age From Maternal Chart are all missing or out of range (see note)	None; Gestational age is missing

Note: Gestational age by LMP is currently considered in range if it is between 15 and 45 weeks

Note: Gestational age by early ultrasound is currently considered in range if it is between 17 and 43 weeks

10.6 Labour and Delivery Presentation and Position

The following table, diagrams, and flowcharts can be used to assess the presentation and position of the baby during labour and delivery.

10.6.1 Table

<table>
<tr><th>Presentation</th><th>Body Part Presenting</th><th>Position</th><th>Fetal Head Position</th></tr>
<tr><td rowspan="5">Vertex (Cephalic, Occipital)[1]</td><td rowspan="5">Head</td><td>Anterior</td><td>ROA, LOA, direct OA[2]</td></tr>
<tr><td>Posterior</td><td>ROP, LOP, direct OP[3]</td></tr>
<tr><td>Tranverse</td><td>ROT or LOT[4]</td></tr>
<tr><td>Other[5]</td><td>Other position where presentation is cephalic (Eg: brow, face)</td></tr>
<tr><td>Unknown</td><td>Head first, but none of the above</td></tr>
<tr><td>Breech NOS</td><td>Breech, not otherwise specified</td><td rowspan="7">Other[5]</td><td rowspan="7">Other position where presentation is not vertex or cephalic
(Eg: breech, transverse lie, oblique lie)</td></tr>
<tr><td>Frank Breech</td><td>Buttocks down, legs extended straight up in front of body, feet near head</td></tr>
<tr><td>Footling Breech</td><td>One or both feet stretched out below buttocks</td></tr>
<tr><td>Complete Breech</td><td>Buttocks down, legs folded at knees, feet near buttocks</td></tr>
<tr><td>Incomplete Breech</td><td>Feet or knees presenting</td></tr>
<tr><td>Transverse</td><td>Long axis of fetal body being perpendicular to the long axis of the mother</td></tr>
<tr><td>Other</td><td>Presentation known, but none of the above
(Eg: compound not presenting as vertex, oblique lie)</td></tr>
<tr><td>Unknown</td><td>Presentation unknown or not documented</td><td>Unknown[6]</td><td>Head position is uncertain or unknown or not documented</td></tr>
</table>

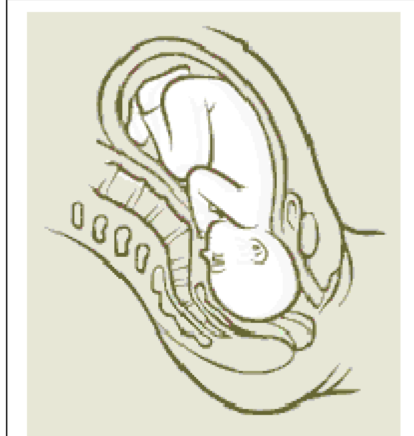
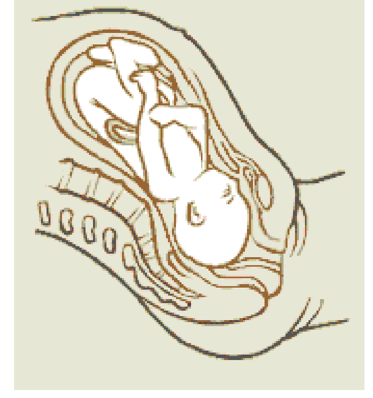
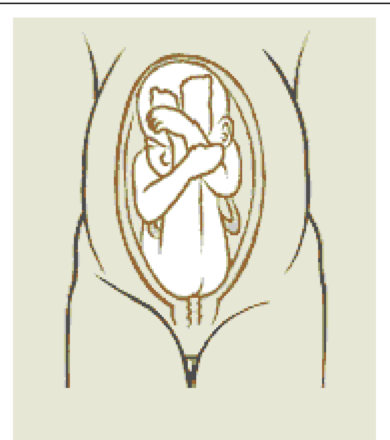
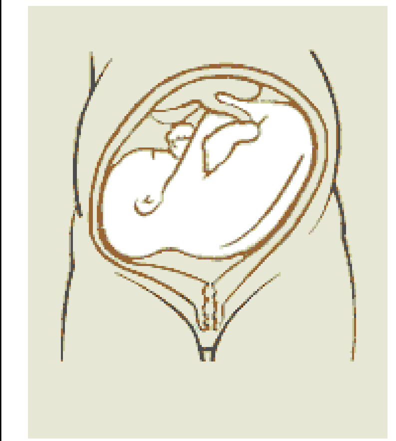
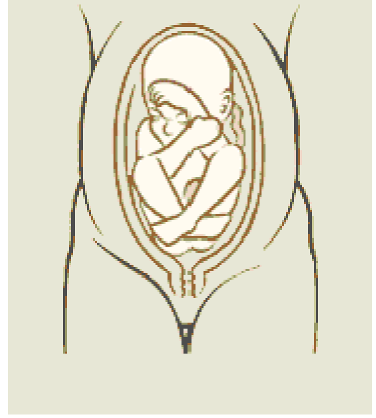
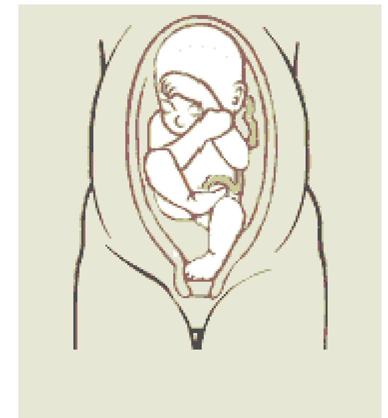
FOOTNOTES

1 **Vertex** indicates the top of the head
2 ROA, LOA, OA = right occiput anterior, left occiput anterior, occiput anterior
3 ROP, LOP, OP = right occiput posterior, left occiput posterior, occiput posterior
4 ROT, LOT = right occiput transverse, left occiput transverse
5 **Other** can be chosen if:
the head is presenting but position is not anterior, posterior or transverse or
presentation is not vertex (cephalic or occiput)
6 **Unknown** Fetal Head Position can be chosen if:
the head is presenting but there is no documentation on the position of the head or
the head position is uncertain, unknown or not documented

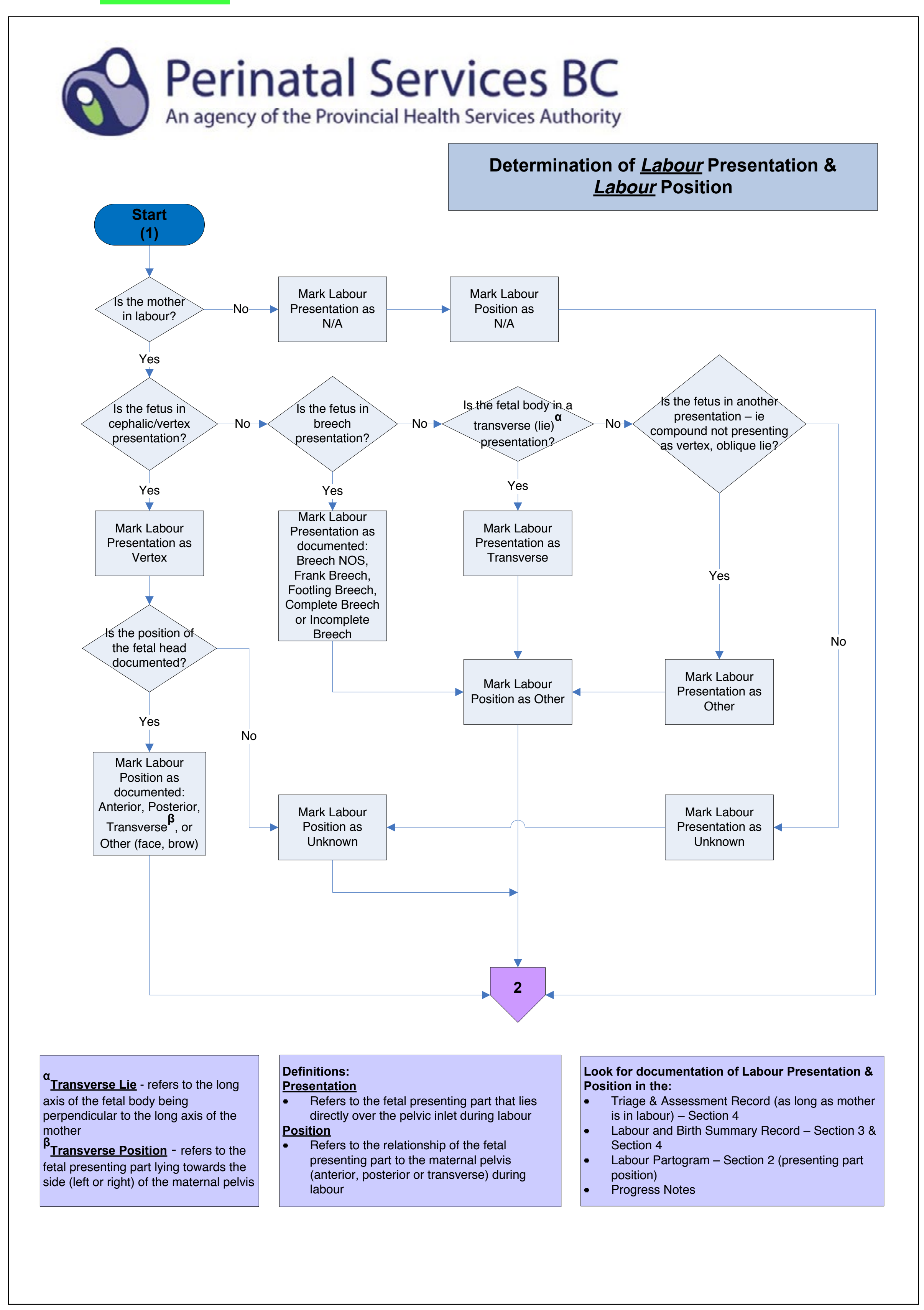
NOTES

- **Vertex Presentation** in delivery can be chosen (even if not stated) if the newborn is term and the delivery is vaginal.
- **Not Applicable Position** in Labour and Not Applicable Presentation in Labour (not described in Table 1) are to be used when a mother is not in labour
- **Labour Presentation/Position can be located in the specific sections of the chart:**
    - Triage and Assessment Record (Section 4 Vaginal Exam) (if the mother is in labour at the time)
    - Labour and Birth Summary Record (Section 3 Intrapartum; Section 4 Delivery)
    - Labour Partogram (Section 2 Presenting part/position)
    - Progress Notes
- **Delivery Presentation/Position can be located in the specific sections of the chart:**
    - Labour and Birth Summary Record (Section 4 Delivery)
    - Labour Partogram (Section 2 Presenting part/position – just before delivery)
    - Progress Notes
    - C/S Operative Report or Delivery Note (Pre & Post Diagnosis, Body of Report)

10.6.2 Diagrams

 Position: Anterior Presentation: Vertex (Cephalic/ Occipital)	 Position: Posterior Presentation: Vertex (Cephalic/ Occipital)	 Position: Other Presentation: Frank Breech
 Position: Other Presentation: Transverse	 Position: Other Presentation: Complete Breech	 Position: Other Presentation: Footing Breech

10.6.3 Flowcharts

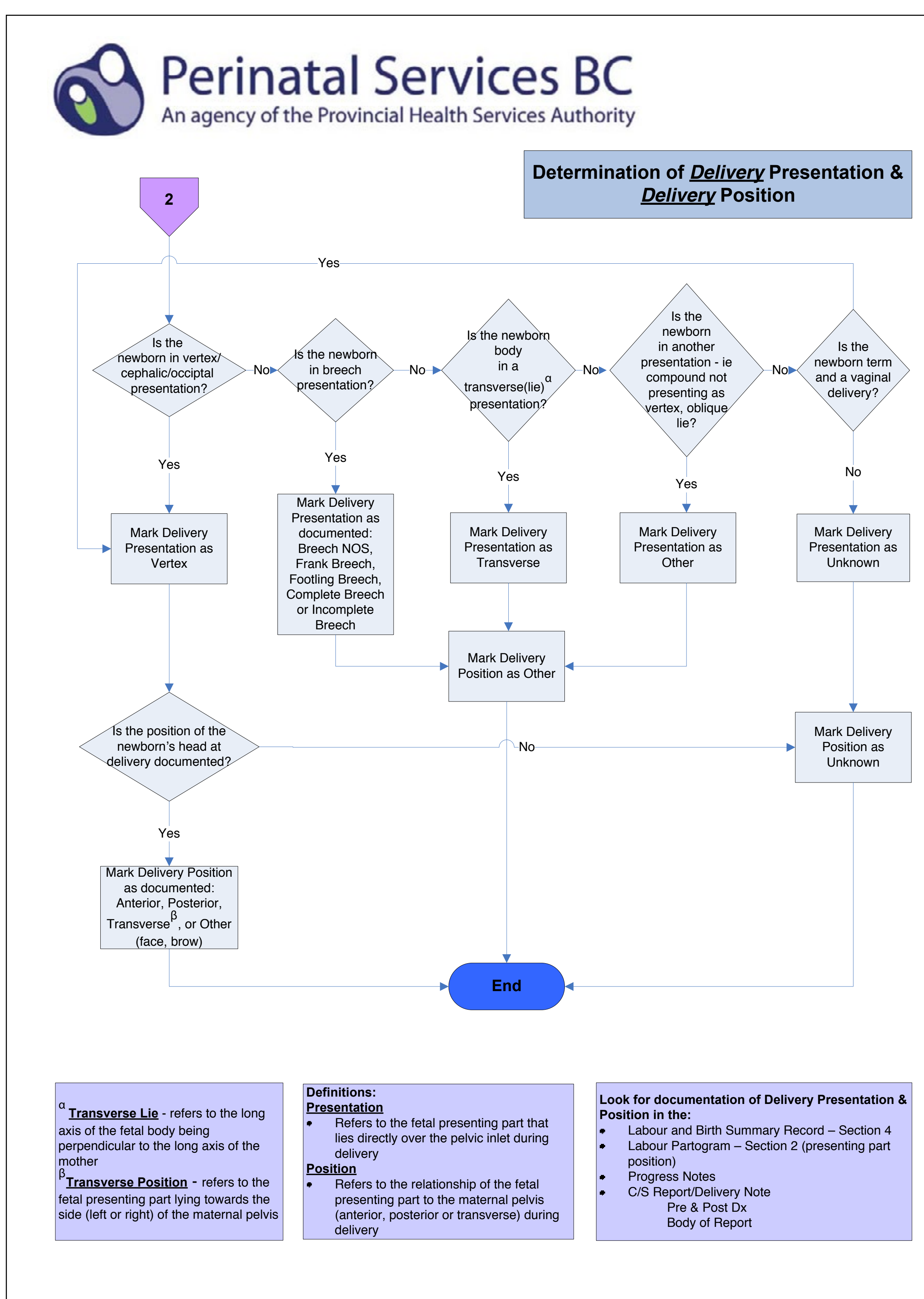


αTransverse Lie - refers to the long axis of the fetal body being perpendicular to the long axis of the mother
βTransverse Position - refers to the fetal presenting part lying towards the side (left or right) of the maternal pelvis

Definitions:
Presentation
- Refers to the fetal presenting part that lies directly over the pelvic inlet during labour

Position
- Refers to the relationship of the fetal presenting part to the maternal pelvis (anterior, posterior or transverse) during labour

Look for documentation of Labour Presentation & Position in the:
- Triage & Assessment Record (as long as mother is in labour) – Section 4
- Labour and Birth Summary Record – Section 3 & Section 4
- Labour Partogram – Section 2 (presenting part position)
- Progress Notes


Perinatal Services BC
An agency of the Provincial Health Services Authority
Determination of Delivery Presentation & Delivery Position
2
Yes
Is the newborn in vertex/ cephalic/occiptal presentation?
No
Is the newborn in breech presentation?
No
Is the newborn body in a transverse(lie) α presentation?
No
Is the newborn in another presentation - ie compound not presenting as vertex, oblique lie?
No
Is the newborn term and a vaginal delivery?
Yes
Yes
Yes
Yes
No
Mark Delivery Presentation as Vertex
Mark Delivery Presentation as documented: Breech NOS, Frank Breech, Footling Breech, Complete Breech or Incomplete Breech
Mark Delivery Presentation as Transverse
Mark Delivery Presentation as Other
Mark Delivery Presentation as Unknown
Mark Delivery Position as Other
Is the position of the newborn's head at delivery documented?
No
Mark Delivery Position as Unknown
Yes
Mark Delivery Position as documented: Anterior, Posterior, Transverse β, or Other (face, brow)
End
α Transverse Lie - refers to the long axis of the fetal body being perpendicular to the long axis of the mother
β Transverse Position - refers to the fetal presenting part lying towards the side (left or right) of the maternal pelvis
Definitions:
Presentation
Refers to the fetal presenting part that lies directly over the pelvic inlet during delivery
Position
Refers to the relationship of the fetal presenting part to the maternal pelvis (anterior, posterior or transverse) during delivery
Look for documentation of Delivery Presentation & Position in the:
Labour and Birth Summary Record – Section 4
Labour Partogram – Section 2 (presenting part position)
Progress Notes
C/S Report/Delivery Note
Pre & Post Dx
Body of Report

10.7 Adapted Case Scenarios for Registration of Births and Stillbirths in British Columbia[1]

Signs of life detected after birth[2]	Birth weight in grams	Gestational age in completed weeks at diagnosis of fetal death	Gestational age in completed weeks at birth / expulsion	Vital statistics registration / PDR abstract requirements[3]	DAD abstract requirement
Yes	≥ 500 g	Not applicable	≥ 20	Live birth	Yes
Yes	≥ 500 g	Not applicable	< 20	Live birth	*
Yes	≥ 500 g	Not applicable	Unknown	Live birth	*
Yes	< 500 g	Not applicable	≥ 20	Live birth	Yes
Yes	< 500 g	Not applicable	< 20	Live birth	*
Yes	< 500 g	Not applicable	Unknown	Live birth	*
Yes	Unknown	Not applicable	≥ 20	Live birth	*
Yes	Unknown	Not applicable	< 20	Live birth	No
Yes	Unknown	Not applicable	Unknown	Live birth	*
No	≥ 500 g	≥ 20	≥ 20	Stillbirth	*
No	≥ 500 g	≥ 20	Unknown	Stillbirth	*
No	≥ 500 g	< 20	≥ 20	Stillbirth	No
No	≥ 500 g	< 20	< 20	Stillbirth	No
No	≥ 500 g	< 20	Unknown	Stillbirth	No
No	≥ 500 g	Unknown	≥ 20	Stillbirth	Yes
No	≥ 500 g	Unknown	< 20	Stillbirth	No
No	≥ 500 g	Unknown	Unknown	Stillbirth	*
No	< 500 g	≥ 20	≥ 20	Stillbirth	*
No	< 500 g	< 20	≥ 20	Stillbirth	No
No	< 500 g	< 20	< 20	None	No
No	< 500 g	< 20	Unknown	None	No
No	< 500 g	Unknown	≥ 20	Stillbirth	*
No	< 500 g	Unknown	< 20	None	No
No	< 500 g	Unknown	Unknown	None	*
No	Unknown	≥ 20	≥ 20	Stillbirth	Yes
No	Unknown	< 20	≥ 20	Stillbirth	No
No	Unknown	< 20	< 20	None	No
No	Unknown	< 20	Unknown	None	No
No	Unknown	Unknown	≥ 20	Stillbirth	*

* If you have a chart that meets these criteria, please contact CIHI via eQuery for guidance.

1 Original document provided by Public Health Agency of Canada. DAD abstracting requirements include input by CIHI Classifications. Canadian Perinatal Surveillance System (June 2008). Case scenarios for reporting of live births and stillbirths in Canada.

2 Signs of life include breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle.

3 Stillbirths include all deliveries of deceased infants, including documented products of conception resulting from intrauterine death or fetal reduction.

10.8 Newborn Resuscitation and Ventilation

10.8.1 Definitions

	PDR Abstract	
TYPE OF VENTILATION	**RESUSCITATION**	**VENTILATION**
Invasive CPAP – no oxygen	Not captured in BCPDR	CPAP Days
Invasive CPAP – with oxygen	Oxygen	CPAP Days plus Oxygen Days
Non-Invasive CPAP – no oxygen	Not captured in BCPDR	CPAP Days
Non-Invasive CPAP – with oxygen	Oxygen	CPAP Days plus Oxygen Days
Invasive IPPV – per ETT – no oxygen	IPPV ETT	Ventilator Days
Invasive IPPV – per ETT – with oxygen	IPPV ETT plus Oxygen	Ventilator Days plus Oxygen Days
Non-Invasive IPPV – per mask – no oxygen	IPPV Mask	Ventilator Days
Non-Invasive IPPV – per mask – with oxygen	IPPV Mask plus Oxygen	Ventilator Days plus Oxygen Days
Non-Invasive IPPV – per Laryngeal Mask Airway (LMA) – no oxygen	IPPV Mask	Ventilator Days
Non-Invasive IPPV – per Laryngeal Mask Airway (LMA) – with oxygen	IPPV Mask plus Oxygen	Ventilator Days plus Oxygen Days

DEFINITIONS:

- Resuscitation – Occurring up to 1 hr following delivery OR immediately prior to arrival in the NICU – whichever comes first
- Ventilation – Occurring >1 hr following delivery OR immediately upon arrival to the NICU – whichever comes first
- Invasive – Use of an artificial airway such as an endotracheal tube or tracheostomy
- Non-Invasive – Use of a mask, LMA, or nasal prongs
- CPAP – Continuous Positive Pressure Ventilation
- ETT – EndoTracheal Tube
- IPPV – Intermittent Positive Pressure Ventilation

10.8.2 Scenario Table

Newborns can be administered oxygen and/or ventilated, both in the Delivery Room and in the NICU. Whether the hospital in which the baby was born in has a NICU can determine whether the information is captured in the Resuscitation Section of the Newborn Record Screen, the Method of Assisted Ventilation in the Baby Chart Screen, or both.

	Oxygen and/or ventilation in first 60 minutes of life OR until admission to NICU			**Oxygen and/or ventilation in NICU**	
Type of Hospital in which Newborn was Delivered	**Newborn Received Oxygen and/or Vented in Delivery Room**	**Age in Minutes when Oxygen and/or Ventilation was Stopped**	**Resuscitation Section – Newborn Record Screen Requirements**	**Newborn Received Oxygen and/or Vented in NICU**	**Method of Assisted Ventilation – Baby Chart Screen Requirements**
Hospital *with* a NICU	No	N/A	N/A	No	N/A
	No	N/A	N/A	Yes	Abstract appropriate # of days
	Yes	<60 minutes	Abstract Start and Stop Age	No	N/A
	Yes	<60 minutes	Abstract Start and Stop Age	Yes	Abstract appropriate # of days
	Yes	>60 minutes	Abstract appropriate Start Age Abstract Stop Age as 60 min	Yes	Abstract appropriate # of days
	Yes	>60 minutes	Abstract appropriate Start Age Abstract Stop Age as 60 min	No	Abstract 1 day of Assisted Ventilation
Hospital *without* a NICU	No	N/A	N/A	N/A	N/A
	Yes	<60 minutes	Abstract Start and Stop Age	N/A	N/A
	Yes	>60 minutes	Abstract appropriate Start Age Abstract Stop Age as 60 min	Yes	Abstract appropriate days of Assisted Ventilation (newborn is usually awaiting transfer to a higher level of care)

10.8.3 Calculation of Start Age and Stop Age for Resuscitation – Examples

The following are examples of how to record **Start Age** and **Stop Age** for different resuscitation types. Applies to **Oxygen**, **IPPV Mask**, **IPPV ETT** and **Chest Compression.**

Eg: Baby born at 1206	
Resusc started at 1207	*Start Age = 1*
Resusc stopped at 1209	*Stop Age = 3*

Eg: Baby born at 1206	
Resusc started at 55 seconds	*Start Age = .92*
Resusc stop at 3 min 15 sec	*Stop Age = 3.25*

Eg: Baby born at 1206	
Resusc started at 10 seconds	*Start Age = .17*
Resusc stopped at 1 min 20 sec	
Resusc started at 3 minutes	
Resusc stopped at 6 minutes	*Stop Age = 6*

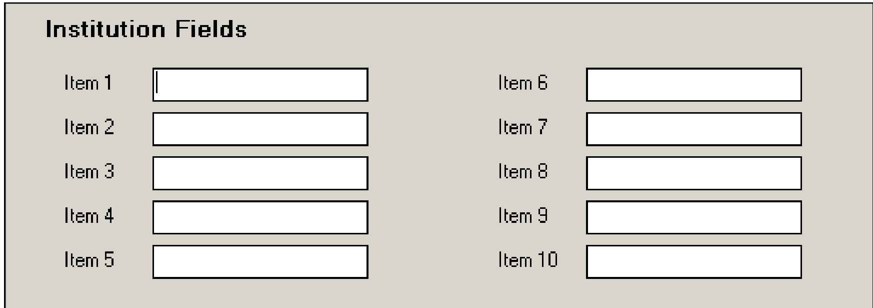
10.9 Supplementary Institution Fields

The BCPDR contains Supplementary Screens in the Mother, Mother Postpartum, Baby Newborn and Baby Transfer/Readmission suites. These screens are included in order to capture additional information not currently collected in the database. There are a total of 10 supplementary fields located within each suite.

The maintenance and management of the institution fields are the responsibility of the Heath Authority/Hospital. It is also the Heath Authority/Hospital's responsibility to develop data quality processes to ensure compliance to the set standards for the data field.

Field Titles

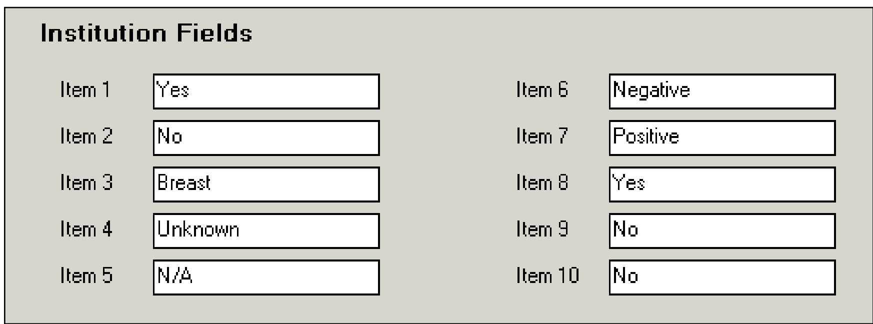
The fields will always be identified as Item 1, Item 2, Item 3, etc and cannot be changed.



Field Values

Each Institution field is in free-text format of 50 characters in length. It is advisable to utilize options such as the ones indicated below to allow for easy data retrieval.

- Yes
- No
- Unknown
- N/A
- Positive
- Negative



The data entered in the Supplementary Institution fields is stored in the inst_optional_fields table.

patient_id	option_1	option_2	option_3	option_4	option_5	option_6	option_7	option_8	option_9	option_10
1	Yes	No	Breast	Unknown	N/A	Negative	Positive	Yes	No	No