Government of **Western Australia**
Department of **Health**

Midwives Notification System

Validation process 2021

WA Health Manual

health.wa.gov.au

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What's new in this version?	New validations have been added to support data items added to MNS from 1 July 2021 as per the N2 data specifications. The document has received a formatting refresh and updated phone numbers.
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1. For problems with internet access or internet browser, please contact your local IT support.

2. For password support for accessing the HSECS Intranet Application contact HSS – ICAM Systems Support

   Email: HSS-ICAMSystemsSupport.RoyalSt@health.wa.gov.au

3. For advice and support in managing the validation ('edit') process for MNS contact the MCH team:

   Email: birthdata@health.wa.gov.au

   Tel: (08) 6373 1825 or (08) 6373 1836

2. Introduction

The Midwives Notification System (MNS) is a compilation of information required by the *WA Health (Miscellaneous Provisions) Act 1911* section 335 to be reported to the Department of Health to enable monitoring of health and welfare of mothers and infants born in WA. The information is essential to service monitoring, planning and allocation of future services, monitoring of patient safety and quality and research.

The MNS has been in operation in its current format since 1997. The MNS contains over one million records of births reported by midwives to the Department of Health since 1980.

The current format of the MNS is an Oracle database managed by the Department of Health. The Oracle database is called the Health Statistical Events Common Store (HSECS) and the MNS section of this database is designated to be MNS or HSECS-MNS in this document.

Creation of data records in the MNS occurs through direct data entry or upload of data files in a specified format. Editing of records and data can occur through direct data entry or updated data file upload. Where updated data files are uploaded, the records that are an update to a previously uploaded record must be marked clearly as updates to prevent duplicate record errors.

The value of MNS data is enhanced by accuracy and timeliness of the information collected. In 2016, almost 36,000 records were uploaded and 100 records were added through data entry to MNS. Each of these records was passed through a rigorous quality assurance, or validation process aimed at identifying inaccurate and incomplete data. This process has multiple steps and responsibility is with the midwife and the Department.

Maternal and Child Health (MCH) at the Department of Health manages the MNS and the validation process.

Each record uploaded to MNS that did not pass the validation process is called an ‘edit’ record and will be returned to the reporting midwife (maternity site) for correction or clarification.

The correction and validation of ‘edit’ records can be an arduous, complicated and time consuming task.

This Manual, prepared by the staff of MCH, is a document made available to midwives and maternity services that describes and advises in detail, how the ‘edit’ process of MNS records can be managed efficiently and effectively.

The Manual also provides background information and detail on the reasoning behind each edit enabling education of midwives on how to reduce the number of future records requiring ‘edits’ management.

3. Data Collection Process

Midwives are required by the *WA Health (Miscellaneous Provisions) Act 1911* to provide information to MNS about every birth they attend. The completeness and accuracy of information provided is the responsibility of the midwife. Reporting this information requires the clinical expertise of a midwife and this responsibility cannot be delegated to staff that are not registered midwives.

All maternity services within WA Health use the application, Stork to report cases to MNS. This system is in use at 26 public maternity services including public homebirth providers.

3.1. Record Identification

Each record reported to MNS must contain identifying data for the mother and the baby. The identifying data attached to each record in MNS is described below in Table 1.

Table 1: Identifying data item descriptions

Identifier	Definition	Added to record by	Used for Validation by
Record Type	The text "BIR" is applied to each infant's record. The text "DEL" is applied to each mother's record	Clinical system or process for providing data file	
Establishment	The health service where the birth occurred	Midwife reporting case	Identifying owner of 'edit' records
UMRN/URN	Unique Medical Record Number or Unit Record Number assigned by the health service to the woman who gave birth and infant born alive. It is used to catalogue medical records and uniquely identify each patient.	Midwife reporting case	Identifying 'edit' records to midwives at maternity services
Date of Birth	The full date of birth of the woman who gave birth and the infant born.	Midwife reporting case	
Name	The first, second and last name of the woman who gave birth	Midwife reporting case	
Address	The street address of the woman who gave birth	Midwife reporting case	
Telephone	The landline or mobile number of the woman who gave birth	Midwife reporting case	
Midwife Name	The first and last name of the midwife reporting the birth information.	Midwife reporting case	
Midwife AHPRA Registration Number	The AHPRA midwifery registration number of the midwife reporting the birth information.	Midwife reporting case	
Batch ID	One unique numeric ID allocated by MNS to all birth records uploaded to MNS in one data file.	MNS	Identifying 'edit' records to MCH staff
Case ID	One numeric ID allocated by MNS to each birth record uploaded to MNS in one data file. This ID is unique for the Batch ID.	MNS	Identifying 'edit' records to MCH staff
Event ID	One unique numeric ID allocated by MNS to each record uploaded to MNS. It is unique for each record within MNS.	MNS	
Update Flag	A status flag that is either NULL or 'Y' for each record in a data file. A 'Y' indicates that the record flagged is an updated record for a record that has been previously uploaded to MNS	Clinical system or process for providing data file	Identifying updated records to MNS at time of file upload

Identifier	Definition	Added to record by	Used for Validation by
Validation ID	A unique ID allocated by MNS to a validation rule	MNS	Identifying validation rule that the record failed to pass. This ID enables the process for validation to be determined

4. Data Validation Process

4.1. Shared responsibilities

The current process, described below, presents multiple opportunities for MNS records to be checked and/or validated for completeness and accuracy.

Midwives and Maternity Services

1. Description and explanation of information required to be reported that is available at time of recording by midwife.
2. Visual checking for completeness and accuracy of paper forms.
3. Automated validation of information at time of recording by midwife.
4. Automated display of data items required or concealment of data items not required dependent on previous information entered e.g. where method of birth was not caesarean section then reason for caesarean section need not be recorded/displayed.
5. Automated requirement to complete a record before it can be reported to MNS.
6. Validation processes for records to be extracted for submission to MNS.
7. Data files extracted conform to file specification required by MNS.
8. Notify MCH staff if records determined to be valid will still raise ‘edits’ with instructions to “override” these validation warnings and accept the record as valid. This will prevent unnecessary duplication of validation at site. (Example: where a maternal weight was greater than 150kg and was determined to be valid.)

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9. Automated process to check data file received for conformance with file specification.
10. Upload to “test” version of MNS to determine if excessive ‘edit’ generation related to error consistent across all records reported e.g. failure to report one data item.
11. Upload to “production” version of MNS.
12. Automated process of applying validation rules to each record uploaded.
13. Automated generation of ‘Edit Report’ that includes all records that did not pass the validation rules and had ‘edits’ generated.
14. Over-ride any ‘edits’ that have been reported by maternity service as already validated. (Example: maternal weight greater than 150 kg.)
15. After ‘edits’ are overridden ensure new version of ‘Edit Report’ is created that excludes ‘edits’ that have been overridden.
16. Ensure ‘edits’ report is refreshed every 24 hours. This occurs at 1400 each day.

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17. Retrieve ‘Edit Report’.
18. Determine the records listed in the ‘Edit Report’ that require investigation to validate content and respond to the validation errors raised.
19. Retrieve and review records and their ‘edits’ and determine if data corrections are required.

20. If no data corrections are required to the record, note this against the record in the ‘Edit Report’. (Example: “data reported is correct – override validation error”.)
21. If data corrections are required to the record, update the record in the clinical system with correct data and note this against the record in the ‘Edit Report’. (Example: “data reported requires correction – Corrected record to be provided as update”).
22. Return your copy of the ‘Edit Report’ that includes your notes to MCH via secure file transfer.
23. Re extract records that must be submitted again with corrected data. Indicate they are update records by setting Update flag to “Y”.

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24. Retrieve the site’s ‘Edit Report’ with notes.
25. Where data reported in original record was correct and site has instructed that validation may be “overridden” (Step 20 above) – go to record in MNS and override the validation result.
26. Where data reported in original record was incorrect and site has instructed they are providing an updated record (Step 21 above) – ensure the record is received from the site for data upload and process as outlined in steps 9 to 13 above.
27. Ensure update flags are set correctly for each record.
28. If another ‘Edit Report’ is generated that includes all records that did not pass the validation rules and had ‘edits’ generated, override any ‘edits’ previously.
29. Notify the site if the ‘Edit Report’ indicates that validation is still required by site.

4.2. Timeline

Since 2014, the delay between a maternity site submitting a data file (NOCA Extract) to MCH and receipt of 'Edit Report' (report of records that failed validation rules)' is one day.

The expected timeline for this process is estimated in Table 2.

Table 2: Expected timeline for data submission and validation

Event	Time
Records for births in each calendar month are batched and submitted as NOCA Extract file/s by maternity services	Within one calendar month[1] of the end birth calendar month, for example, by 30th June for births occurring in May.
NOCA Extract file/s uploaded to HSECS-MNS by MCH	Within two business days of receipt.
An automated process summarises records that did not pass validation rules to an 'Edit Report' posted to a web portal for download by approved users.	Within 24 hours of upload of NOCA Extract
For maternity services that cannot access the download web portal, the 'Edit Report' is provided by MCH staff by secure file transfer.	Within two business days of upload of NOCA Extract.

[1] Sites with more than 5% of infants having length of stay greater than 14 days (e.g. SCN admissions) may submit later than this deadline.

5. Submission and Upload of NOCA Extract

A NOCA Extract or M9 data file must be provided to MCH by all maternity services to report all births attended. (Births reported by paper form are not included in this submission process.)

The NOCA Extract is a data file specified in the document “NOCA Extract Feeder File Specification M9” where M9 is the version in use from July 1st, 2017. This document is available at http://ww2.health.wa.gov.au/Articles/J_M/Midwives-Notification-System.

5.1. Submission process

1. Maternity services provide this data file by secure file transfer to MCH email address birthdata@health.wa.gov.au.
2. MCH staff log receipt of the file.

5.2. Upload process

3. MCH staff queue the received data file for uploading to MNS.
4. Data files queued are uploaded to HSECS-MNS overnight.
5. For each NOCA Extract uploaded, one shared Batch ID is applied to all DEL and BIR records.
6. For each DEL and BIR record in the NOCA Extract, a unique Case ID is applied.
7. The upload process includes validation programming for each DEL and BIR record.
8. DEL and/or BIR records that do not pass any validation rule are isolated from those that pass every rule.
9. The Validation rule ID and Validation explanatory message is added to the DEL or BIR record.
10. A notification of upload success is generated by HSECS-MNS and emailed to birthdata@health.wa.gov.au.

6. Creation of ‘Edit Report’

Every day at 1400, HSECS-MNS compiles to an ‘Edit Report’ all DEL and BIR records that have failed validation. For each record one or more Validation IDs are displayed. An “Edit Report’ is provided for each separate establishment or maternity service

6.1. Why are already validated records still in the ‘Edit Report’?

A DEL or BIR record will continue to be compiled to the ‘Edit Report’ each day until:

- A record that failed the validation rule has been corrected and that record has been uploaded again to HSECS-MNS, and
- MCH staff have “overridden” the HSECS-MNS validation rules as directed by maternity service for that record, and
- The record has no other validation failures.

6.2. Why are there duplicate records in the ‘Edit Report’?

A record that has failed multiple validation rules will be displayed multiple times in the ‘Edit Report’, once for each validation rule described.

When a record has failed multiple validation rules, correction of one data item in error may fix all ‘edits’.

7. Retrieve ‘Edit Report’ from HSECS Intranet Application

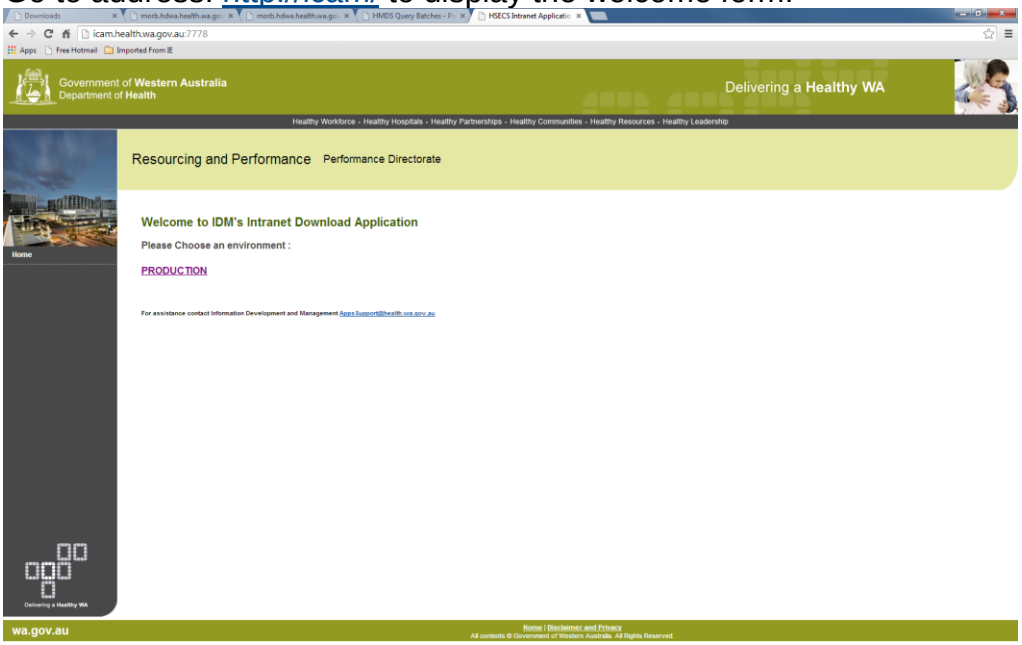
7.1. User logon to HSECS Intranet Application

Requirements:

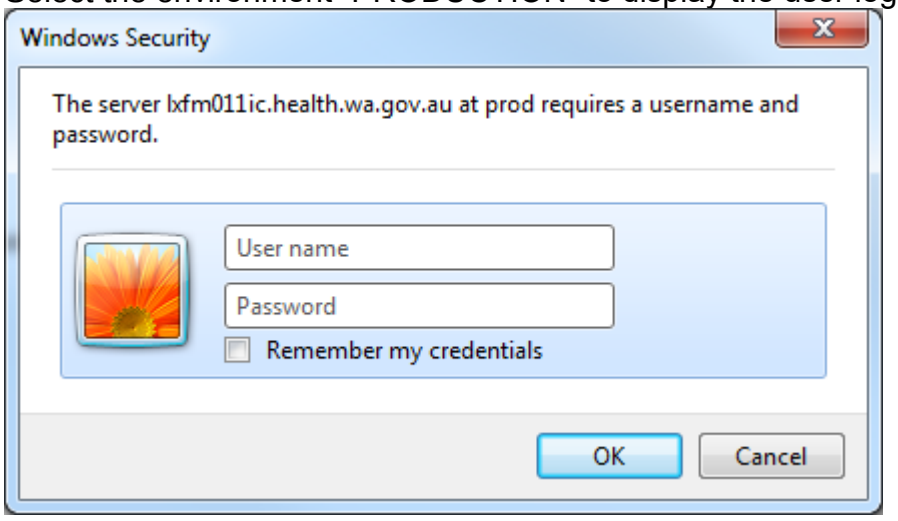
- Internet Explorer
- Internet access from a WA Health device.

Logon process

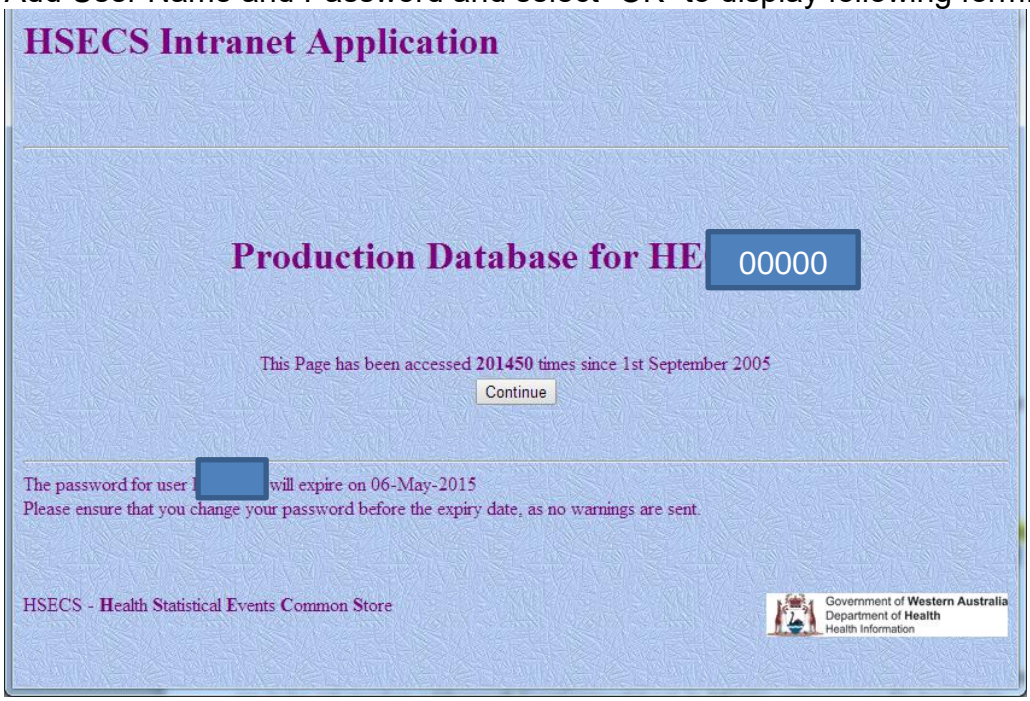
1. Open browser window using Internet Explorer or Google Chrome
2. Go to address: http://icam/ to display the welcome form:



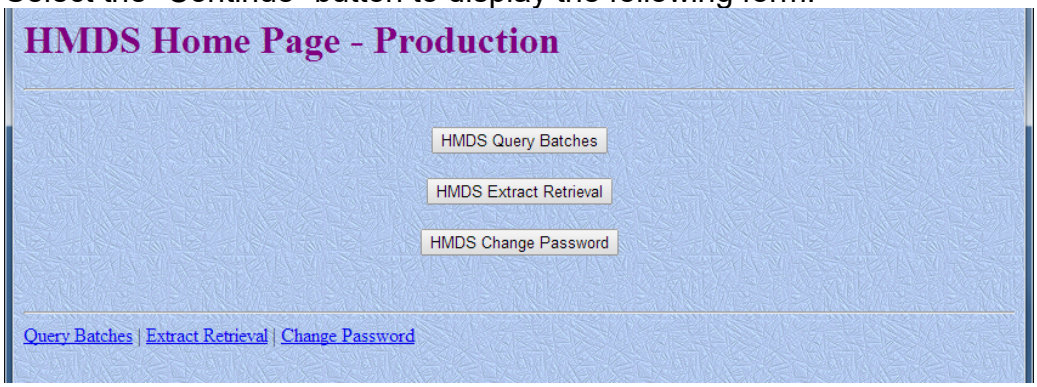
3. Select the environment “PRODUCTION” to display the user login form:



4. Add User Name and Password and select “OK” to display following form:

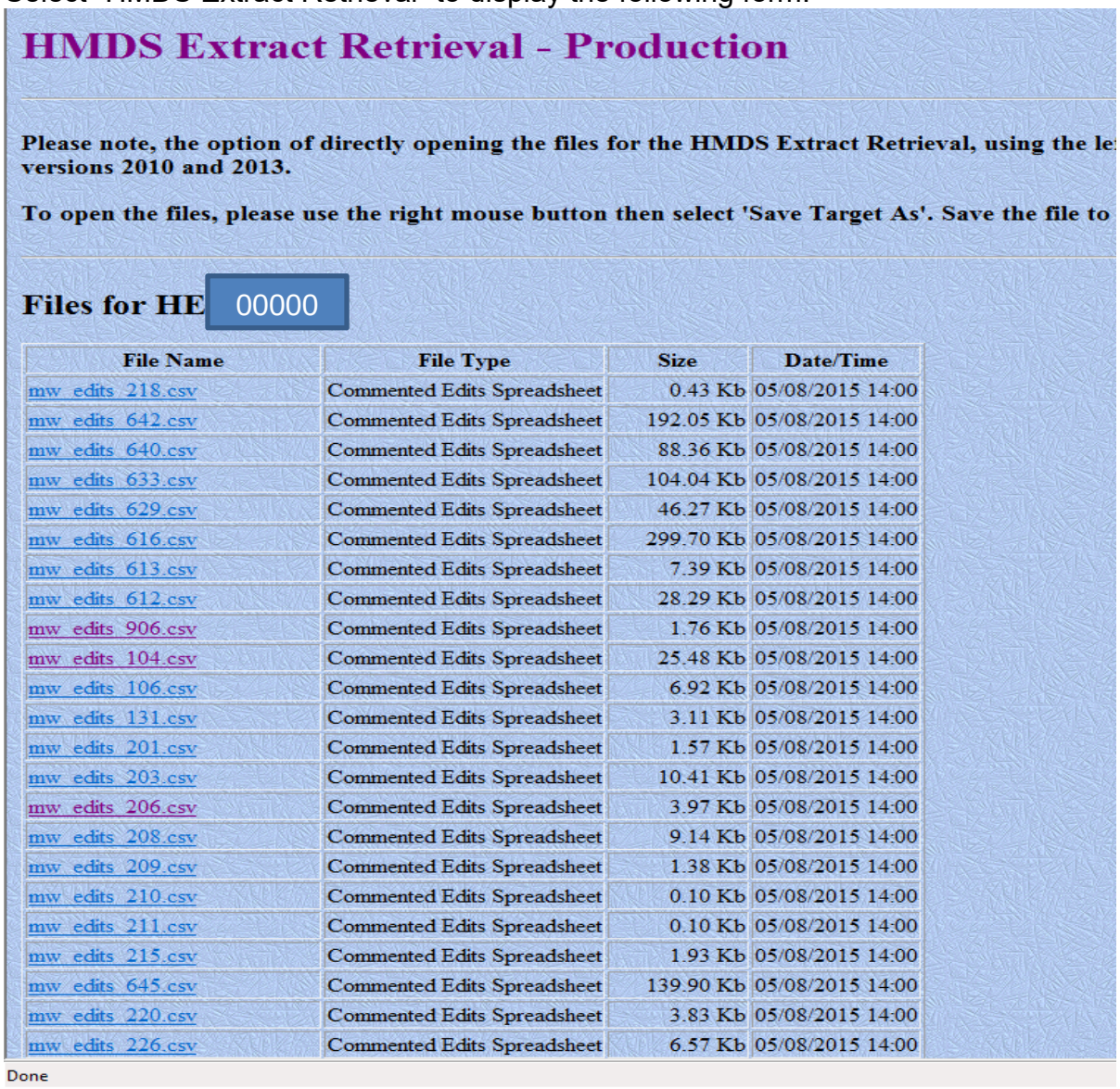


5. Select the “Continue” button to display the following form:



6. Note the two options for report download, “HMDS Query Batches” and “HMDS Extract Retrieval” and the third option “HMDS Change Password” (To use this third option see section 10.4 Password reset for the HSECS Intranet Application).

7. Select “HMDS Extract Retrieval” to display the following form:



HMDS Extract Retrieval - Production

Please note, the option of directly opening the files for the HMDS Extract Retrieval, using the le
versions 2010 and 2013.

To open the files, please use the right mouse button then select 'Save Target As'. Save the file to

Files for HE 00000

File Name	File Type	Size	Date/Time
mw_edits_218.csv	Commented Edits Spreadsheet	0.43 Kb	05/08/2015 14:00
mw_edits_642.csv	Commented Edits Spreadsheet	192.05 Kb	05/08/2015 14:00
mw_edits_640.csv	Commented Edits Spreadsheet	88.36 Kb	05/08/2015 14:00
mw_edits_633.csv	Commented Edits Spreadsheet	104.04 Kb	05/08/2015 14:00
mw_edits_629.csv	Commented Edits Spreadsheet	46.27 Kb	05/08/2015 14:00
mw_edits_616.csv	Commented Edits Spreadsheet	299.70 Kb	05/08/2015 14:00
mw_edits_613.csv	Commented Edits Spreadsheet	7.39 Kb	05/08/2015 14:00
mw_edits_612.csv	Commented Edits Spreadsheet	28.29 Kb	05/08/2015 14:00
mw_edits_906.csv	Commented Edits Spreadsheet	1.76 Kb	05/08/2015 14:00
mw_edits_104.csv	Commented Edits Spreadsheet	25.48 Kb	05/08/2015 14:00
mw_edits_106.csv	Commented Edits Spreadsheet	6.92 Kb	05/08/2015 14:00
mw_edits_131.csv	Commented Edits Spreadsheet	3.11 Kb	05/08/2015 14:00
mw_edits_201.csv	Commented Edits Spreadsheet	1.57 Kb	05/08/2015 14:00
mw_edits_203.csv	Commented Edits Spreadsheet	10.41 Kb	05/08/2015 14:00
mw_edits_206.csv	Commented Edits Spreadsheet	3.97 Kb	05/08/2015 14:00
mw_edits_208.csv	Commented Edits Spreadsheet	9.14 Kb	05/08/2015 14:00
mw_edits_209.csv	Commented Edits Spreadsheet	1.38 Kb	05/08/2015 14:00
mw_edits_210.csv	Commented Edits Spreadsheet	0.10 Kb	05/08/2015 14:00
mw_edits_211.csv	Commented Edits Spreadsheet	0.10 Kb	05/08/2015 14:00
mw_edits_215.csv	Commented Edits Spreadsheet	1.93 Kb	05/08/2015 14:00
mw_edits_645.csv	Commented Edits Spreadsheet	139.90 Kb	05/08/2015 14:00
mw_edits_220.csv	Commented Edits Spreadsheet	3.83 Kb	05/08/2015 14:00
mw_edits_226.csv	Commented Edits Spreadsheet	6.57 Kb	05/08/2015 14:00

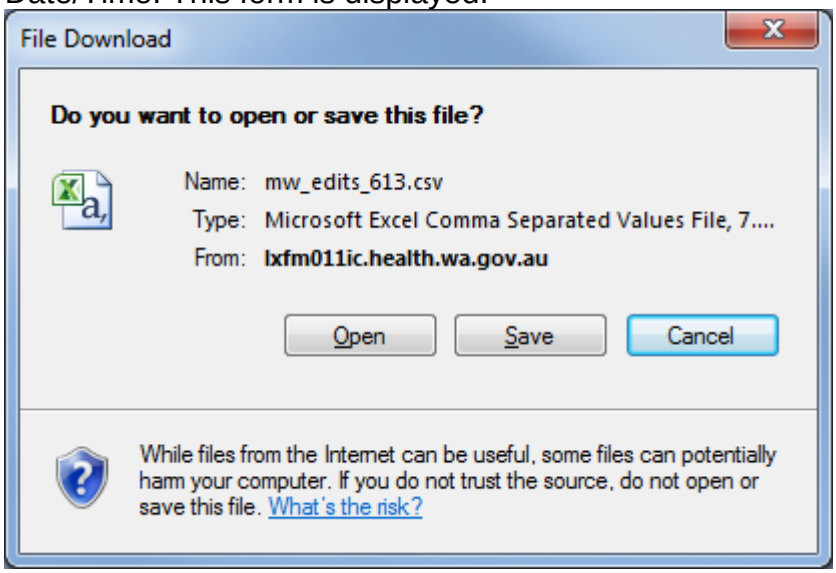
Done

8. Your security group membership determines the number of data files displayed here.

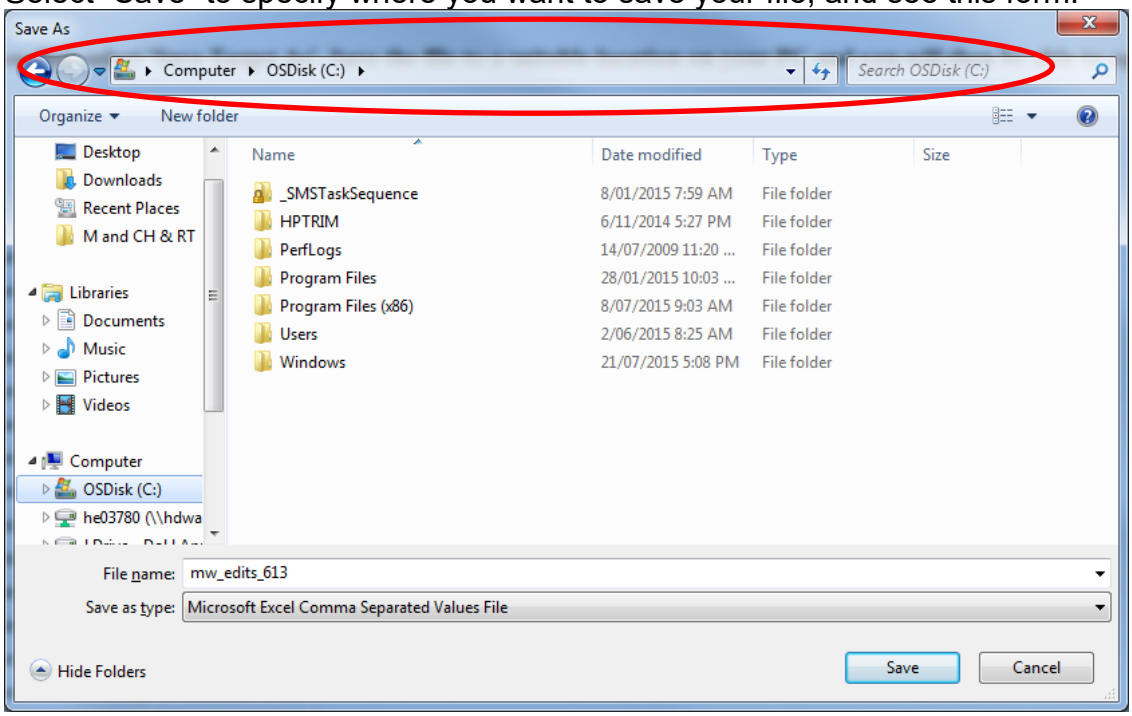
9. The table displayed provides the following information:
   - File Name – unique file name for data file available for review
   - File Type – Format of data file that indicates what software will enable it to be used i.e. CSV or Text files
   - Size – Size of data file in kilobytes. Be wary of large file sizes. They may take a lot of time to download. All ‘Edit Report’ data files for maternity services should be less than 500 kilobytes.
   - Date/Time – date and time that this file was created from MNS. These files are scheduled to be created every 24 hours at 1400 hours.

10. The File Name format is arranged as follows:
    - “mw” indicates a “midwives” data file
    - “edits” indicates that the data file contains record edits information
    - “NNN” indicates the reporting site’s Establishment ID, that is this data file includes all records reported by that maternity service
    - “.csv” indicates the file type.

11. Select the data file you require on by selecting the blue file name with the most recent Date/Time. This form is displayed:



12. Select “Save” to specify where you want to save your file, and see this form:



13. Select the appropriate file directory for your maternity service and ensure the directory location indicated above is correct

14. Add a date of download to your file name i.e. rename the File_name to be “mw_edits_613_20210806” to indicate Year, Month and Day of saving it to this directory

15. .This report may only be saved as a Comma Separated Values or CSV file at this stage. (When it is opened it is opened in MS Excel and can be edited just like any MS Excel spreadsheet.)

16. Select the “Save” button.

17. This document file must be used to record results of validation of MNS ‘edit’ records. See section “Manage Validation of Records” for guidelines on this process.

8. Manage Validation of Records

This process is for maternity services staff. The staff of the MCH can assist if required.

To validate records that failed validation rules you will need to use patient identifying data to retrieve information about these births from your health services' other documentation, for example:

- Birth Register
- Stork clinical system
- Medical Record
- ICD-10 coding
- Patient Administration System (TOPAS, WebPAS, H-Care)
- Other sources of information.

8.1. Prepare the 'Edit Report'

1. Open your 'Edit Report' from the directory where it was saved e.g. the document will be called "mw_edits_203_20210806.csv".

2. Do not delete any columns provided in the original 'Edit Report'.

3. All columns are equal in size so some information (e.g. baby DOB, error description) may need columns to be resized so they can be read properly. To change column widths:
   a. move the cursor to the heading row
   b. place over the line at the right of the column to be expanded
   c. click and drag until the required width is reached and all information can be viewed clearly.

8.2. Determine the correct information for each case

4. Refer to the section 9.3 "List of Data Validations to be managed by Maternity Services" in this document for information on which data items and which errors often cause a failure of the record to meet the validation rule/s.

5. From the 'Edit Report' use record identifiers, validation ID, validation message and validation type to investigate what information in the record has been incorrectly reported and must now be corrected.

6. Determine sources of information required to validate each case.

7. Retrieve these sources of information i.e. go to Birth Register or request Medical Record.

8. Determine the correct data for each record listed in the 'Edit Report'.

9. Determine the appropriate action to manage the record, examples as follow.
   a. Data in record requires correction

      EXAMPLE A
      Case to be resubmitted
      Validation Message: *Anaesthesia value is invalid for the method of birth.*
      Comments: Updated record to be provided.

      - The Validation is Type **Warning or Error.**
      - The data that raised the 'edit' is incorrect and must be amended.
      - The action "Updated record to be provided" is added against the Record/Validation ID in column "Comments".

- The updated record must be resubmitted to MNS

b. Data in record does not require correction

EXAMPLE B
Case will not be resubmitted
Validation Message: *Marital status reported is unlikely for age category*
Comments: Override validation as mother was 19 and divorced

- The Validation Type is **Warning**
- The data that raised the 'edit' is confirmed as correct even if it is unusual.
- The action "Override validation rule" is added against the Record/Validation ID in column "Comments".
- The record need not be resubmitted to MNS as an Update.

10. Ensure each record and Validation in the 'Edit Report' has an appropriate action against each record in the "Comments" column.

11. Save the 'Edit Record' with your Comments.'

8.3. Return of 'Edit File' to MCH

12. Ensure the 'Edit File' has an appropriate comment recorded for all records (outcomes a. and b. as described above).

13. Return the 'Edit File' to MCH using secure file transfer and email to birthdata@health.wa.gov.au.

14. MCH will action all records/validations in the file that require the Validation Rule to be "overridden" (outcome b).

15. MCH will ensure the updated records that will be resubmitted are all received from the maternity service and uploaded as update files to HSECS-MNS (outcome a).

8.4. Resubmission of updated (corrected) records

16. Records that had outcome a. must be resubmitted as Update records in a NOCA Extract data file.

17. The NOCA Extract must be submitted via secure file transfer to birthdata@health.wa.gov.au.

8.5. When is this Validation Process complete?

18. If an 'Edit Report' for the maternity service has not records included. There are no records requiring validation.

19. The process begins again when the next NOCA Extract data file is uploaded.

9. Data Validation Rules 2021

9.1. Introduction

Each validation rule applied during the MNS validation process has a unique Validation ID and validation message explaining why the 'edit' would have been generated.

Table 3 below explains the headings used in the following tables that describe these validation rules.

Table 3: Data Validations - Table heading descriptions

Item	Description	Edit Report column name
Validation ID	The unique ID allocated by MNS to a validation rule	Code
Validation Type – System error	Content or format of file that prevents the file loading to MNS. Displayed at time of file upload to MNS. Will be managed by MCH staff and may include request to maternity service to provide a correctly formatted data file.	Type
Validation Type – Fatal error	Content or format of data in a record prevents the record from loading to MNS even if other records in the file are loaded. Displayed at time of file upload to MNS. Will be managed by MCH staff and may include request to maternity service to provide the record as an updated record.	Type
Validation Type – Error	A data item value or combination of values or combination of values for multiple data items does not pass an "error" logic test e.g. woman with spontaneous onset of labour has no duration of labour. Displayed in 'Edit Report'. Will be managed by maternity service staff and will require submission of an updated record.	Type
Validation Type – Warning	A data item value or combination of values or combination of values for multiple data items does not pass a "suspicion" logic test e.g. infant of 28 weeks gestation has birthweight over 2500 grams. Displayed in 'Edit Report'. Will be managed by maternity service staff and may require either submission of an updated record or advice to MCH that data reported, while unusual, was correct.	Type
Validation message	The actual text reported to explain the validation rule that was failed by the record	ErrorDesc
Responsibility	The area responsible for managing the 'edit'. If Site, then it is because the source record needs to be consulted for accuracy of reporting. If MCH it is because it is a technical problem that can only be managed within the Unit or that input from site is not required.	Not applicable
Action	Explains the logic that the validation rule is testing and why a record might fail this rule. Also explains data items reported that should be checked for accuracy.	Not applicable

9.2. Data Validation Types

Data validations test for a variety of issues. These can be categorised as follows.

Single data item issues

Is there any value reported for a mandatory data item?

Is the value reported for the data item the correct format? For example, date reported in a date field, 2 digit number in a 2-digit number field.

Is only one data value reported for a data item that must have only a single value response?

Conditional data item issues

Are the conditions met for a value to be reported in the data field? For example, reason for CS data field has a value reported but method of birth was not CS.

When conditions are met is there a value reported in the data field? For example, the Last Menstrual Period (LMP) Date was Certain is there a date reported in the LMP data field?

Combination of data item issues

Are data items across multiple data fields consistent with each other? For example when onset of labour is Induction the Induction method data field cannot have value of “None”.

9.3. List of Data Validations to be managed by Maternity Services

- Provides a list and description of Validation Rules that can be managed by the maternity service
- Provides advice on action to take to manage the 'edit' records that failed to pass these validation rules
- Is presented in order of Validation ID and indicates differences in Validation Types with different highlight colours, and Includes all validation rules that can be reviewed and managed by maternity services.

Table 4: Data Validations to be managed by maternity services

Valid ID	Validation message	Val Type	Action
71	Apgar score not present	Error	Ensure the record has an Apgar Score reported for 1 minute and 5 minutes for the infant between 0 and 10 or 99 if unable to be determined.
72	Apgar score is invalid	Error	Ensure the record has a valid Apgar Score reported for 1 minute and 5 minutes (0-10 or 99 for unable to be determined). An infant with a birth status of 2,3 or 4 (stillborn) must have Apgar scores of 0.
75	Birth Order not present	Error	Ensure the record has a Birth Order reported between 1 and 9.
76	Birth Order value is invalid	Error	Ensure the record has a valid Birth Order reported between 1 and 9.
77	Born Before Arrival is not present	Error	Ensure the record has a Born Before Arrival indicator reported (1-Yes or 2-No).
78	Born Before Arrival value is not valid	Error	Ensure the record has a valid Born Before Arrival indicator reported (1-Yes or 2-No).
79	Caesarean Last Delivery is not present	Error	Ensure the record has a valid CS Last Delivery indicator reported (1-Yes or 2-No).
80	Caesarean Last Delivery value is invalid (must be 1 or 2)	Error	Ensure the record has a valid CS Last Delivery indicator reported (1-Yes or 2-No).
81	Caesarean Last Delivery cannot be 1 if previous pregnancies is 0	Error	Ensure the CS Last delivery value of 1-Yes is reported accurately. If accurate then Number of previous pregnancies cannot be 0.
92	Date LMP Certain value is invalid	Error	Ensure the record has a valid LMP Certain value (1-Yes or 2-No).
93	Date LMP is blank and Date LMP Certain is not equal to 2 (no)	Error	Ensure the record has an LMP date reported if LMP Certain value is 1 (Yes).
97	Duration Of Labour is not present	Error	Ensure the record has duration of labour reported in hours and minutes for both 1st stage and 2nd stage. Where no labour then report 00:00 (HH:MM) for both stages of labour.
98	Duration Of Labour value is not in the valid range	Error	Ensure the record has a total duration of labour for both 1st and 2nd stages that is less than 99 hours and 99 minutes
100	Estimated Gestation is not present	Error	Ensure the record has a gestational age (as estimated at time of birth) reported in whole completed weeks i.e. 38+6 reported as 38. Record has gestational age (as estimated at time of birth) reported in weeks + days

Valid ID	Validation message	Val Type	Action
101	Estimated Gestation value is not in valid range (20 -47)	Error	Ensure the record has an estimated gestational age for each infant in completed weeks that is between 20 and 47 weeks. Confirm any gestational age greater than 42 completed weeks (42+6) is accurately reported. Ensure the Estimated Date of Delivery (EDD) and Baby DOB supports the gestational age reported.
103	Head Circumference is not in valid range (10 - 50 or 99)	Error	Ensure the record has a head circumference reported for each infant that is between 10 and 50 cms or 99 if unable to be determined. Confirm any head circumference greater than 39cm is accurate. Confirm that the baby's gestational age, birthweight and length support the head circumference reported.
104	Head Circumference is not present	Error	Ensure the record has a head circumference reported for each infant. If unable to be determined report 99 cm
105	Head Circumference is greater than length	Error	Ensure the record has a valid head circumference reported (between 10 and 40 cms). Confirm that the baby's gestational age, birthweight and length support the head circumference reported.
107	Height value is outside valid range (100 - 230)	Error	Ensure the record has a maternal height reported that is between 100 and 230 cms. Confirm any height less than 150 or more than 190 cms, is accurate.
110	Infant Weight is mandatory and is presently blank.	Error	Ensure the record has a birthweight reported. If unable to be determined report 9999 grams.
112	Infant Weight is outside the valid range (0050 - 7000 or 9999)	Error	Ensure the record has a birthweight reported for each infant that is between 0050 and 7000 grams. Report 9999 grams if unable to be determined. Confirm any birthweight greater than 5000 grams. Confirm that the baby's gestational age, head circumference and length support the birthweight reported.
124	Length value is outside valid range (20 - 65 or 99)	Error	Ensure the record has a length reported for each infant that is between 20 and 65 cms or 99 if unable to be determined. Confirm any length greater than 55cm is accurate. Confirm that the baby's gestational age, birthweight and head circumference support the length circumference reported.
126	Name of delivery ward is not present	Error	Ensure the record has text describing the Delivery Ward where the birth occurred.
127	Indicator of whether woman had a previous multiple birth must be reported as 1 (Yes) or (2) No	Error	Ensure the record has a response of 1 (Yes) or 2(No) for question "Was any previous birth a multiple birth?"
128	Previous multiple birth is not in valid range	Error	Ensure the record has a valid previous multiple birth value reported (1-Yes or 2-No).
129	When 0 previous pregnancies, previous multiple birth indicator must 2 (No)	Error	Ensure the record has compatible data in both "Previous Multiple Birth" and number of previous pregnancies. If a woman had no previous pregnancies, she cannot have had a previous multiple birth.
130	Previous Pregnancy value is not present	Error	Ensure record has number of previous pregnancies reported, if no previous pregnancies report 0.

Valid ID	Validation message	Val Type	Action
137	Total days in Special Care before discharge/transfer from birth site is outside of valid range (0 - 180). This duration is unlikely unless at SCN3 level.	Warning	Confirm that infant's Date of Birth and Date of Discharge from the birth site are correct. The length of stay is calculated as more than 180 days which is very unlikely in any site other than one with a level 3 nursery.
149	Separation Establishment is not present	Error	Ensure the record has a valid separation establishment reported (0900 = discharged home, 0912 = died, 0102 = transferred to PMH)
155	Invalid Gender / Reference Code Association	Error	Ensure the record has a valid infant sex reported (1-male, 2-female, 3-indeterminate)
162	Expected due date is not present and is mandatory	Error	Ensure record has a date to indicate when pregnancy gestation was calculated to be 40 weeks or due. If not able to be determined during pregnancy report date determined from assessment of newborn infant.
165	Accoucheur value cannot be blank	Error	Ensure the record has one or more accoucheur at birth (birth attendant) reported.
167	Accoucheur value is not a valid reference codes	Error	Ensure the record has one or more valid values reported for accoucheur at birth (birth attendant).
174	Marital Status is not present	Error	Ensure the record has a marital status reported for the mother.
175	Marital Status is outside of the valid range	Error	Ensure the record has a valid value reported for marital status of the mother.
178	Mode Of Separation is not present	Error	Ensure the record has a separation or discharge outcome value reported.
179	Mode Of Separation is outside of the valid range	Error	Ensure the record's separation or discharge outcome reported is a valid value e.g. 9 = discharged home, 1 = transferred, 8 = died.
180	Mode Of Separation is not numeric	Error	Ensure the record's separation or discharge outcome value is number between 1 and 9.
183	Onset Of Labour value is not present	Error	Ensure the record has an onset of labour value reported (1, 2 or 3).
184	Onset Of Labour value is outside valid range	Error	Ensure the record's onset of labour value is between 1 and 3.
187	Perineal Status is not present	Error	Ensure the record has at least one perineal status value reported.
190	Plurality value is not present	Error	Ensure the record has a plurality of birth value reported between 1 and 9.
192	Intended Place Of Birth value is not present	Error	Ensure the record has an intended place of birth at onset of labour value reported.
193	Intended Place Of Birth value is outside the valid range	Error	Ensure the record's intended place of birth at onset of labour is a valid value (1,2,3,4 or 8)
194	Presentation value is not present	Error	Ensure the record has a fetal presentation value reported.
195	Presentation value is outside of the valid range	Error	Ensure the record's fetal presentation value is a valid value (1,2,3,4 or 8)
201	Resuscitation is not present	Error	Ensure the record has an infant resuscitation at birth value reported.
207	Status Of The Baby value is not	Error	Ensure the record has an infant birth status value reported.

Valid ID	Validation message	Val Type	Action
	present		
219	Time value not numeric	Error	Ensure the time of birth value reported is a valid time in numeric format i.e. 0230 or 2347
220	Time value is outside of the valid range	Error	Ensure the time of birth value is between 0000 and 2359
222	Client Identifier like UMRN or URN is not present	Error	Ensure the record has a Unit Medical Record Number reported for the mother and for each liveborn infant.
223	Date Of Birth is not present	Error	Ensure the record has a date of birth value reported for the mother and the infant.
224	Gender code is not present	Error	Ensure the record has a valid infant sex reported (1-male, 2-female, 3-indeterminate)
239	The mother date of birth must be at least 10 years greater than the baby date of birth	Error	Ensure the mother's DOB and the infant's DOB are accurately reported. Calculation of years between mother's DOB and infant's DOB indicate the mother is less than 10 years old and is not clinically feasible.
242	The baby date of birth is greater than the separation date	Error	Review and correct the infant's date of birth or infant's separation/discharge/transfer from birth site date as it is not reported accurately. The dates reported indicate that the infant was discharged before it was born and the dates must be corrected.
255	Ethnic Origin is not present	Error	Ensure the record has an ethnic origin reported for the mother.
257	Basis Expected Due Date is not present	Error	Ensure the record has the basis on which the EDD was calculated reported. (1-dates, 2-ultrasound less than 20 wks, 3-ultrasound at 20 wks or greater).
260	Indigenous Code is outside valid range	Error	Ensure the record's aboriginal status for infant reported is a numeric value between 1 and 4.
262	When never married the maiden name must be the same as the surname	Warning	Ensure women who are unmarried have the same name recorded as Surname, family name and Maiden Name. The Maiden Name field is not for recording, alias names or different spellings of family name.
263	The name contains numeric characters	Error	Ensure the name of the mother reported does not contain numbers (Surname, First name, second name or maiden name)
265	The surname is mandatory and cannot be blank	Error	Ensure the record has a maternal surname reported in text.
267	The value for surname is UNKNOWN	Warning	A woman's surname is required to be reported. If it is genuinely unable to be determined by time of reporting then this must be confirmed in writing to the MCH
289	Invalid Suburb/Postcode combination	Error	Ensure the suburb reported in text is a valid value. If suburb is accurate then the postcode reported as a 4-digit number is not valid and must be corrected.
295	Analgesia value is not present	Error	Ensure the record has at least one analgesia during labour value reported even if it is 1-None.
297	Analgesia value does not exist in the reference codes	Error	Ensure the records' analgesia during labour values are valid.
298	Anaesthesia value is not present	Error	Ensure the record has at least one anaesthesia at delivery value reported even if it is 1-None.
300	Anaesthesia value does not exist in the reference codes	Error	Ensure the records' anaesthesia at delivery values are valid.

Valid ID	Validation message	Val Type	Action
339	Gender code is either 3-Indeterminate or 4-Other	Warning	If Infant's Gender has been reported as Indeterminate, Please confirm that infant's gender was considered Indeterminate at time of first reporting. It is not recommended that infant's records for those originally considered Indeterminate are updated with more recent information. If infant's gender has been reported as "Other" please edit and report only one of Female, Male or Indeterminate."
343	Invalid postcode / suburb for State	Error	Ensure the suburb reported in text is a valid value. Ensure the postcode reported as a 4-digit number is valid for the suburb. If both these are accurate, then state value must be corrected e.g. state value of 5 for postcodes like 6####.
351	Marital Status reported is unlikely for the age category	Warning	Confirm data for records is correct when marital status of divorced, widowed or separated is correct for mothers less than 20 years old.
377	Anaesthesia value is invalid for the method of birth	Error	Ensure that the record for each infant has anaesthesia of General Anaesthesia, Spinal, Epidural etc if birth method was caesarean section. Confirm data in record when anaesthesia of General Anaesthesia was reported for a vaginal birth.
378	Basis expected due date value is not a valid reference code	Error	Ensure the record's basis on which the EDD was calculated which was reported is one of the valid values: 1-dates, 2-ultrasound less than 20 wks, 3-ultrasound at 20 wks or greater.
379	Number of previous liveborn babies now dead is not reported	Error	Ensure record has number of liveborn babies that have since died from previous pregnancies reported, if none report 0.
380	Number of previous liveborn babies still living or liveborn babies now dead must be between 0 and 25	Error	Ensure the number reported for liveborn babies from previous pregnancies that still living is between 0 and 25.
381	Number of previous pregnancies is 0, however liveborn babies still living and/or liveborn babies now dead is more than 0. Data combination is invalid.	Error	Ensure the number reported for liveborn babies from previous pregnancies that still living is between 0 and 25.
385	Complication during Labour/Delivery value is not a valid reference code	Error	Ensure the record's complications during labour and birth that were reported have values that are valid i.e. between 01 and 13 excluding 06.
386	Ethnic origin code is not a valid reference code	Error	Ensure the record's ethnic origin reported for the mother is a valid value between 01 and 12 and not 02.
387	Medical Condition value is not a valid reference code	Error	Ensure the records' medical condition values reported are valid options (01,03,04,05,06,08).
400	Method Of Birth value is not a valid reference code	Error	Ensure the record's method of birth values reported for the infant are valid values between 01 and 08.
401	Method Of Birth value is not valid for the presentation code	Error	Ensure the record has correct fetal presentation and birth mode reported. A breech presentation cannot have a vacuum delivery. A vertex presentation cannot have a breech extraction.

Valid ID	Validation message	Val Type	Action
405	Method of birth values are unlikely combination please confirm	Warning	Ensure the methods of birth combinations reported are accurate. The unlikely combinations tested for are "01-Spontaneous" with any other item between 02 and 08 and 02-Vacuum Successful with 04 or 06 or 08.
406	Method of birth value 3 or 5 cannot be on its own	Error	Ensure the record's method of birth values reported for unsuccessful methods of assisted delivery are also accompanied by a successful method.
407	Perineal Status code is an invalid reference code	Error	Ensure the record's perineal status values reported for the mother are valid values between 01 and 08 excluding 06.
408	Method of Birth is invalid for the perineal status	Error	Ensure the method of birth reported is accurate. If method of birth is 7-Elective CS then perinatal status can only be 01-Intact.
409	Plurality value is not a valid reference code	Error	Ensure the birth plurality value reported is between 1 and 9.
410	Plurality value must greater than or equal to birth order	Error	Ensure the birth plurality value reported is accurate. If accurate, then the highest birth order reported for all infants cannot be greater than the plurality value. For example if birth plurality is 2 for twins, then no baby can have a birth order of 3 or 3rd baby born from pregnancy.
411	Procedure/Treatment is not a valid reference code	Error	Ensure the record's procedure or treatment values reported for the mother are valid values between 01 and 07.
413	Previous pregnancy value is outside of the valid range	Error	Ensure the record's number of previous pregnancies reported is between 0 and 20.
414	When no previous pregnancy, children living/died and stillbirth values must also be 0	Error	Ensure that 0 reported as number of previous pregnancies is correct and if yes, then ensure that only 0 is reported for number of infants previously born alive and still alive, number of infants previously born alive but now dead and number of infants previously stillborn are all also 0.
415	Resuscitation code is not a valid reference code	Error	Ensure the record's method of resuscitation reported for the infant is between 1 and 8
416	Status of the baby code is an invalid reference code	Error	Ensure the record's birth status for the infant is between 1 and 4
418	Type of augmentation value is not present, 01 must be reported if no augmentation.	Error	Review and correct the method of augmentation reported. If no augmentation of spontaneous labour then must report 01-None.
419	Type of augmentation value is not a valid reference code	Error	Ensure the record's method/s of augmentation reported only includes 01, 02, 03, 04 and 08
421	Induction method value has not been provided	Error	Ensure that at least one method of induction is reported if onset of labour has been reported as INDUCTION.
422	Type of induction value is not a valid reference code	Error	Ensure the record's method/s of induction reported only includes 01, 02, 03, 04, 05 and 08

Valid ID	Validation message	Val Type	Action
457	Separation Date is not present	Error	Ensure the infant's separation/discharge/died date is reported.
458	Apgar 5 minute score not present	Error	Ensure the infant's Apgar score at 5 minutes of age is reported. If unable to be determined report 99, If infant stillborn, then report 0.
459	Birth time is not present	Error	Ensure the infant's time of birth is reported.
460	Previous pregnancies living is not present	Error	Ensure the record has a value reported for the number of children still alive that were born from a previous pregnancy. This data item must have a value between 0 and 20.
461	Method of birth value is not present	Error	Ensure the infant's method or methods of birth are reported.
464	Midwife Registration number must be present	Error	Ensure the reporting midwife's AHPRA registration number is reported in the correct format.
488	The expected due date must be within six months of the delivery date.	Error	Ensure that the EDD (expected due date) is accurate, ensure that the Baby DOB is accurate. The period calculated between dates currently reported is greater than 6 months which means infant's calculated gestation is less than 20 weeks and thus is not within scope for reporting.
538	Complication during pregnancy is not a valid reference code	Error	Ensure the record's complications during pregnancy reported only include valid values e.g. between 01 and 12 and 99, excluding 10.
572	One or more baby cases contain errors - Mothers case held	Warning	There is no direct issue to manage this validation rule. Manage all other validation issues for this baby and this validation rule will also be managed.
579	Apgar # Status Of Baby # and Time Of Respiration ## is an invalid combination	Error	Ensure that the birth status for the infant is reported accurately as stillbirth and if true, then ensure that Apgar Scores are 0 and time of respiration is 0 minutes.
609	The telephone number must only be numeric.	Error	Ensure the maternal telephone number is in numeric format and does not include any text or other characters.
610	The plurality value cannot be greater than the total number of babies	Error	Ensure the birth plurality value reported is accurate. If accurate, then the highest birth order reported for all infants cannot be greater than the plurality value. For example if birth plurality is 2 for twins, then no baby can have a birth order of 3 or 3rd baby born from pregnancy.
623	Mothers age greater than 50 years old	Warning	Please check the maternal date of birth for accuracy.
625	Separation Establishment cannot be the same as current Establishment	Error	Ensure that the hospital that is site of birth is accurate then ensure that the infant is actually being transferred. Then ensure that the hospital to which the infant is being transferred is accurate. The current data indicates the infant was born at the same site as the one to which it is being transferred.
631	Diagnosis code ###.###### is a rare diagnosis	Warning	The other condition reported as an ICD10 code for a medical condition, pregnancy complication or labour & birth complication is a very rare condition and should be confirmed as accurate.

Valid ID	Validation message	Val Type	Action
637	Analgesia value is inappropriate for the onset of labour.	Error	Onset of Labour has been reported as NO LABOUR, analgesia during labour can only be reported as NONE. Ensure that onset of labour is accurately reported and if necessary, change Analgesia during labour to NONE.
670	Stillbirth separation date must = DOB	Error	Ensure that the date of separation (death) of a stillborn infant equals the date of birth.
671	Nulliparous women must not have prev CS or multi birth	Error	Ensure that 0 reported as number of previous pregnancies (gravidity) is correct and if correct, then ensure that answer to "CS for previous birth" = No (2) and "previous multiple birth" = No (2) AND Ensure that 0 reported as number of previous pregnancies resulting in a birth (parity) is correct and if correct, then ensure that answer to "CS for previous birth" = No (2) and "previous multiple birth" = No (2).
681	First Forename should not be blank	Warning	The maternal first name should be known and must be reported. If not known please confirm it is not known.
691	When Onset of Labour = 2 (Induction) then Method of Induction must have value other than 1 (none)	Error	When Onset of Labour = 2 (Induction) then Method of Induction must have value other than 1 (none)
795	Gestational weeks at first antenatal visit required.	Error	Ensure the gestation at first antenatal visit is reported.
796	Cigarettes per day before/after 20 weeks is required.	Error	Ensure the average number of cigarettes smoked per day is reported for both before 20 weeks gestation and beyond 20 weeks gestation.
816	Number of Previous Caesareans mandatory	Error	Ensure that a value has been reported for number of Previous CS between 0 and 25.
817	Baby indigenous status mandatory	Error	Ensure that a value has been reported for baby's Aboriginal status between 1 and 4.
818	Prev Caesar, Num Caesar, Caesar Last Birth and Prev Pregnancies do not correspond.	Error	Ensure the Previous CS Yes/No value, CS Last delivery Yes/No value, and the Number of Prev Caesareans is reported accurately and is consistent. For example if Number of Prev Caesareans = 3 then Previous CS Yes/No value must be Yes.
819	Mothers weight outside range of 40kg to 140kg.	Warning	Please check the maternal weight at booking. If confirmed - advise MCH.
820	Number antenatal visits mandatory	Error	Ensure that a value has been reported for number of Antenatal Visits attended during pregnancy is between 0 and 30. The value "99" to be reported if antenatal care was attended but actual number is unable to be determined.
822	Postal address provided, only residential address required	Warning	The maternal street address should be provided to enable visiting by Child Health Nurses to be directed appropriately. The maternal street address is also used for determining how isolated women are in WA. A street address is preferred to a postal address. If only a postal address can be provided, please advise MCH.

Valid ID	Validation message	Val Type	Action
823	Postcode corresponds to a postal address, only residential postcodes are permitted	Warning	The maternal street address should be provided to enable visiting by Child Health Nurses to be directed appropriately. The maternal street address is also used for determining how isolated women are in WA. A street address is preferred to a postal address. If only a postal address can be provided, please advise MCH.
828	Perineal trauma cannot be reported if Intact Perineum (01) is already selected	Error	Ensure that value reported 01 for Intact Perineum is accurate, if not remove value 01 and report the correct values.
829	Perineal Status can only be one degree of tear	Error	Ensure that all values reported for perineal status are accurate. Current data reported indicates two different degrees of tear which is clinically incorrect. The values 05 for Episiotomy and 08 for Other are the only values that can be reported with a degree of trauma i.e. Episiotomy + 3rd degree tear would be reported as both 04 and 05.
830	Number of infants born equals number of previous CS, Caesarean Last Delivery cannot be No	Error	Ensure that the number reported as number of livebirths previously born (still living and now dead) is accurate, and that number of stillbirths previously born is accurate, and that number of previous CS is accurate. If all correct then response to question CS last delivery must be changed from 2-No to 1-Yes.
831	Record with CS Birth should not have Precipitate Delivery as a Complication of Labour	Error	Ensure that value reported 07 or 08 for method of birth of CS is accurate. If accurate, then remove value 02 for precipitate delivery from complication of labour. These data are clinically incompatible and must be changed.
834	Number of AN Visits is not valid as cannot be between 31 and 98	Error	Ensure that the value reported for number of Antenatal Visits attended during pregnancy is between 0 and 30. The value "99" to be reported if antenatal care was attended but actual number is unable to be determined. Any value between 31 and 98 is not acceptable.
835	Number of AN Visits cannot be 0, if first AN Visit occurred between 1 and 45 weeks gestation	Error	Ensure that the value reported as gestation at first antenatal care visit is accurate. If this number is between 1 and 45 then the number of AN Visits must be at least 1 or if unable to be counted can be 99. The data combination reported is clinically incompatible and must be changed.
836	Hypertension cannot be reported in Medical Conditions as well as Pregnancy Cond	Error	Ensure that the value reported as hypertensive condition is reported correctly. A hypertensive condition can only be reported as a pregnancy complication arising in pregnancy or as a pre-existing medical condition. For example Gestational Hypertension and Pre-Eclampsia can only be reported as a pregnancy complication value 11 or 04. Essential hypertension can only reported as pre-existing medical condition value 01. If the woman has Pre-Eclampsia superimposed on Essential hypertension then it must be reported as a pregnancy complication value 12. Each of these conditions cannot be reported in combination. That is a woman cannot have both Pre-Eclampsia and Gestational Hypertension reported. The data combination reported is clinically incompatible and must be changed.

Valid ID	Validation message	Val Type	Action
837	Diabetes cannot be reported in Medical Conditions as well as Pregnancy Condition	Error	Ensure that the value reported as diabetes condition is reported correctly. Diabetes can only be reported as a pregnancy complication arising in pregnancy or as a pre-existing medical condition. For example Gestational Diabetes can only be reported as a pregnancy complication value 09. Diabetes Type 1 or Diabetes Type 2 can only reported as pre-existing medical condition value 05 or 06. Each of these conditions cannot be reported in combination. That is a woman cannot have both Gestational Diabetes and Diabetes Type 2. The data combination reported is clinically incompatible and must be changed.
847	Number Previous Caesareans must be numeric	Error	Ensure that the value reported for number of Previous CS is a valid number between 0 and 9.
858	Pregnancy parity value is not present	Error	Ensure that a value has been reported for number of previous pregnancies resulting in a birth at 20 weeks gestation or greater (Parity).
859	Pregnancy parity value is outside of the valid range	Error	Ensure that the value reported for number of previous pregnancies resulting in a birth at 20 weeks gestation or greater (Parity) is between 0 and 25.
860	Pregnancy parity number is greater than previous pregnancies number, one of these numbers must be corrected	Error	Ensure that the number reported as number of previous pregnancies (gravidity) is correct and if correct, then ensure that the number of previous pregnancies resulting in a birth (parity) is correct and is less than or equal to gravidity.
861	Postnatal blood loss value is not present	Error	Ensure that a value has been reported for number of mLs blood lost in 3rd stage and up to 24 hours post birth (Primary blood loss). If unable to be determined report 99999 mLs.
862	Postnatal blood loss value must be between 5 and 20000 or 99999 if unknown	Error	Ensure that the value reported for number of mLs blood lost in 3rd stage and up to 24 hours post birth (Primary blood loss) is between 5 and 20000 mLs. If unable to be determined report 99999 mLs.
863	Principal reason for Caesarean is not valid reference code	Error	Ensure that the value reported for reason for CS this birth is accurate and that it is included in the valid options able to be reported i.e. is between 01 and 20.
864	Principal reason for Caesarean has not been recorded for Caesarean birth	Error	Ensure that the value reported for method of birth which includes 07 or 08 for CS is accurate. If accurate, then ensure a reason for CS has been reported as a value between 01 and 20.
865	Principal reason for Caesarean indicates unsuccessful attempted vaginal delivery and is not consistent with Method of Birth.	Error	Ensure that the value reported for method of birth which includes 07 or 08 for CS is accurate and that 03 or 05 for unsuccessful instrumental delivery not being reported is accurate. If method of birth values reported are accurate, then reason for CS cannot be value 12 unsuccessful assisted delivery and a reason for CS must be reported that is clinically compatible with methods of birth reported.
866	Principal reason for CS provided is incompatible with No Labour.	Error	Ensure that the onset of labour value reported of 3-No labour is correct, then review actual reason for CS is correct. The current combination is clinically incompatible and must be changed.
867	Principal reason for Caesarean can only occur in multiple birth and plurality is singleton.	Error	Ensure that the value of 1-Singleton reported for plurality of birth is accurate. If plurality is accurate then reason for CS cannot be value 11 multiple pregnancy and a reason for CS must be reported that is clinically compatible with plurality of birth.
868	Principal reason for Caesarean is previous caesarean and Number of	Error	Ensure that the value of 0 for number of previous CS is accurate. If accurate then reason for CS cannot be value 15 previous CS and a reason for CS must be reported that is clinically

Valid ID	Validation message	Val Type	Action
	previous Caesareans is 0		compatible with history of CS.
869	Principal reason for Caesarean can only occur with induction with or without labour and onset of labour is not induction.	Error	Ensure that the value of 1-Spontaneous or 3-No Labour for onset of labour is accurate. If accurate then reason for CS cannot be value 13 unsuccessful induction as no induction occurred. Reason for CS must be reported that is clinically compatible with onset of labour.
870	Principal reason for Caesarean is recorded for non-Caesarean birth	Error	Ensure that the value reported for method of birth which does not include either 07 or 08 for CS is accurate. If accurate, then there was no CS and a reason for CS must not be reported.
871	Principal reason for Caesarean is not reported as Complication of Labour & Delivery	Error	Ensure that the value of 1 or 4 or 5 or 6 or 14 or 15 reported as Reason for CS is accurate. If accurate then values 2 or 3 or 10 or 11 or 12, or 13 (with corresponding ICD code), must be reported as a complication of labour and delivery. As reason for CS cannot be one of these values if this was not a complication of the labour or delivery.
872	Complications of Pregnancy, Pre-Eclampsia and Gestational Hypertension cannot occur together	Error	Ensure that the value reported as hypertensive condition is reported correctly. Only one hypertensive condition can be reported as either a pregnancy complication arising in pregnancy or as a pre-existing medical condition. Each of these conditions cannot be reported in combination. That is a woman cannot have both Pre-Eclampsia and Gestational Hypertension reported. The data combination reported is clinically incompatible and must be changed.
873	Complications of Pregnancy, Pre-Eclampsia and Pre-eclampsia on Essential Hypertension cannot occur together	Error	Ensure that the value reported as hypertensive condition is reported correctly. Only one hypertensive condition can be reported as either a pregnancy complication arising in pregnancy or as a pre-existing medical condition. Each of these conditions cannot be reported in combination. That is a woman cannot have both Pre-Eclampsia and Pre-Eclampsia superimposed on Essential Hypertension reported. The data combination reported is clinically incompatible and must be changed.
874	Complications of Pregnancy, Gestational Hypertension and Pre-Eclampsia on Essential Hypertension cannot occur together	Error	Ensure that the value reported as hypertensive condition is reported correctly. Only one hypertensive condition can be reported as either a pregnancy complication arising in pregnancy or as a pre-existing medical condition. Each of these conditions cannot be reported in combination. That is a woman cannot have both Gestational Hypertension and Pre-Eclampsia superimposed on Essential Hypertension reported. The data combination reported is clinically incompatible and must be changed.
875	Medical Condition, Essential Hypertension cannot occur with Gestational Hypertension reported in pregnancy condition	Error	Ensure that the value reported as hypertensive condition is reported correctly. A woman cannot have both Essential Hypertension reported as a pre-existing medical condition and Gestational Hypertension arising in pregnancy. The data combination reported is clinically incompatible and must be changed.
876	Medical Condition, Type 1 diabetes and Type 2 diabetes cannot occur together	Error	Ensure that the value reported for diabetes is reported correctly. Only one diabetes condition can be reported as a medical condition. Type 1 Diabetes and Type 2 Diabetes are mutually exclusive and a woman can't have both. The data combination reported is clinically incompatible and must be changed.
877	Medical Condition, Type 1 diabetes cannot occur with Complication of	Error	Ensure that the value reported for diabetes is reported correctly. Only one diabetes condition can be reported as either a medical condition or a condition arising in pregnancy. Gestational

Valid ID	Validation message	Val Type	Action
	Pregnancy, Gestational Diabetes		Diabetes, Type 1 Diabetes and Type 2 Diabetes are mutually exclusive and a woman can't have more than one. The data combination reported is clinically incompatible and must be changed.
878	Medical Condition, Type 2 diabetes cannot occur with Complication of Pregnancy, Gestational Diabetes	Error	Ensure that the value reported for diabetes is reported correctly. Only one diabetes condition can be reported as either a medical condition or a condition arising in pregnancy. Gestational Diabetes, Type 1 Diabetes and Type 2 Diabetes are mutually exclusive and a woman can't have more than one. The data combination reported is clinically incompatible and must be changed.
879	Type of induction cannot be reported as both None and a type	Error	Ensure that the value reported for onset of labour as 2-Induction is accurate. If accurate then at least 1 value must be reported as method of induction and this method cannot be 1-None. An induction method of 1-None cannot be reported with any other value for method of induction. The data combination reported is clinically incompatible and must be changed.
880	Principal reason for Caesarean is not the same for babies born from this Pregnancy	Error	Ensure that the value of method of birth of all infants born from the pregnancy are accurate and that more than one infant was born by CS. If accurate then reason for CS of first infant born by CS will be the same for all infants born by that CS. Ensure that all infants born by CS have the same reason for CS reported.
884	Complication of Labour and Birth is incompatible with Method of Birth - Elective Caesarean	Warning	Confirm both the L&B complication and method of birth reported as a L&B complication that arises in labour is incompatible with an elective CS which can only occur when there is no labour.
885	Principal reason for Caesarean is incompatible with Method of Birth - Elective Caesarean	Error	Ensure that the value of method of birth of 07 elective CS is accurate. If accurate then Reason for CS reported (1, 4, 5, 6, 8, 10, 12, 13, or 14) is not compatible with this method of birth.
889	Vaginal Method of Birth is not valid if first and second stage of labour duration is 0 hrs, 0 mins	Error	Ensure that the value of method of birth reported is accurate. If both accurate then duration of labour must be greater than 0 minutes for both 1st and 2nd stage. It is not clinically compatible to have no minutes of labour for 1st and 2nd stage if an infant was born vaginally.
890	If Other (99) Pregnancy Complication indicated, must be described with an ICD10 code	Error	Ensure that the value of 99-Other condition for pregnancy complication is accurate. If accurate then at least one condition must be reported as an ICD-10 code to describe the condition.
891	If Other (8) Medical Conditions indicated, must be described with an ICD10 code	Error	Ensure that the value of 8-Other condition for pre-existing medical condition is accurate. If accurate then at least one condition must be reported as an ICD-10 code to describe the condition.
892	If Other (13) Labour & Birth Complication indicated, must be described with an ICD10 code	Error	Ensure that the value of 13-Other condition for labour and birth complications is accurate. If accurate then at least one condition must be reported as an ICD-10 code to describe the condition.
893	If other Pregnancy Complication described with an ICD10 code, then Other (99) Pregnancy Complication must be indicated	Error	Ensure that the value of 99-Other condition for pregnancy complication is reported if any other condition has been reported as an ICD-10 code to describe the condition.
894	If other Medical Condition described with an ICD10 code, then Other (8)	Error	Ensure that the value of 8-Other condition for pre-existing medical condition is reported if any other condition has been reported as an ICD-10 code to describe the condition.

Valid ID	Validation message	Val Type	Action
	Medical Condition must be indicated		
895	If other Labour & Birth Complication described with an ICD10 code, then Other (13) Labour & Birth Complication must be indicated	Error	Ensure that the value of 13-Other condition for labour and birth complications is reported if any other condition has been reported as an ICD-10 code to describe the condition.
896	Onset of Labour is not consistent with duration of labour for 1st stage and 2nd stage of labour e.g. if spontaneous onset then 1st stage must be at least 1 minute.	Error	Ensure that the value reported for onset of labour is accurate. If accurate then duration of labour must be greater than 0 minutes for 1st stage. It is not clinically compatible to have no minutes of labour for 1st stage if labour commenced spontaneously.
897	When Onset of Labour is Spontaneous or No Labour, then Method of Induction must only be 01 - None.	Error	Ensure that the value reported for onset of labour is accurate. If accurate then there was no induction of labour attempted and method of induction must be reported as 1-None.
898	When Onset of Labour is Induction or No Labour, then Method of Augmentation must only be 01 - None.	Error	Ensure that the value reported for onset of labour is accurate. If accurate then there was no spontaneous onset of labour and thus labour could not be augmented. Method of augmentation must be reported as 1-None.
899	If method of Augmentation is value 01 – None, then no other augmentation method may be reported.	Error	Ensure that no Augmentation of labour occurred, if so then only 01-None can be reported as method of Augmentation. If there was an augmentation then onset of labour must be reported as 1-Spontaneous and the method of Augmentation must be reported and 01-None cannot be reported..
900	If method of Analgesia in labour is value 01 – None, then no other Analgesia method may be reported.	Error	Ensure that no Analgesia in labour was administered, if so then only 01-None can be reported as method of Analgesia during labour. If there was analgesia during labour then the method must be reported and 01-None cannot be reported.
901	If place of birth = 0906 (Homebirth) then Analgesia in labour values for epidural and/or spinal are not valid methods.	Error	Ensure that the site of birth reported (homebirth) is accurate. If accurate then it is extremely unlikely that epidural and/or spinal was administered as analgesia during labour. If this unlikely scenario occurred and the data reported is accurate please contact the Maternal and Child Health Unit by email (birthdata@health.wa.gov.au) to explain the scenario to be recorded.
902	If Caesarean Last Delivery is 1 (Yes) then Previous Caesarean Indicator must be 1 (Yes)	Error	Ensure that the value of 1-Yes recorded for Caesarean Last Delivery is accurate, if accurate than the number of Previous CS must be more than 0 and whether the woman had a previous CS cannot be 2-No. This is an unfeasible clinical scenario and reporting must be corrected.
903	Number of previous pregnancies is less than number of infants born previously, Previous Multiple Pregnancy is not set to 1 (Yes)	Error	Ensure that the number of previous pregnancies reported and whether the value of 2-No for a previous multiple pregnancy is accurate. If accurate then the number of infants born alive or stillborn cannot be more than the total number of previous pregnancies. This is an unfeasible clinical scenario and reporting must be corrected.
904	Number of previous pregnancies is >0 and the number of infants born previously is < 2 and Previous Multiple Pregnancy is set to 1 (Yes) - invalid combination	Error	Ensure that the total number for infants born previously alive or stillborn of 0 or 1 is accurate. If accurate then the value of 1-Yes for a previous multiple pregnancy cannot be accurate. This is an unfeasible clinical scenario and reporting must be corrected.
905	Gestation at 1st Antenatal visit must be	Error	Ensure that the gestation at first Antenatal visit is between 1 and 45 completed weeks. Report

Valid ID	Validation message	Val Type	Action
	between 1 and 45 or 98 or 99		98 if no antenatal care was attended. Report 99 if gestational age at first Antenatal visit was unable to be determined.
906	Gestation at 1st Antenatal visit if not 98 or 99 cannot be greater than infant's estimated gestational age in weeks at time of birth.	Error	Ensure that the estimated gestation of infant at time of birth is accurately reported. If accurate then the value reported for gestation at first antenatal care visit cannot be more than the gestation of infant at birth. This is an unfeasible clinical scenario and must be corrected. Report 98 if no antenatal care was attended. Report 99 if gestational age at first Antenatal visit was unable to be determined.
907	Number of AN Visits cannot be between 1 and 30 or 99 if Estimated Gestation at 1st Antenatal Visit value is 98 (no antenatal care)	Error	Ensure that the estimated gestation of infant at time of birth is accurately reported as 98 - no antenatal care. If accurate then the value reported for number of AN Visits reported must be 0. This is an unfeasible clinical scenario and must be corrected.
908	Number of Previous Caesareans must be 0 if Previous Caesarean Indicator is No.	Error	Ensure that the value of 2-No recorded for Previous Caesarean? is accurate, if accurate than the number of Previous CS must be 0. This is an unfeasible clinical scenario and reporting must be corrected.
909	Estimated date of delivery is indicated to be based upon LMP date and is not between 38 and 42 weeks after LMP, please edit the incorrect date or dates.	Error	Ensure that the dates reported for LMP and EDD are accurate. EDD is a mandatory data item, LMP is only mandatory if the dates are certain. A calculation of difference between these dates does not equal 40 weeks +/- 2 weeks indicating that one of the dates reported is not clinically feasible. If LMP is unknown then do not report a date.
911	If Previous Multiple Birth Indicator = 2-No, then Previous Parity must equal number of previous infants born alive (still live and now dead) and stillborn.	Error	Ensure that the value reported for previous multiple birth indicator of 2-No is accurate. If accurate then the number of previous pregnancies resulting in a birth at 20 weeks gestation (Parity) must equal the total number of infants born alive or stillborn. The data reported is not clinically feasible and must be corrected.
912	If Caesarean Last Delivery = 2-No, then total number of previous CS must be 0 or less than Previous Parity	Error	Ensure that the value of 2-No recorded for CS last delivery is accurate, if accurate than the number of Previous CS must be 0 or may be at least 1 less than the total number of previous pregnancies resulting in a birth at 20 weeks or greater gestation (Parity). This is an unfeasible clinical scenario and reporting must be corrected.
913	Smoking During Pregnancy Indicator is No but average number of cigarettes before or beyond 20 weeks of pregnancy is not 0 or 999	Error	Ensure that the value between 001 and 998 reported for average number of cigarettes before 20 weeks gestation and after 20 weeks gestation is accurate. If correct then it is known that the woman smoked tobacco during pregnancy and thus Smoking during pregnancy indicator must be 1-Yes. 999 is reported as average number of cigarettes if it is unable to be determined if the woman smoked. 998 is to be reported if the woman smoked occasionally.
914	Average number of cigarettes smoked before 20 weeks of pregnancy is very high (greater than 50 per day)	Error	Ensure that the value between 051 and 997 reported for average number of cigarettes before 20 weeks gestation is accurate. To smoke more than 50 cigarettes per day seems improbable as it equates to a cigarette every 30 minutes even while sleeping. If accurate please contact the Maternal and Child Health Unit to explain why the data is accurate. 999 is reported as average number of cigarettes if it is unable to be determined if the woman smoked. 998 is to be reported if the woman smoked occasionally.
915	Average number of cigarettes smoked after 20 weeks of pregnancy is very	Error	Ensure that the value between 051 and 997 reported for average number of cigarettes after 20 weeks gestation is accurate. To smoke more than 50 cigarettes per day seems improbable as

Valid ID	Validation message	Val Type	Action
	high (greater than 50 per day)		it equates to a cigarette every 30 minutes even while sleeping. If accurate please contact the Maternal and Child Health Unit to explain why the data is accurate. 999 is reported as average number of cigarettes if it is unable to be determined if the woman smoked. 998 is to be reported if the woman smoked occasionally.
916	Method of Birth is Elective CS (7), but Onset of Labour is not "No Labour (3)". One is incorrect.	Error	Ensure that the value reported for method of Birth 07 for Elective CS is accurate. If accurate, then onset of labour must be reported as 3-No labour. If labour commenced before birth then urgency of CS must be reported as Emergency value 08.
917	If Method of Birth for baby born first was Elective CS (7) then other babies from pregnancy must also have birth by Elective CS (7).	Error	Ensure that the value reported for method of Birth 07 for Elective CS for first infant of a multiple birth is accurate. If accurate, then all infants born from the pregnancy must have method of birth of 07-Elective CS also.
918	If Previous Caesarean Indicator = 1 (Yes) then number of previous Caesareans must be equal to or less than Previous Parity	Error	Ensure that the value of 1-Yes recorded for previous CS is accurate, if accurate than the number of Previous CS must be equal to or less than the total number of previous pregnancies resulting in a birth at 20 weeks or greater gestation (Parity). This is an unfeasible clinical scenario and reporting must be corrected.
919	Baby's length of stay is 10 or more days at birth site, days in SCN is 0	Warning	Confirm that a baby stayed at the birth site more than 10 days but did not require admission to the Special Care Nursery. This length of stay is unusual.
920	If baby BBA = "yes" then Analgesia in labour values for epidural and/or spinal are not valid methods.	Error	Ensure that the value reported for born before arrival (BBA) of 1-Yes is accurate. If accurate then it is very unlikely that an epidural or spinal would have been administered for analgesia during labour. If this very unlikely clinical scenario did occur then contact Maternal and Child Health Unit to advise of actual case details.
921	If Birth mode includes 02, 03, 04,05, 07,08 then Birth attendant must include 1 or 2	Error	Ensure that the method of birth value/s reported were accurate. If accurate then birth attendants must include a medical officer.
922	Mother is reported as Aboriginal, TSI or Aboriginal and TSI and baby is reported as "other" aboriginal status. This is unlikely.	Warning	Confirm that Aboriginal or Torres Strait Islander status has been reported correctly for both mother and infant. It is very unlikely that a mother is Aboriginal or Torres Strait Islander and her baby is NOT Aboriginal or Torres Strait Islander.
924	If method of Anaesthesia at delivery is value 01 – None, then no other Anaesthesia method may be reported.	Error	Ensure that there was no Anaesthesia at delivery. If no Anaesthesia then report 1-None. If there was a method of Anaesthesia at delivery then 1-None cannot be included in methods reported.
925	If infant is stillborn, baby separation must be 8 (died) and separated to establishment must be 912 (deceased)	Error	Ensure baby birth status is accurately reported as either 2-stillborn, 3-stillborn (antenatal) or 4-stillborn (intrapartum). If accurate, then baby separation/outcome must be reported as 8-died and cannot be blank and separated to establishment value must be 912 -deceased.
926	If method of Induction is value 01 – None, then no other induction method may be reported.	Error	Ensure that there was no Induction method used. If accurate then report 1-None. If there was an induction method used then 1-None cannot be included in methods reported.
927	The reported maternal height is equal to reported maternal weight. Are both values correct?	Warning	Confirm maternal height and weight reported. They are both equal i.e. 150cm high and 150kg in weight. This combination is possible but may indicate a data entry error.

Valid ID	Validation message	Val Type	Action
928	The average number of Cigs smoked per day is higher after 20 weeks then before 20 weeks. Did the woman increase her tobacco smoking in pregnancy?	Warning	Confirm that average number of Cigarettes smokes per day has been reported accurately. It is possible that a woman increases number of cigarettes smoked during pregnancy but it is unlikely.
929	Combination of birthweight with estimated gestational age is unlikely	Warning	Confirm that infant's birthweight and estimated gestational age at birth is reported accurately. A combination like 1800 grams and 41 weeks gestation is unlikely.
930	Combination of estimated gestational age with birthweight is unlikely	Warning	Confirm that infant's birthweight and estimated gestational age at birth is reported accurately. A combination like 28 weeks gestation and 3200 grams is unlikely.
931	Gest age calculated from Estimated date of delivery and Baby DOB is more than 7 days different from estimated gestational age reported.	Error	Ensure that the EDD reported is accurate. Ensure that the estimated gestation of infant at time of birth is accurately reported. The calculation of difference between EDD (when baby would be 40 weeks gestation and actual baby DOB should equal the estimated gestation of infant at time of birth within 7 days accuracy. data reported indicates that either EDD or estimated gestation or infant's DOB is not accurately reported. This is an unfeasible clinical scenario and must be corrected.
932	A combination of birth attendant of Obstetrician and a baby born before arrival at site is unlikely.	Warning	Confirm that infant's birth attendant and born before arrival Yes/No response have been reported accurately. It is unlikely that an obstetrician was in attendance when a baby was born before arrival at the hospital.
933	A combination of baby born before arrival with this birth attendant and birth method is unlikely.	Warning	Confirm that infant's birth attendant, method of birth and born before arrival Yes/No response have been reported accurately. For example, It is unlikely that an obstetrician was in attendance or that vacuum extraction was performed when a baby was born before arrival at the hospital.
934	If baby BBA = "yes" then Anaesthesia at delivery values for epidural, spinal or general anaesthetic are not valid.	Error	Ensure that the value reported for born before arrival (BBA) of 1-Yes is accurate. If accurate then it is very unlikely that an epidural or spinal would have been administered for anaesthesia at delivery. If this very unlikely clinical scenario did occur then contact Maternal and Child Health Unit to advise of actual case details.
935	Number of days between infant DOB and Separation date is less than the number of days spent in SCN during the admission at birth site.	Error	Ensure that the infant's DOB is reported accurately. Ensure that the infant's separation date is reported accurately. Ensure that the number of days spent in SCN at birth site is accurately reported. The calculation of days between infant's DOB and discharge date is less than the number of days the infant spent in SCN. This is an unfeasible clinical scenario and must be corrected.
936	More than 0 days in SCN at birth site was reported. The birth site reported does not have a SCN.	Error	Ensure that the number of days spent in SCN at birth site is accurately reported. For sites that do not have a SCN it is possible that an ill infant is cared for a short period before transfer. If this occurred please contact the Maternal and Child Health Unit to explain the details of the case.
937	Maternal BMI calculated from height and weight reported is not between 15 and 55. This is unlikely	Warning	Confirm maternal height and weight reported. A BMI calculated from them is unusually low or high. This combination is possible but may indicate a data entry error.
939	Baby length is greater than 57 cm but weight is less than 3500 grams. This is	Warning	Confirm baby length and weight reported. It is unlikely that such a long baby would have such a low birthweight.

Valid ID	Validation message	Val Type	Action
	unlikely.		
942	Method of birth value combination is not clinically possible	Error	Ensure that the value/s reported for method of birth are accurate. The combination provided is not clinically feasible e.g. breech extraction and vacuum extraction for one infant and must be corrected.
943	When Onset of Labour was Induced and duration of labour was 0 minutes then Method of Birth must be Emergency CS.	Error	Ensure that the value of 2-induction for Onset of labour is accurately reported. Ensure that the duration of labour was 0 hours and 0 minutes in total i.e. labour did not commence before CS was warranted. If both accurate then Method of birth must be 08 - Emergency CS.
944	The duration of labour reported is not valid for method/s of birth reported.	Error	Ensure that the duration of labour was accurately reported. If duration of labour was 0 hours and 0 minutes in total then only a method of birth of CS 07 or 08 value can be reported. If duration of labour was not 0 hours and 0 minutes then value 07 - elective CS cannot be reported.
945	Second stage of labour of reported is not valid when first stage is 0 hours and 0 minutes.	Error	Ensure that the duration of labour for first stage was accurately reported as 0 hours and 0 minutes in total. If accurate then second stage of labour cannot be more than 0 hours and 0 minutes.
948	If onset of labour = 3-No Labour then method of birth must include 7 or 8	Error	Ensure that the value of 3-No labour for Onset of labour is accurately reported. If accurate then method of birth must include either 7 - elective CS or 8 - emergency CS.
949	If separation date is > than current date then error	Error	Review and correct the infant's separation (discharge or died) date as it is not reported accurately. The date reported is a future date or was after the date the record was submitted to the Midwives Notification System.
950	If baby DOB > than current date then error	Error	Review and correct the infant's date of birth as it is not reported accurately. The date reported is a future date or was after the date the record was submitted to the Midwives Notification System.
962	If Failure to Progress and prolonged 1st & 2nd stage is reported as a Complication of Labour and Birth then 1st stage of labour must be more than 0 minutes.	Error	Ensure that 1st stage of labour is greater than 0 minutes, if complications of labour and birth include failure to progress <= 3cm, failure to progress > 3 cm, 20 Prolonged 1st stage &/or 21 Prolonged 2nd stage
969	Interpreter Service Required indicator is not present	Error	Ensure the record has one interpreter service required value reported.
970	Mother's language is not present	Error	Ensure the record has one mother’s language value reported, where interpreter required is yes.
971	Influenza vaccination during pregnancy value is not present	Error	Ensure the record has one influenza vaccination during pregnancy value reported.
972	Pertussis vaccination during pregnancy value is not present	Error	Ensure the record has one pertussis vaccination during pregnancy value reported.
973	Principal reason for induction of labour value is not present	Error	Ensure the record has one principal reason for induction of labour value reported, where the onset of labour is induction.
974	Water immersion at birth value is not present	Error	Ensure the record has one water immersion at birth value reported.

Valid ID	Validation message	Val Type	Action
976	Onset of labour is 2 and no value for reason for induction selected	Error	Ensure the record has one principal reason for induction of labour value reported, where the onset of labour is induction.
977	Onset of labour is not 2 and value for reason for induction selected	Error	Ensure the record does not have a principal reason for induction of labour value reported, where the onset of labour is not induction.
978	Water immersion at birth value is invalid, must be 1 or 2	Error	Ensure the records' water immersion at birth value is valid.
979	Interpreter Service Required value is invalid, must be 1 or 2	Error	Ensure the records' interpreter service required value is valid.
980	Principal reason for induction is not valid reference code	Error	Ensure the records' principal reason for induction value is valid.
981	Influenza vaccination during pregnancy value is not valid reference code	Error	Ensure the records' influenza vaccination during pregnancy value is valid.
982	Pertussis vaccination during pregnancy value is not valid reference code	Error	Ensure the records' pertussis vaccination during pregnancy value is valid.
983	Mother's language value is not valid reference code	Error	Ensure the records' mother's language value is valid.
984	Mother's language contains a value but Interpreter required is 2 (No)	Error	Ensure the record does not have a mother's language value reported, where interpreter required is no.
985	No value for Mother's language and interpreter required is 1 (Yes)	Error	Ensure the record has one mother's language value reported, where interpreter required is yes.
999	Alcohol frequency value is not present	Error	Ensure the record has the alcohol frequency value reported.
1000	Number alcohol drinks value is not present	Error	Ensure the record has the number alcoholic drinks value reported.
1001	Screening for depression/anxiety value is not present	Error	Ensure the record has the screening for depression/anxiety value reported.
1002	Follow up for perinatal mental health value is not present	Error	Ensure the record has the follow up for perinatal mental health value reported.
1006	Alcohol frequency value is not valid reference code	Error	Ensure the alcohol frequency value is valid.
1007	Number alcohol drinks value is not valid reference code	Error	Ensure the number alcoholic drinks value is valid.
1008	Screening for depression/anxiety value is not valid reference code	Error	Ensure the screening for depression/anxiety value is valid.
1009	Follow up for perinatal mental health value is not valid reference code	Error	Ensure the follow up for perinatal mental health value is valid.
1010	Screening for depression/anxiety during 3rd trimester value is not valid reference code. Mandatory for Stork sites only	Error	Ensure the screening for depression/anxiety during 3rd trimester value is valid.
1011	Follow up for perinatal mental health	Error	Ensure the follow up for perinatal mental health during 3rd trimester value is valid.

Valid ID	Validation message	Val Type	Action
	during 3rd trimester value is not valid reference code. Mandatory for Stork sites only		
1014	The duration of labour reported is not valid for Principle reason for caesarean	Error	Ensure that 1st stage of labour is greater than 0 minutes, if Principle reason is Lack of progress in the 1st stage, 4cm to <10cm.
1015	The duration of labour reported is not valid for Principle reason for caesarean	Error	Ensure that 1st and 2nd stages of labour are greater than 0 minutes, if Principle reason is Lack of progress in the 2nd stage.
1016	If alcohol frequency during pregnancy = 01 never the number of standard drinks in typical day must be 00 zero	Error	Ensure that alcohol frequency during pregnancy is accurately reported as 01 Never. If accurate then Number of standard drinks in typical day must be 00 Zero.
1017	The alcohol frequency during pregnancy reported is not valid for number of standard drinks on a typical day	Error	Ensure that value reported for alcohol frequency during pregnancy is accurately reported. If accurate then number of standard alcohol drinks on a typical day must be greater than 00 zero or 99 unknown.
1018	The Principle reason for Caesarean is not valid for onset of labour and complication of labour & delivery	Error	Review and correct the Principle reason for Caesarean as it is not reported accurately When onset of labour is Induced, Complication of Labour & Delivery is Failure to progress <=3cm and Method of birth is Emergency caesarean.
1019	When Principal reason for Caesarean indicates unsuccessful attempted vaginal delivery duration of labour 2nd stage must be greater than 0 minutes	Error	Ensure that 2nd stage of labour is greater than 0 minutes if Principle reason for caesarean reported as unsuccessful attempt at assisted delivery. Ensure that method of birth value/s are accurately reported as vacuum unsuccessful and/or forceps unsuccessful.
1025	Check if baby length accurate as 58cm or longer has been reported.	Warning	Ensure baby length accurately reported greater than 57cm.
1026	The duration of labour reported indicates that labour occurred and therefore the unsuccessful induction of labour reported in complication of labour and delivery is incorrect.	Error	Ensure unsuccessful induction of labour reported accurately for complication of labour and delivery. If accurate then duration of labour 1st stage must be 0 minutes.
1027	If the complication of labour and delivery unsuccessful induction of labour is correct then onset of labour must be induced.	Error	Ensure unsuccessful induction of labour reported accurately for complication of labour and delivery. If accurate then Onset of Labour must be Induced.
1028	The duration of labour reported is not valid for Principle reason for caesarean. Unsuccessful induction may need to be reported for Principle reason for caesarean instead.	Error	Ensure that 1st stage of labour is greater than 0 minutes, if Principle reason for caesarean lack of progress <= 3cm. Unsuccessful induction may need to be reported for Principle reason for caesarean when onset of labour Induced.
1029	Intended place of birth at onset of labour reported as Home is not valid for site	Error	Ensure intended place of birth at onset of labour value reported accurately for site.

Valid ID	Validation message	Val Type	Action
1042	As the reason for caesarean is 1 (fetal compromise) there must be 32 and/or 42 in complications of pregnancy OR 2 in labour and birth complications.	Error	Please check value for complication of pregnancy is reported correctly. If it is reported correctly, check if value of 1 or 2 is reported in reason for caesarean.
1043	If apgars at 1 minute is <= to 5 Resus must report 4,5,6,7 or 8	Error	Please check apgar at 1 minute is reported correctly, if correct check all resuscitation values are added.
1044	If apgars at 5 minute is <= to 7 Resus must report 4,5,6,7 or 8	Error	Please check apgar at 5 minute is reported correctly, if correct check all resuscitation values are added.
1048	The principal reason for induction of prolonged pregnancy (>=41 weeks) does not match the gestational age provided	Warning	Ensure that the gestational age is correct, if correct ensure that principal reason for Induction of labour is correct.
1049	The Pregnancy complication indicates fetal death but birth status does not match.	Warning	Ensure that the pregnancy complication and birth status are correct.
1050	The Alcohol frequency > 20 weeks indicated never drank but number of drinks > 20 weeks is NOT 0.	Warning	Ensure that frequency of drinking alcohol > 20 weeks and number of alcohol drinks > 20 weeks are correct.
1051	The Alcohol frequency > 20 weeks indicated they drank alcohol but number of drinks > 20 weeks is 0.	Warning	Ensure that frequency of drinking alcohol > 20 weeks and number of alcohol drinks > 20 weeks are correct.
1052	Estimated Gestation must be reported as whole weeks + days 0 to 6	Error	Ensure the record has a gestational age (as estimated at time of birth) reported in weeks and days i.e. 38+6
1065	If gestation is between 20 - 34 weeks and birth weight is below 2800grams then must have admission to special care nursery or separation = transfer.	Error	Ensure that gestation, weight, and separation of infant are all correct as confirmed by EDD.
1067	Screening for family violence value is not present	Error	Ensure the record has the screening for family value reported.
1068	Value provided for screening for family violence is not a valid value	Error	Ensure the screening for family violence value is valid
1069	The principal reason for induction of late term pregnancy (40+0 to 40+6 weeks) does not match gestational age provided.	Error	Ensure that the gestational age is correct, if correct ensure that principal reason for induction of labour is correct.
1070	Primary maternity model of care value is not present	Warning	Ensure the record has a primary maternity model of care value reported.

Valid ID	Validation message	Val Type	Action
1071	Primary maternity model of care value provided does not match a maternity model of care available during this pregnancy.	Warning	Ensure Primary maternity model of care value provided is one from the approved list.
1072	Maternity model of care at the onset of labour value is not present	Warning	Ensure the record has a maternity model of care at the onset of labour value reported.
1073	Maternity model of care at the onset of labour value provided does not match a maternity model of care available at the time of this birth.	Warning	Ensure Maternity model of care at the onset of labour value provided is one from the approved list.

Additional Validation rules are managed by the MCH staff. These additional rules are not described in this Manual.

10. Access to HSECS Intranet Application

10.1. Internet Browser

Internet Explorer is the browser of choice. Google Chrome or Firefox may not work as expected.

10.2. Approval to access the HSECS Intranet Application

Access requires completion of the following steps:

- Submission of request by applicant to MCH
- Determination of appropriate User group by MCH staff
- Approval by the Manager, MCH
- Forward form to IDM for person to be added to appropriate User Group/s
- IDM emails applicant advising of Username and Password details and instructions for logging on to application
- User tests login and function to ensure set up works
- MCH provides support for using this system and managing their validation process for MNS records.

10.3. Form to submit a Request for Access to HSECS Intranet Application

Contact the MCH staff to receive a “Request for Access” Form.

10.4. Password reset for the HSECS Intranet Application

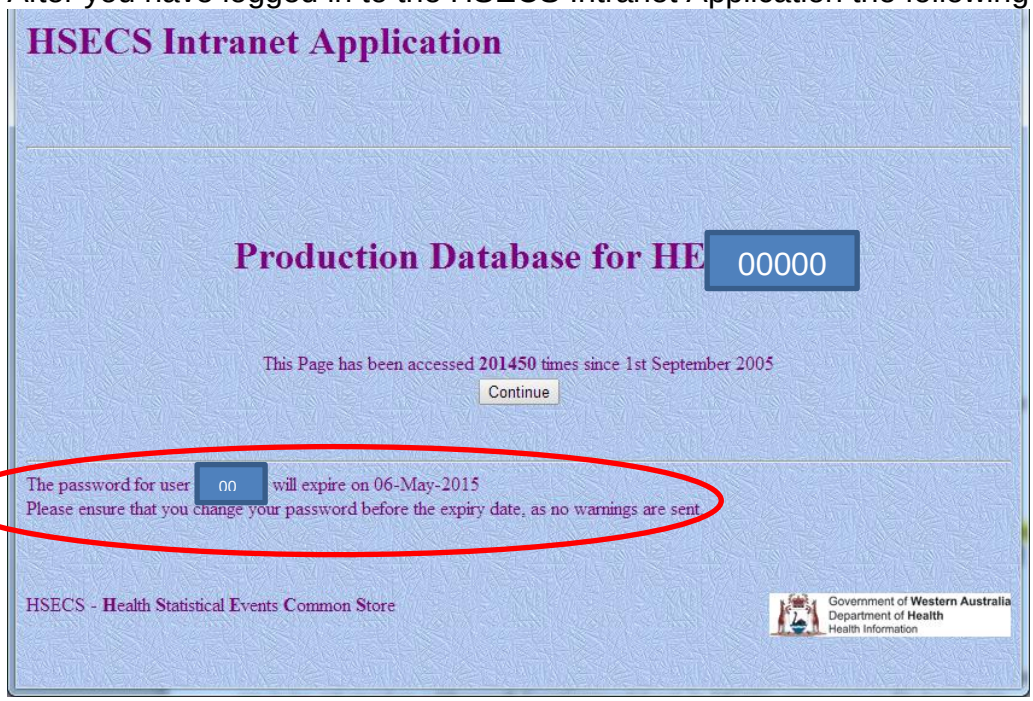
Introduction

Passwords must be reset every 90 days or access will expire. Users are notified of their password expiry date at the bottom left corner of the Login confirmation form as below.

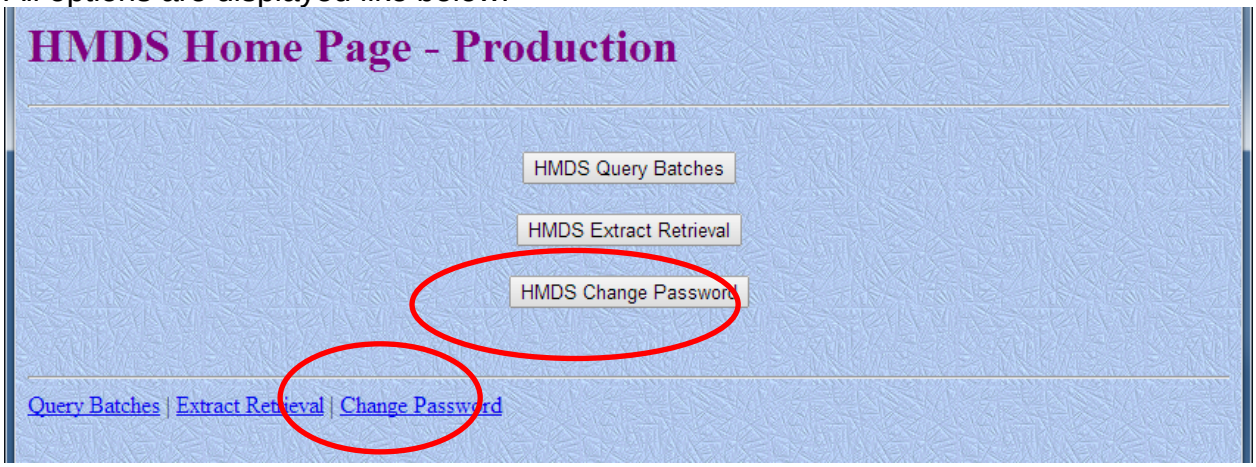
Changing your Active Directory (AD) password for email or logging in to PC does not automatically change your HSECS password.

Changing your password

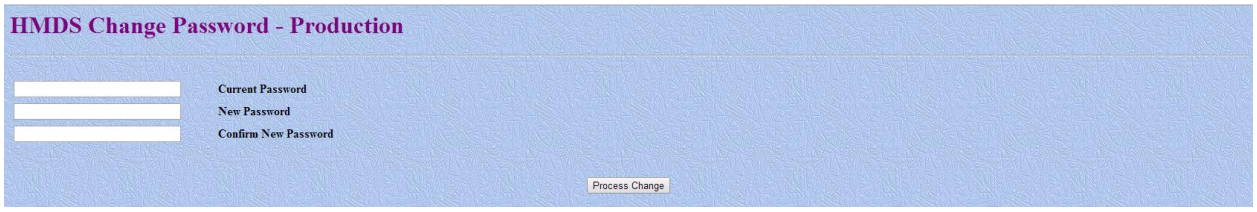
1. After you have logged in to the HSECS Intranet Application the following form is displayed:



2. Select the “Continue” button displayed in the above form
3. All options are displayed like below.



4. Select “Change Password” button or hyperlink at bottom of page to display form below:



5. Complete this form and select “Process Change”.
   - The password must be at least 6 characters with at least 1 numeric value. For example “tarzan1” or “w1nd0w” are both acceptable passwords.
   - Passwords may never be reused.
6. You will be advised if your password change was successful.

11. What is the ‘Edit Report’ document?

The ‘Edit Report’ is a Comma Separated Value (CSV) spreadsheet with a name format like “mw_Edits_NNN.csv”.

The ‘Edit Report’ name format and what it indicates is explained as follows:

- “mw” indicates a “midwives” data file
- “edits” indicates that the data file contains record edits information
- “NNN” indicates the reporting site’s Establishment ID, that is this data file includes all records reported by that maternity service
- “.csv” indicates the file type.

This report provides a list of all edits for the maternity service or establishment. The maternity service must use this report to identify which records they provided previously have failed validation rules.

This report is produced each day. ‘Edit’ cases will remain on the ‘Edit Report’ until an update record for the case has been uploaded to MNS or the ‘Edit’ has been managed by MCH by overriding the validation rule failure on advice by the maternity service.

Table 5 provides a list and description of the data displayed under the headings provided in the ‘Edit Report’:

Table 5: ‘Edit Report’ – heading descriptions

Column Heading	Description
MUMRN	Mothers Client ID allocated by site
BUMRN	Baby Client ID allocated by site
Surname	Mothers Surname
Firstname	Mothers Forename
Baby DOB	Baby Date of Birth
Code	Programming number assigned by the DoH to the validation algorithm and validation descriptive text
Type	Description of seriousness of the validation failure. Is the issue an Error in logic and the record can’t be processed? Or is it an unlikely data combination that warns the reporter that this scenario must be confirmed before the record can be processed?
Error Desc	Meaningful text that describes what data combination reported in the record has failed the validation algorithm test.
Hosp	Establishment ID for the maternity service. These have been assigned by the DoH.
BatchId	Number allocated by HSECS-MNS to each NOCA Extract as it is uploaded to MNS. All cases within the one NOCA Extract will have the same BatchID.
CaseId	Number allocated by HSECS-MNS to each DEL and BIR record within one NOCA Extract as it is uploaded to MNS. All DEL and BIR Records with the same BatchID will have a unique CaseID.

Column Heading	Description
Update	An “N” indicates that this is the first time this record has been supplied and uploaded to MNS by the maternity service A “Y” indicates that this record has been supplied and uploaded to MNS more than once as an update to the record originally supplied.
Extract Date	The date the record’s NOCA Extract identified by BatchID was first uploaded to HSECS-MNS
Comments	Provided to enable maternity service staff to indicate how this error is to be managed i.e. • Updated record to be supplied (record had incorrect data, it has been corrected in the system at the maternity service and an updated record will be supplied to MNS.) • Override validation rule (record data is correct and clinically valid, MNS must accept data as supplied).

This document can be made available in alternative formats on request for a person with a disability.