Government of Western Australia
Department of Health

Guidelines for Completion of the Notification of Case Attended

Health (Notification by Midwives) Regulations 1994 Form 2

Update: 2012
Maternal and Child Health Unit
Data Integrity Performance Activity and Quality Division

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Introduction

This document has been produced as a reference guide for clinical midwives in the completion of the 'Notification of Case Attended' (NOCA) Health (Notifications by Midwives) Regulations 1994 Form 2, on using either a paper based or electronic system.

These guidelines will also act as a reference for other health professionals required to complete the form, in the absence of an attending midwife. In addition, these guidelines provide definition of data items for users to fully comprehend the basis on which information is recorded. In the remainder of this document, the Notification of Case Attended Form 2 will be referred to as the NOCA (Form 2).

These guidelines aim to improve the consistency and standardisation of definition of terms for data provision. Health care professionals interested in obtaining additional or specific statistics from the Midwives' Notification System. Additional information for any other queries and requests are asked to contact (see below):

Contact Information:

The Manager at Maternal and Child Health Unit
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Department of Health, Western Australia

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Telephone: (08) 9222 2147
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The Midwives' Notification System

Objectives

The objectives of the Midwives' Notification System are to:

- Provide notification and summary of all births in the state to the Commissioner of Health.
- Monitor maternal and neonatal events.
- Facilitate the provision of postnatal and child health services.
- Assist in the planning of obstetric and neonatal services. Assist with ongoing research in the areas of obstetrics and maternity services.
- Provide a continuing source of information for ongoing education in clinical practice.
- Provide Western Australian (WA) perinatal data for inclusion in national perinatal statistical reports.

Overview

The Midwives' Notification System was introduced in WA in 1974. Ongoing reviews of collected data items have been possible since the computerisation of records in 1980.

It is a requirement under the Health Act 1911(Section 335) that the midwife in attendance at any birth complete a 'Notification of Case Attended' Form 2. This form has been prescribed in the Health Act as (Notifications by Midwives) Regulations 1994 and is known as Form 2 of Schedule 1.

Data from the Midwives' Notification System is used to compile annual reports of perinatal statistics and perinatal, infant and maternal mortality in WA. These statistics provide the basis of planning by the Department of Health for matters such as obstetric facilities, neonatal care units and community child health centres. In WA, epidemiological research into issues of low birth weight babies, gestational differences and congenital malformations is recognised worldwide and these studies rely to a large extent on a complete and valid data base from the WA Midwives' Notification System.

Many additional data requests are received from external organisations and individuals for studies aimed at improving the health of confined women and their newborn babies. Data requests are encouraged and, subject to confidentiality guidelines, relevant subjects of data are extracted from the Midwives' Notification System files.

Notification of Case Attended Regulations Form 2 (NOCA)

A NOCA (Form 2) (paper-based) or computerised (electronic) record is to be completed for every baby born, either stillborn or liveborn, of 400 grams or more infant birth weight and for births at 20 weeks or more gestation occurring in WA. The midwife in attendance usually completes the form.

In the absence of an attending midwife, the medical officer is asked to complete a NOCA (Form 2). If there is no midwife or medical officer in attendance when the birth event occurs, the first qualified midwife or medical officer to attend the mother and baby should complete a Midwives' Form 2.

The NOCA (Form 2) is a three-part form on NCR (no carbon required) paper. For this reason, care should be taken to avoid unintentional marking of duplicate and triplicate copies. Dependent on the hospital, this form may be in an electronic format. Only one copy needs to be completed (i.e. either a paper or an electronic form not – NOT BOTH)

The paper-based NOCA comprises the following:

- Health Department's Copy – The original form printed on green paper. This is forwarded to the Maternal and Child Health, Data Integrity Performance Activity and Quality Division at the Department of Health WA, when details of the discharge of the baby from hospital of birth have been completed.
- Medical Records' Copy – A blue paper form that is retained in the hospital medical records, except in the case of midwives in private practice attending births outside hospital, where it is kept as an individual record.
- Child Health's Copy – A white paper form which is forwarded within 48 hours of birth also to Maternal and Child Health, Data Integrity Performance Activity and Quality Division at the Department of Health, WA so that it may be redirected to the appropriate community health nurse to facilitate continuity of care of mother and baby(s).

Please note that multiple births require a separate NOCA (Form 2) for each baby with the same identifying maternal demographic information.

General Instructions (applies to paper-based NOCA(Form 2) only).

Please note: Instructions for entering in data values electronically, dependent on the hospital, each to their own will have different instructions.

Dependent on the hospital, this form may be in an electronic format

1. When filling in the paper-form please use ballpoint pen and place on a firm surface to ensure legibility of all three copies.
2. Answer complete ALL questions.
3. If a particular item of information is not available then record as ‘Unknown’ in a text field or ‘9999’ in a numeric field.
4. When text is required please PRINT, preferably with the use of block let.ers.
5. Abbreviations should be limited to those in common use to avoid miscoding of information.
6. Addressograph labels may be used, but please ensure that one is placed on each copy of the paper form.
7. Wherever possible insert home or contact telephone numbers to facilitate continuity of care by child health nurses.
8. Where there are more boxes provided than necessary, please ‘right adjust’ your response.

   e.g. birthweight of baby – 975 grams

0	9	7	5

9. For all dates, eight boxes are provided, two for each day, two for each month and four for each year. If only month and year are known, leave boxes for days blank.

   e.g. mother’s date of birth – 6 June 1975

0	6	0	6	1	9	7	5

10. Some questions allow for more than one response. Of these, although numbered for data entry purposes, you are only required to ‘tick’ the appropriate box(s) and where not applicable please leave blank.

    e.g. ‘Complications of Pregnancy’ section

    Items not listed in tick boxes should be recorded as text under the appropriate headings.

11. The Midwives' Form 2 should be forwarded to the Department of Health WA as soon as possible. Prompt notification is especially important at the end of the calendar year to enable closure of the data file.

Data cannot be analysed until the file is closed and late receipt of forms could result in delayed provision of reports.

Sections for the Midwives' Form 2 (NOCA)

DEMOGRAPHIC INFORMATION

Last Name – The legal surname should always be given. If an alias or assumed name is used, this should be indicated in brackets in same space following the legal surname.

First Name – No anglicised versions of first names are to be given, e.g. Maria-Mary; Marguiretta-Margaret.

Maiden name – This should be the mother's surname at her birth. If the mother has never married or changed her name by deed poll, record that name.

Address of usual residence – The usual residential address of the mother should be recorded for population statistical purposes. If the mother normally resides in country areas or overseas and is temporarily resident in another place at the time of the delivery, her usual address should be recorded. However, if applicable, a temporary address should additionally be noted to assist child health nurses with earlier contact. It is preferable that a full address be provided rather than a post office or road mail box number.

State – The State or territory of the mother's residential address, e.g. WA.

Post code – The usual residential postcode should be inserted as four digits.

Unit record number – This is the number allocated by the hospital to each patient. If there are more boxes provided than are necessary, 'right adjust' your response

e.g. Unit Record No. 17234

0	0	0	1	7	2	3	4

Birth date (Mother) – Record the date as an 8 digit numeric field, i.e. ddmmyyyy.

Height – Record the mother's height in centimetres.

Weight – Record the mother's booking weight in whole kilograms. (If the mother is not seen until after 20 weeks, use a self-reported weight at conception)

Telephone number – Inclusion of home or contact telephone numbers at usual place of residence are valuable to child health nurses. For women intending to reside temporarily at other than their usual address, please record an additional contact number.

Establishment – This refers to the establishment or hospital where the baby was born.

- Hospital – Record the name of the hospital.
- Home – If a planned homebirth, record 'Homebirth'.
- B.B.A. – If an intended hospital birth but born before arrival, record B.B.A. and name of admitting hospital.

Marital status – This refers to the current social status of the mother, which is not necessarily her legal status. If the mother is single, but living in a defacto relationship then for the purpose of this form, record married/defacto. Defacto relationships in this context may be identified as where the mother and her partner live at the same residential address.

Ethnic status – Refers only to mother's ethnic origin, not that of the baby or the father of the baby.

- Caucasian – Includes all people of Caucasoid (European) heritage e.g. Maltese, Lebanese, Italian, etc.
- Aboriginal/TSI – Includes persons of Australian Aboriginal and/or Torres Strait Islander (Australoid) heritage.
- Other – Includes any racial group other than Caucasian or Aboriginal/TSI, e.g. Asian, Indian, African, Polynesian, etc. Please identify in text in the space provided on paper form.

PREGNANCY DETAILS

Previous Pregnancies

Total number (excluding this pregnancy) - Record the total number of known previous pregnancies of any gestation regardless of outcome e.g. livebirth, stillbirth, termination or spontaneous abortion. This section EXCLUDES the present pregnancy but includes the total number of:

Previous pregnancy outcomes:

- Liveborn, now living – Should include all children born to the mother, including any child given up for adoption, known to be alive.
- Liveborn, now dead – Include all children (born alive to this woman) that are no longer living.

- Stillborn – Includes all babies (born to this woman) of 400 grams or more birthweight and/or 20 weeks or more gestation, which showed no sign of life at birth.

Number of previous caesareans – Record the number of previous caesareans sections that the woman has had.

Caesarean last delivery – requires a Yes/No answer (1=yes 2=no)

Previous multiple births – requires a Yes/No answer (1=yes 2=no

THIS PREGNANCY

Antenatal:

Estimated gestation at first antenatal visit – This is the total number of completed weeks of a pregancy's estimated duration at the first presentation for antenatal care. The 'first' presentation for antenatal care is the 'first' contact with a doctor or midwife where actual antenatal care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that related to other non pregnancy related issues.

Early antenatal care visits (such as at conception for IVF) in the 1st incompleted gestation week should be coded as '00'. Use '98' if woman did not attend any antenatal care visits; and use '99' if not stated or inadequately described.

Date of last menstrual period (LMP) – This date should be recorded in the appropriate boxes. If the date is unknown, indicate with 'Unknown' and leave the coding boxes blank. If the mother has had a recent previous pregnancy and not had a menstrual period prior to this, then record as unknown and record as 'Not Certain'.

This date Certain – Certain/Not Certain – requires a Yes/No answer (1=yes 2=no).

Expected due date – Record date directly into coding boxes. If date is unknown then leave boxes blank and record 'Unknown' under the question. Assessments by either clinical acumen or ultrasound are acceptable. *(Note: If recording in electronic format please leave 'blank' do not record or type 'unknown', nil and none etc…)*

Smoking:

Number of tobacco cigarettes usually smoked each day during first 20 weeks of pregnancy – The self-reported number of cigarettes usually smoked daily by a pregnant woman during the first 20 weeks of pregnancy. This data should be collected after the first 20 weeks of pregnancy, e.g., the next antenatal visit after the first 20 weeks would be an ideal time.

Number of tobacco cigarettes usually smoked each day after 20 weeks of pregnancy – The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until birth. This data should be collected after the birth. 'After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (≥20 weeks + 0 days). 'Usually' is defined as 'according to established or frequent usage, commonly, ordinarily, as a rule. If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

Use '000' if woman did not smoke, '998' if smoked less than 1 cigarette per day and '999' if undetermined.

Complications of pregnancy:

Tick appropriate listed complications or record in text (in the space provided) any other complication that has occurred during the current pregnancy. The following definitions should be used when completing the NOCA (Form 2)

Threatened abortion (under/less than 20' weeks) – Uterine bleeding in pregnancy before the 20th week.

Threatened preterm labour (under/less than 37' weeks) – Uterine contractions present (> 20 weeks and <37 weeks gestation)

Urinary tract infection – Confirmed by bacteriological culture of urine.

Pre-eclampsia – The development of hypertension with either proteinuria, oedema, or both, induced by pregnancy after the 24th week. It is a specific disease of pregnancy.

Pregnancy induced hypertension – Is defined by the Perinatal and Infant Mortality Committee as:

> 'A rise in the systolic blood pressure to 140 mm Hg or more and/or a rise in the diastolic blood pressure to 90 mm Hg or more in a woman who has been normotensive before the 24th week of pregnancy with or without proteinuria'.

Essential hypertension – A diastolic blood pressure of 90 mm Hg or more recorded on at least two occasions before 24 weeks of pregnancy and not due to any identifiable aetiological factor. This should be recorded in medical conditions in text.

Eclampsia – The occurrence of convulsions, not caused by any coincidental neurological disease. If this condition occurs, record in text.

Superimposed pre-eclampsia or eclampsia – The development of pre-eclampsia in a woman with chronic hypertension. If this condition occurs, record in text.

Antepartum haemorrhage (APH) – placenta praevia – Antepartum haemorrhage resulting from the placenta being located over or very near to the internal cervical os.

Antepartum haemorrhage (APH) – placental abruption – Antepartum haemorrhage resulting from the placenta becoming totally or partially detached from the uterine wall whilst the fetus is still in utero. Abruption without antepartum haemorrhage (APH) should be recorded under 'other' in text.

Antepartum haemorrhage (APH) – other – Antepartum haemorrhage resulting from causes other than placenta praevia or placental abruption.

Pre-labour rupture of membranes – Rupture of the membranes at any time before the onset of labour irrespective of gestation at the time of membrane rupture.

Gestational diabetes – Diabetes in pregnancy as confirmed by clinical investigations (e.g. Glucose Tolerance Test). Pre-existing diabetes is to be marked in the 'Medical Conditions' section.

Other (specify) – If there are other complications of pregnancy that are not listed with a tick box but which have occurred, please record in text in space provided. For example:

- Intrauterine growth restriction (IUGR)
- Genital herpes
- Intrauterine death
- Anaemia – haemoglobin less than 11 grams/100ml
- Oligohydramnios
- Polyhydramnios
- Hyperemesis Gravidarum, etc.

(Note: When "Other (specify)" has been selected, it is mandatory that users midwives' or ward clerks to specify in either 'free text' or ICD code' (if known) otherwise leave 'blank' and don't select "Other (specify)" at all.)

Medical conditions:

Any current medical condition relevant to pregnancy, or maternal congenital abnormality or carrier trait (e.g. Thalassaemia) should be recorded. Care should be taken to ensure that any of the following medical conditions are recorded:

- Essential hypertension
- Pre-existing diabetes mellitus
- Asthma
- Genital Herpes
- Other (Specify)
    - Examples include: Epilepsy, Malignant *neoplasms,* Renal disease, Thyroid disease

(Note: When "Other (specify)" has been selected, it is mandatory that users midwives' or ward clerks to specify in either 'free text' or ICD code' (if known) otherwise leave 'blank' and don't select "Other (specify)" at all.)

Procedures/treatments:

Any procedures or treatments relevant to this pregnancy. Fertility treatments such as IVF can also include drug only treatments, not necessarily surgical procedures. Below are the treatments and/or procedures that should be recorded.

Fertility treatments (include drugs) – Fertility procedures include any Assisted Reproductive Technology treatments such as In-Vitro-Fertilisation (IVF), Frozen Embryo Transfer (ET), Gamete Intrafallopian Transfer (GIFT), Artificial Insemination (AI), any use of donor, micro-manipulation, Intrauterine Insemination (IUI), tubal transfer, etc. Fertility drugs include Cetrotide, Clomid, Crinone, Gonal-F, Lucrin, Metrodin, Pregnyl, Progesterone, Puregon, Synarel, etc.

Cervical suture – For treating weak cervix to prevent baby from coming through the cervix. It can help prevent miscarriage or premature birth. Other terms are cervical stitch or cervical cerclage.

CVS/Placental biopsy – Chorionic villus sampling (CVS) is a test for abnormal chromosomes such as sickle-cell disease.

Amniocentesis – Testing amniotic fluid to check for abnormal chromosomes such as Down's Syndrome.

Ultrasound – Ultrasound used to examine a fetus during pregnancy.

CTG antepartum – Monitoring of fetal heart frequency before birth in order to assess impending prematurity in relation to the pattern or intensity of the antepartum uterine contraction. Normal antenatal Cardiotocograph (CTG) is associated with a low probability of fetal compromise and has the following features:

- Baseline fetal heart rate (FHR) is between 110-160 bpm
- Variability of FHR is between 5-25 bpm
- Decelerations are absent or early
- Accelerations x2 within 20 minutes.

CTG intrapartum – Monitoring of fetal heart frequency during birth in order to assess impending prematurity in relation to the pattern or intensity of the intrapartum uterine contraction. Normal intrapartum CTG is associated with a low probability of fetal compromise and has the features:

- Baseline FHR is between 110-160 bpm
- Variability of FHR is between 5-25 bpm
- Decelerations are absent or early

The significance of the presence or absence of accelerations is unclear. Therefore, exclude accelerations during interpretation.

Intended place of birth at onset of labour Acceptable values are:

1 = Hospital, excluding birth centre - includes women who have elective caesarean sections

2 = Birth centre, attached to hospital

3 = Birth centre, free standing

4 = Home – should be restricted to the home of the woman or a relative or friend

8 = Other – includes community health centres.

MIDWIFE DETAILS

The Midwife completing the form must clearly PRINT their name and AHPRA (AustralianHealth Practitioner Regulation Agency) registration number in the provided spaces. If a Doctor completes the form, their AHPRA registration number should be recorded.

LABOUR DETAILS

As an attempt to standardise and improve the quality of information collected, please use the following definitions to complete NOCA Form 2.

Onset of labour – There must be at least one response indicated in this question.

1 = Spontaneous – Contractions commence spontaneously. Spontaneous rupture of membranes by itself does NOT constitute spontaneous onset of labour.

2 = Induction – Is either a medical and/or surgical procedure performed for the purpose of stimulating and establishing labour in a woman who has not commenced labour spontaneously.

3 = No labour – Indicates the absence of labour (e.g. where there is an elective caesarean section or a failed induction followed by an emergency caesarean section).

Augmentation of labour – The labour is augmented when, following spontaneous onset of labour, medical and/or surgical interventions (e.g. Syntocinon Infusion and A.R.M.) are used to assist progress.

More than one method of augmentation can be indicated on the NOCA Form 2.

Induction of labour – More than one method of induction can be indicated on the NOCA Form 2.

Failed induction – Occurs when an induction procedure, either medical and/or surgical, fails to establish labour. If an induction has failed, perhaps at another hospital then record 'Failed Induction' in text under 'Complications of Labour and Delivery'.

Analgesia – This question refers to analgesia during labour only. A response must be recorded, however, more than one response is permitted.

Duration of labour – hours of established labour - Time is recorded in four figures for the hours and minutes of the first and second stages of labour.

e.g. Time of First Stage = 5 hours and 25 minutes

0	5	2	5

e.g. Time of Second Stage = 1 hour and 5 minutes

0	1	0	5

First stage of labour – Commences when uterine contractions of sufficient frequency, intensity and duration bring about demonstrable effacement and dilation of the cervix. Although the differential diagnosis between false and true labour is difficult at times, it can usually be made on the basis of the following features.

Contractions of true labour

- Occur at regular intervals
- Occur at gradually shorter intervals
- Gradually increase in intensity
- Cause discomfort in the back and abdomen
- Cause cervical dilation
- Are not stopped by analgesia

Contractions of false labour

- Occur at irregular intervals
- Remain at long intervals
- Do not increase in intensity
- Cause discomfort chiefly in the lower abdomen
- Do not cause cervical dilatation
- Are usually stopped by analgesia

Second stage of labour – Begins when dilatation of the cervix is complete and ends with delivery of the infant. For those women who have either an elective caesarean section or failed induction resulting in an emergency caesarean section, please record the hours of first stage of labour as closely as possible and record the second stage as 0000.

Generally, it is not appropriate to calculate the hours of established labour from the time of admission to hospital.

DELIVERY DETAILS

Anaesthesia

The question refers to anaesthesia during delivery only. A response must be recorded, however, more than one response is permitted.

None – Anaesthesia is not used.

Local anaesthesia to perineum – Includes local anaesthetic infiltration for an episiotomy.

Pudendal – Refers to anaesthetic a type of pain relief that is used just before delivery. A numbing medicine is injected through the vaginal walls to decrease pain during the birth of the baby.

Epidural/Caudal – Includes lumbar epidural and caudal anaesthetics.Please Note: If an epidural/caudal block is recorded for analgaesia during labour, it is usually recorded for anaesthesia during delivery also.

Spinal – Refers to spinal anaesthetic. Often performed in combination with an epidural. In this case, indicate both epidural and spinal responses.

General – Refers to anaesthetic that renders the patient completely unconscious and unaware of pain or other sensations for a period of time.

Combined Spinal/Epidural – is a regional anaesthetic technique, which combines the benefits of both spinal anaesthesia and epidural anaesthesia and analgesia. The spinal component gives a rapid onset of a predictable block. The indwelling epidural catheter gives the ability to provide long lasting analgesia and to titrate the dose given to the desired effect.

Other – Includes nerve blocks.

Complications of labour and delivery

Tick the appropriate listed complication or record any other complication that has occurred in text in the space provided. Ensure the indications for caesarean section are included in this question.

*(Important Note: It is mandatory when "Method of birth" is "Elective Caesarean" or "Emergency Caesarean" that midwives/caregivers include the **reason** for operative delivery value at this "Complication of labour and delivery field on the NOCA Form 2*

The following definitions should be used when completing the NOCA Form 2.

Precipitate delivery – Is a term to describe any rapid delivery deleterious to condition of the mother or baby.

Precipitate labour – Is rapid labour and delivery where the total duration is less than two hours. If this occurs please record recorded under 'Other (specify)' in text or ICD code if known.

Fetal distress – Identified by any means including a fresh meconium staining of the liquor in the first stage of labour, abnormalities of the fetal heart rate, etc.

Prolapsed cord – The cord prolapses between the presenting part and the pelvic inlet.

Cord tight around neck – Record only if the cord required clamping and cutting prior to delivery of the shoulders.

Any other cord complications should be recorded under 'Other (specify)' in text (e.g. vasa praevia) or ICD code if known.

Cephalopelvic disproportion – When the fetal head is disproportionately large for the mother's pelvis, sufficient to create problems with delivery.

Post-partum haemorrhage (PPH >= 500mls) – Bleeding from the genital tract after delivery of 500mls of blood or more.

Retained placenta– manual removal – A third stage lasting more than 30 minutes.Complications that contribute to intervention in labour should be recorded e.g.

- Delay in 2nd stage labour – Vacuum extraction.
- Fetal distress – Emergency caesarean section.
- Deep transverse arrest – Forceps rotation and delivery.

Persistent occipito posterior – A fetal position of baby when the back of the baby's head is against the mother's back.

Shoulder dystocia – An obstetrical emergency that occurs when the anterior shoulder of the fetus becomes lodged behind the superior symphysis pubis, preventing further delivery.

Failure to progress <= 3cm – Failure to progress in labour when dilation is less than or equal to than 3cm.

Failure to progress > 3cm – Failure to progress in labour when dilation is greater than 3cm.

Previous caesarean section – Complications due to previous caesarean section.

Other (specify) – If there are other complications of labour or delivery that are not listed with a tick box, in the space provided.

(Note: When "Other (specify)" is selected it is mandatory that the user, midwives' or caregivers to specify either in 'free text' or in "ICD code" (if known) otherwise leave 'blank' and do not select "Other (specify)" value at all.)

Other complications of labour and delivery can include the following:

Maternal distress – Physical and psychological distress with a lowered pain threshold. Signs may include dehydration, ketoacidosis or rise in pulse or temperature.

Prolonged labour – Where the total of first and second stages of labour exceed 24 hours.

Eclampsia – The occurrence of convulsions, not caused by any coincidental neurological disease.

Prolonged rupture of membranes – Either artificial or spontaneous rupture of membranes occurring more than 24 hours before delivery.

Perineal lacerations – Specify whether first, second or third degree of severity.

Perineal status

The state of the perineum following the birth.

Acceptable values are:
1 = Intact
2 = 1st degree tear/vaginal tear – this is the same as vaginal tear to be consistent with ICD-10-AM. Other degrees of laceration are as defined in ICD-10-AM
3 = 2nd degree tear
4 = 3rd degree tear
5 = Episiotomy
6 = Episiotomy plus tear
7 = 4th degree tear
8 = Other

ABORIGINAL STATUS OF BABY

The status of baby value is identified by determining whether the baby's mother is of Aboriginal, Torres Strait Islander origin or not. Please select and 'tick' *only one option*.

There are four options:

- Mother is Aboriginal but not Torres Strait Islander.
- Mother is Torres Strait Islander but not Aboriginal
- Mother is of Aboriginal and Torres Strait Islander origin.
- Mother is not Aboriginal and/or Torres Strait, then 'tick' = Other.

BABY'S DETAILS

Adoption

Indicate in appropriate box if the baby is for adoption. Should the mother change her mind about the child for adoption whilst in hospital, please indicate on the green copy of NOCA Form 2.

Born before arrival

Indicate if baby was born before arrival at the intended place of birth.

For babies born before arrival (B.B.A.), the first midwife to attend the mother and baby should complete the Midwives' Form 2 with as much information as possible.

Birth date

Record the date of birth of the baby as an 8 digit numeric field i.e. ddmmyyyy.

Birth time

Should be recorded using the twenty-four hour clock. Four boxes are provided, two for hours and two for minutes.
e.g. 3.05 in the afternoon should be recorded as

1	5	0	5

For babies born at midnight, please record 2400.

Plurality – Refers to the number of fetuses or babies resulting from the pregnancy. On this basis, pregnancy may be classified as singleton or multiple and the outcome will be a single baby, twins, triplets, etc.

> Singleton birth – Is the expulsion or extraction of one baby (live or stillborn) from the mother.

Multiple births – Is the expulsion or extraction of more than one baby (live and/or stillborn) from the mother.

Birth order

Each baby of a multiple birth is individually identified by recording its order of birth.

Please remember that all multiple births must have a NOCA Form 2 completed for each baby (e.g. twins require two forms, triplets require three forms).

Presentation

There can be only one response indicated in this question. For a multiple pregnancy with differing presentations, please record the presentation of each fetus on the individual form completed for that baby.

1 = Vertex – Presentation is when the occipital fontanelle is the presenting part.
2 = Breech – Presentation includes breech with extended legs, breech with flexed legs, footling and knee presentations.
3 = Face – Baby's face is the presenting part
4 = Brow – Baby's brow is the presenting part
8 = Other – Presentations include chin presentation (mentum), shoulder presentation, etc.

Method of birth

This question must have at least one response recorded. It is possible to have a combination of several types of delivery (e.g. failed vacuum and emergency caesarean section).

Spontaneous – Any spontaneous delivery that is achieved solely by the mother's expulsive efforts. This includes any spontaneous breech delivery.

Vacuum – The attachment of traction by suction to the fetal scalp.

Forceps – Used for traction and/or rotation.

Breech manoeuvre – For the purpose of this form the following methods of breech delivery through the vagina are included.

1. Assisted breech delivery – The baby is delivered spontaneously as far as the umbilicus, but the remainder of the body is assisted by the obstetrician or accoucheur.

2. Breech extraction – The entire body of the baby is extracted by the obstetrician.

If forceps are applied to the after-coming head of a breech delivery, then record forceps as well as breech delivery. However, if a spontaneous breech delivery occurs then read below.

Spontaneous breech delivery – Occurs where the baby is expelled spontaneously without any traction or assistance other than support; this should be recorded as a normal delivery with a breech presentation.

Caesarean section – Is defined as delivery of the fetus through an incision in the abdominal wall (laparotomy) and the uterine wall (hysterotomy).

Elective caesarean section – A planned procedure performed

1. Prior to onset of labour and before spontaneous rupture of membranes, and
2. Without any procedure to induce labour

Emergency (non-elective) caesarean section – Is undertaken at short notice for a complication either

1. Before the onset of labour (e.g. life threatening A.P.H).
2. During labour whether that labour is spontaneous or induced labour (e.g. fetal distress).

If the woman is booked for an elective caesarean section and either goes into spontaneous labour or has a spontaneous rupture of membranes and the caesarean section is performed in advance of the elective caesarean section, then for the purpose of this form, emergency caesarean section should be recorded.

Accoucheur(s)

The principal person who assisted the mother in the birth of the baby. If the principal accoucheur is other than those listed, tick 'Other'.

Acceptable values are:

1 = Obstetrician – a medical doctor who is qualified in the field of obstetrics

2 = Other medical officer – Includes registrars, junior officer, resident, general practitioner, etc.

3 = Midwife – A registered nurse who is qualified in the field of midwifery

4 = Student – either a registered nurse training to obtain qualifications in the field of midwifery or a medical student training to obtain qualifications to become a medical doctor

5 = Self/no attendant

6 = Other – includes a registered nurse without midwifery qualifications, doulas, ambulance officer, husband, other patient, etc.

Gender

Record the sex of the baby in the appropriate box.

Options are as follows:

1 = male

2 = female

3 = indeterminate

Status of baby at birth

Refers to the condition of baby at birth, either alive (liveborn) or dead (stillborn).

The following definitions must be used when completing the NOCA Form 2.

Liveborn – Is the complete expulsion or extraction from the mother of a product of conception, irrespective of duration of pregnancy, which after separation shows sign of life.

Stillborn – Is the complete expulsion or extraction from the mother of a product of conception, of at least 20 weeks gestation or 400 grams in weight, which, after separation, did not show any sign of life.

Infant weight

All babies should be weighed to the nearest five grams. This is usually obtained within the first hour of birth. If the birthweight is less than 1000 grams then right adjust the response e.g. a birthweight of 975 grams should be recorded as

0	9	7	5

Length

All babies should be measured to the nearest centimetre from crown to heel. For cases where a measurement is midway between two numbers, please round up e.g. 51.5 cm should be recorded as 52 cm.

Head circumference

This is the measurement to the nearest centimetre with the tape just above the eyebrows anteriorly and at the maximum point of the occiput posteriorly. For cases where a measurement is midway between two numbers, please round up e.g. 35.5 cm should be recorded as 36 cm.

Time to establish unassisted regular breathing

Record to the nearest minute the time taken to establish and maintain spontaneous respirations. If a baby takes less than one minute to establish unassisted breathing, please record as 01 on the NOCA Form 2. If a baby is intubated AND ventilated, and accurate assessment of time is not possible, then record as 98.

For stillbirths and neonatal deaths that do not establish spontaneous respirations and are not intubated, record as 00.

Resuscitation

If the infant was intubated or if oxygen only was administered then tick the appropriate box. For cases where there are more than one type of resuscitation used, please record the most invasive.

Apgar scores

At one minute and five minutes are recorded on the NOCA Form 2. The scoring system is a numerical scoring system used to evaluate the baby at birth and is based on:

- Heart rate
- Respiratory effort
- Muscle tone
- Reflex irritability
- Colour

If the score is a single digit score then ‘right adjust’ the response

e.g. Apgar score 7 should be recorded as

0	7

If the baby is stillborn then record Apgar score as 00.If Apgar score unknown record as 99.

Please Note: For Born Before Arrival (BBA) cases, Apgar scores cannot be guessed – record as 99.

Estimated gestation (whole weeks)
Gestational age at delivery may be estimated by clinical examination of the baby using the following summary chart as a guide.

Estimation of gestational age of the newborn

Gestational Age			
Site	**< 36 weeks**	**37 – 38 weeks**	**39 + weeks**
Sole creases	Anterior transverse crease only	Occasional creases anterior two thirds	Sole covered with creases
Breast module diameter	2 mm	4 mm	7 mm
Scalp hair	Fine and fuzzy	Fine and Fuzzy	Coarse and silky
Ear lobe	Pliable, no cartilage	Some cartilage	Stiffen by thick cartilage
For males, testes and scrotum	Testes in lower inguinal canal scrotum small and few rugae	Intermediate	Testes pendulous scrotum full with extensive rugae (except undescended)

A more definitive estimate could be made utilizing the complete Dubowitz Score which may be found in most obstetric texts. For example: Pritchard, J., MacDonald, P., & Gant, N. (1985). Williams Obstetrics (17th ed.). Norwalk: Appleton-Century-Crofts.

This only applies to livebirths. The gestation of stillbirths is based on the duration of pregnancy, which may be different from the gestation of the fetus at the time of fetal death (e.g. if the fetus dies in utero at 32 weeks gestation and is not delivered until 36 weeks gestation then the estimated gestation should be recorded as 36 weeks).

Birth defects

When a congenital anomaly or malformation is recorded on the Midwives' Form 2 then it provides a source of notification to the Birth Defects Registry of Western Australia. Malformations should be described in detail and multiple anomalies identified and listed whenever possible.

However, when a late diagnosis or a more specific diagnosis of the congenital malformation is made after completion of the Midwives' Form 2 it is necessary to notify the Birth Defects Registry of Western Australia directly. This enables the Register staff to update records. Any duplication of notification is easily handled by the Register staff.

The Register defines a congenital malformation as any defect probably of developmental origin in either liveborn or stillborn babies. Therefore, the following defects are included in the Register: dtructural (e.g. spina bifida), genetic/and

chromosomal (e.g. Down's Syndrome) and biochemical (e.g. glucose 6-phosphate dehydrogenase deficiency).

Most minor malformations are excluded unless they are disfiguring or require treatment. The following list identifies those minor malformations that should be ***excluded.***

If in doubt, please record malformation and allow Birth Defects Registry staff to exclude.

Western Australian Register of Developmental Anomalies (previously Birth Defects Registry of Western Australia) (exclusions):

Birthmarks:
– Naevus (<4 cm)
– Angioma (<4 cm)
– Haemangioma (<4 cm)
– Lymphangioma (<4 cm)
Blocked tear duct
Broncho-pulmonary dysplasia
Clicky hips
Congenital pneumonia
Delayed milestones
Epigastric hernia
Epilepsy
Failure to thrive
Hydrocele testis
Hypoglycaemia
Intrauterine growth restriction
Imperforate hymen
Inguinal hernia
Intussusception
Labial adhesion or fusion
Large fontanelles
Low birthweight
Meconium ileus
Mental retardation
Mongolian blue spot
Motor Impairment
Oesophageal reflux
Paroxysmal atrial tachycardia
Persistent fetal circulation
Pilonidal sinus
Positional or postural foot deformities
Raynaud's disease
Sacral dimple/sinus
Single palmar crease
Skin tag
Small anomalies of ear
Small anomalies of toe
Strabismus
Submucous retention cyst
Tachycardia
Tongue tie, even if surgery
Umbilical hernia
Undescended testes - unless treated
Wide suture lines
Webbing 2nd and 3rd toes

The following list of malformations is not complete but if identified, should be recorded on the NOCA Form 2.

Western Australian Register of Developmental Anomalies (inclusions)

Nervous system

Anencephaly
Spina bifida
Encephalocoele
Congenital hydrocephalus
Microcephaly
Cysts

Skin

Cystic hygroma
Birthmarks
Haemangiomas
Naevi
Please state size, site and whether multiple or not for the above three malformations)

Eye

Absence of eye
Microphthalmia
Congenital glaucoma
Congenital cataract

Genital system

Undescended testis *(requiring treatment)*
Hypospadias
Indeterminate sex

Cardiovascular system

Congenital heart defects *(please specify)*
Coarcation of the aorta
Patent ductus arteriosus
Dextrocardia

Gastro-intestinal system

Cleft lip and/or palate
Tracheo-oesphageal fistula
Pyloric stenosis
Intestinal atresia
Hirschsprung's disease
Ectopic anus
Imperforate anus

Urinary system

Cystic kidney
Absent kidney
Ectopic kidney
Double ureter
Vesico-ureteric reflux

Blood

Thalassaemia
Sickle cell anaemia
Haemophilia

Respiratory system

Pulmonary hypoplasia
Diaphragmatic hernia
Undescended testis *(requiring treatment)*
Hypospadias
Indeterminate sex

Metabolic disorders – Inborn

Errors of metabolism
Phenylketonuria
Cystic fibrosis
Congenital hypothyroidism
Adreno-genital syndrome
Glycogen storage disorder
Lipid storage disorder
Albinism

Chromosomal anomalies

Downs syndrome
Trisomy 13
Trisomy 18
Turner's syndrome
Klinefelter's syndrome
Cri-du-chat syndrome

Musculo-skeletal system

Congenital dislocation of hip
Talipes *(requiring plasters or surgery)*
Polydactyly
Syndactyly
Absence of limbs *(complete of partial)*
Craniostenosis
Osteogenesis imperfect
Exomphalos

Congenital infections

Rubella
Toxoplasmosis
Cytomegalovirus
Herpes
Syphilis

Birth trauma

Describe the site, type and cause of trauma if possible (e.g. fractured skull, cephalhaematoma, nerve palsy, etc.)

BABY'S SEPARATION DETAILS

This section is completed, when using the paper based system, on the green copy and the blue copy of the Midwives' Form 2 on discharge, transfer or death of the baby. (The white third copy should have already been forwarded to the Health Department of WA within 48 hours of birth).

Separation date

Record the appropriate date of discharge, transfer or death.

Mode of separation

Refers to whether the baby was discharged home, died or transferred.

If transferred to another hospital, then the name of that hospital should be recorded in text in the space provided.

Special care

Any baby who is admitted to an intensive or special care nursery (Level 3 or 2) must have the number of whole days in special care recorded on NOCA Form 2.

N.B. Special care facilities are defined in the Hospital Morbidity Data System Reference Manual, July 2005, which may be found on http://www.health.wa.gov.au/publications/subject_index/p/Perinatal_infant_maternal.cfm

Follow-up information

The NOCA Form 2s are checked for completeness and accuracy when received at the Health Department. Incomplete or incorrect forms are set aside for follow-up. Photocopies of NOCA Forms 2 with follow-up forms are returned when necessary to the hospital where confinement occurred. The midwife who initially completed the NOCA Form 2 should normally provide the required additional information, but in the case of baby separation details this is often not possible.

Birth information provided by Midwives' on Notification of Case Attended forms is not amended/completed by clerical staff of this office without further consultation with the midwife concerned.