SEA-ORCHID Project

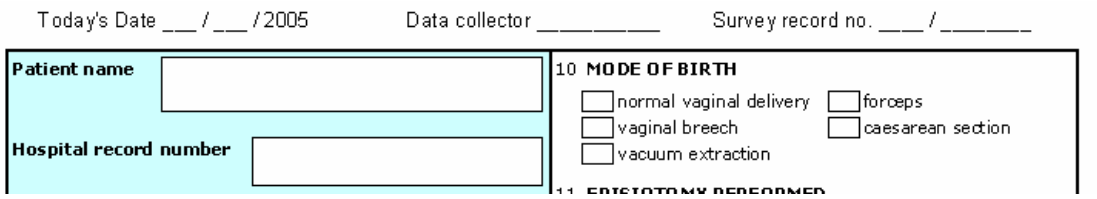
South East Asia — Optimising Reproductive and Child Health Outcomes in Developing Countries

Manual for Data Collection Form and online data entry

1. Data Collection Form

The data collection form consists of two pages containing 36 questions. Please provide a response to all questions.

Before answering each question, record the following information at the top of the form:



- **Today's Date**
  Record the date the form is completed (using the format DD/MM/2005).

- **Data Collector**
  Record the name (or initials) of the person completing the form.

- **Survey record number**
  The survey record number consists of three letters and four numbers (eg. RSS / 0001). This is a unique number which is assigned to each record.

  The **three-letter code** refers to the hospital where the data are collected:

Code	Hospital	Code	Hospital
RSS	Dr Sardjito Hospital	PGH	Philippine General Hospital
SLM	Sleman District Hospital	JFH	Jose Fabella Memorial Hosp.
KKU	Khon Kaen University Hosp.	IPH	Ipoh Hospital
KKH	Khon Kaen Hospital	USM	Kelantan Hospital
KLS	Kalasin Hospital		

  The **four-digit number** should be assigned consecutively to each record (ie the first case is assigned 0001, the second case 0002, etc).

  For example, the eleventh case collected at Khon Kaen Hospital would have a survey record number of KKH / 0011.

- **Patient name and hospital record number**
  From the patient's chart, record their name and hospital record number in the boxes.

Q 1	From chart review, record the mother's date of birth in the format DD / MM / YY. Numbers less than ten should be preceded by 0. • *a date of birth of 5 April 1979 should be recorded as 05 04 79*
Q 2	From chart review , tick YES if the mother has had any previous pregnancies that have lasted for a period of greater than or equal to 22 completed weeks. • *if no information is given on previous pregnancies, then tick UNKNOWN*.
Q 3	From chart review, record the mother's weight in kilograms (kg). Where given, record the gestational age the recording was taken. • *for weight, please use the first recorded weight on the chart* • *record weight in whole numbers. If measurements are given in fractions, round numbers down regardless of decimal point (eg 50.3 kg = 50 kg, 50.7 kg = 50 kg)* • *if gestational age is given in months, please convert from months to weeks*
Q 4	From chart review, record the mother's height in centimetres (cm). • *if height is given in metres, please convert from metres to centimetres.* • *record height in whole numbers. If measurements are given in fractions, round numbers down regardless of decimal point (eg 160.3 cm = 160 cm, 160.7 cm = 160 cm)*
Q 5	From chart review, record whether there was preterm prelabour rupture of the membranes (pPROM). • *rupture of the membranes should be before 37 weeks gestation and before labour.* • *if yes, record if antibiotics were given and specify the type of antibiotic given.*
Q 6	From chart review and/or staff interview, record whether the baby was in the breech position (bottom first) at 37 or more weeks. • *if no or unknown tick the appropriate box and move to question 7.* • *if yes, record whether ECV was offered to the mother. If ECV was offered, record whether it was performed.* • ***ECV** is external cephalic version and is defined as the turning of the baby by manual manipulation through the mother's abdomen.*
Q 7	From chart review and/or staff interview, record whether the mother's pubic hair was shaved.
Q 8	From chart review and/or staff interview, record whether an enema was used during labour.
Q 9	From chart review and/or staff interview, record whether support was provided during labour, who provided the support, and how much time they spent with the mother. • **support** is defined as continuous one-to-one support that is provided during labour and birth. • the support person may have qualifications as a healthcare professional (eg midwife or nurse), be a specially trained lay person (eg doula) or a family member/friend. • the **support person's main role is to provide emotional support** (eg counselling, reassurance, sympathetic listening) and information/advice. • the support person may provide support to more than one woman at a time. The important point is that the support provided by the support person when he/she is with the mother should be of a continuous, one-to-one and emotional nature. • use the time-indicator boxes to record an estimate of the time spent with the mother providing this type of one-to-one emotional/psychological support (as opposed to assisting with the birthing process and/or assisting and supporting other women).

	If the mother received support in labour, there are several types of support person to select: • **skilled birth attendant** is a member of the caregiver team who is professionally trained and certified to provide professional support (eg midwife). • **doula** is a member of the caregiver team who has received special training in labour support (may also be called a labour companion, birth companion, labour support specialist, labour assistant or birth assistant). • a **husband**, **mother**, **sister**, **other family member**, **stranger** or **friend** are not part of the caregiver team and have no special training in labour support. • a **childbirth educator** is someone who offers educational support to the mother about labour and birth. For **each category** record whether the support person spent time with the mother, and approximately how much time. • for example, if the mother's sister was present most of the time during the labour, tick the box "all/most of the time" to the right of "sister". • if you know the mother did not receive any continuous one-to-one support during labour, record this by ticking the "none of the time" box against each category. • if you are unsure whether the mother received support, tick the "unknown" box.
Q 10	From chart review, record the mode of birth. • *even if mode of birth is caesarean section please also complete questions 11, 12 and 13 (episiotomy, perineal trauma and suturing).*
Q 11	From chart review, record whether an episiotomy was performed. • ***episiotomy** is defined as the surgical enlargement of the vagina by an incision of the perineum during the last part of the second stage of labour or delivery.*
Q 12	From chart review and/or staff interview, record the level of perineal trauma (ie degree of tearing) experienced by the mother. • ***perineal trauma** is defined as perineal trauma sustained during childbirth that requires stitches. Vaginal and perineal tears are classified according to the following four levels* • ***first degree tears** involve the vaginal mucosa and connective tissue* • ***second degree tears** involve the vaginal mucosa, connective tissue and underlying muscles* • ***third degree tears** involve complete transaction of the anal sphincter (confirmed by clinical observation/examination)* • ***fourth degree tears** involve the rectal mucosa*
Q 13	From chart review and/or staff interview, record whether the perineum was sutured. If yes, please specify the suture material used and the technique used for skin closure. • ***continuous** suturing is the use of simple, non-locking, loose and continuous subcuticular sutures* • ***interrupted** suturing is the use of interrupted transcutaneous sutures*
Q 14	From chart review and/or staff interview, record the main indication for caesarean section. • ***breech presentation** refers to bottom first.* • ***fetal distress** refers to signs of fetal distress during labour, such as an unusual heart rate or the passing of a bowel motion.* • ***placenta praevia** is when the placenta is implanted entirely or partly in the lower uterine segment covering entirely or partly the cervix.* • ***CPD (cephalopelvic disproportion)** refers to the disproportionate size of the head of fetus in relation to the mother's pelvis.* • *if other, please specify the reason* . If antibiotics were administered, record when they were administered and the type of antibiotics given. Also record whether the dosage was single or multiple.

Q 15	From chart review, record whether the baby was resuscitated. If yes, record the method of resuscitation. • ***IPPV via ETT*** *refers to the intermittent positive pressure ventilation delivered via endotracheal tube.*
Q 16	From chart review and/or staff interview, record whether a skilled resuscitator was present at birth. • ***skilled resuscitator*** *is a person who has been assessed as competent in the management of providing ventilatory assistance to the baby*.
Q 17	From chart review, record the 1 minute APGAR score.
Q 18	From chart review, record the 5 minute APGAR score.
Q 19	From chart review, record the baby's birthweight in grams. • *convert weight from pounds to grams if necessary.* • *to convert to grams, multiply pounds by 453*
Q 20	From chart review, record the estimated gestational age at birth in completed weeks. • *convert from months to weeks if necessary.*
Q 21	From chart review, record the estimated blood loss in millilitres (mls).
Q 22	From chart review and/or staff interview, indicate if a prophylactic oxytocic drug was given for the third stage of labour. • *if yes, indicate when the drug was given, and specify the drug name (tick one only)* • *only record data on the* ***prophylactic bolus dose****, NOT the continuation of an IV drip for labour augementation/induction* • *if the mode of birth (Q.10) is caesarean section, this question will appear greyed-out and can be omitted.*
Q 23	• ***Early cord clamping*** *is defined as clamping of the umbilical cord immediately after the birth of the baby (ie not waiting for the cord to stop pulsating)* • *if the mode of birth (Q.10) is caesarean section, this question will appear greyed-out and can be omitted.*
Q 24	From chart review and/or staff interview, indicate if controlled cord traction was used. • ***Controlled cord traction*** *involves traction on the cord, while maintaining counter-pressure upwards on the lower segment of the uterus using a hand placed on the lower abdomen.* • *if the mode of birth (Q.10) is caesarean section, this question will appear greyed-out and can be omitted.*
Q 25	From chart review, record whether postpartum haemorrhage occurred. • ***postpartum haemorrhage*** *is defined as blood loss ≥500 mls* • *include under postpartum haemorrhage a haemorrhage that starts during delivery and continues after the baby has been delivered.* If postpartum haemorrhage occurred, specify whether oxytocic drugs were given. If yes, specify the type of oxytocic drug (tick all drugs that apply).
Q 26	From chart review, record whether a postpartum blood transfusion was given.

Q 27	From chart review, indicate if the mother developed pre-eclampsia. • ***pre-eclampsia*** *is defined as BP ≥ 140/90 mmHg and proteinuria* If yes, record when pre-eclampsia was first observed.
Q 28	From chart review, record whether the mother was given magnesium sulphate for pre-eclampsia and if yes, when it was first given.
Q 29	From chart review, indicate if the mother suffered an eclamptic fit. • ***eclampsia*** *is defined as the occurrence of a seizure or convulsion in association with pre-eclampsia* If yes, record when an eclamptic fit was first observed.
Q 30	From chart review, record whether the mother was given magnesium sulphate for eclampsia and if yes, when it was first given.
Q 31	From chart review and/or staff interview, record whether the mother was given antenatal corticosteroids. • *If yes, indicate at what gestational age (weeks) the most recent dose was given* • *If the gestational age at the time of administration of antenatal corticosteroids is not known, record '99' in the GA field (= 'unknown').* From chart review, record whether the course of antenatal corticosteroids was repeated.
Q 32	Record whether the newborn was immunised for hepatitis B. • *immunisation should occur before discharge from hospital*
Q 33	From chart review, indicate if there was puerperal morbidity, and whether antibiotics were given postpartum. • ***puerperal pyrexia*** *is defined as a single episode of ≥ 38ºC on at least two consecutive days within the first ten days after birth (excluding the first 24 hours).* • *record 'unknown' against puerperal pyrexia if the mother is discharged from hospital during the 24 hours after birth.* If antibiotics were prescribed for puerperal pyrexia, please indicate why they were prescribed by ticking the appropriate box(es). • ***endometritis*** *is inflammation of the endometrium (lining of the uterus), characterized by pelvic pain and vaginal discharge* • ***puerperal infection*** • ***mastitis*** *is inflammation of the mammary gland or breast* • ***urinary tract infection (UTI)*** *is a bacterial infection of the urethra, bladder, ureters or kidneys* • ***upper respiratory tract infection (URTI)*** *is an acute illness with symptoms of runny nose and sore throat (with or without fever and/or cough)* • ***chorioamnionitis*** *is a bacterial infection of the fetal membranes* • ***PPROM*** *is preterm (before 37 weeks) prelabour rupture of the membranes* • ***prophylaxis*** *if antibiotics are given to prevent pyrexia*
Q 34	If the mother died before discharge, record the cause of death.
Q 35	If the baby was stillborn, record the cause of death.
Q 36	If the baby was born alive but died before discharge, record the cause of death.

2. Multiple births

For multiple births (twins, triplets etc.) complete the standard data collection form for the first born only. For the second and third births complete the supplementary data collection form (Orchid data collection form multiple births.pdf) which asks questions specific to the baby.

When entering the data online, select the **check box for second and third births** at the bottom of the online form to display the supplementary questions. As the database is only set up to handle twins and triplets, please contact the Project Co-ordinator for quadruplets and beyond.

3. Online Data Entry

Data collected on these forms needs to be entered online and submitted to a secure central database. Each country has their own data page on the SEA-ORCHID website.

To enter data

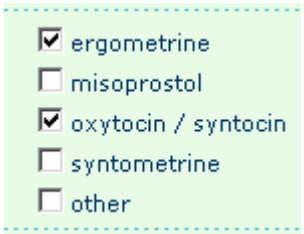
- go to http://www.seaorchid.org/survey/
- select the appropriate country location for data entry
- enter your username and password in the dialog box

Before entering data, ensure the three data fields at the top of the form have been completed.

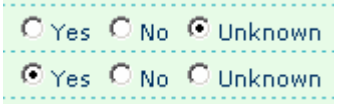
- 'Date survey was completed' corresponds to 'Today's Date' on data collection form.
- 'Survey record' corresponds to the 'survey record no.' on the data collection form.
- only the mother's hospital record number is required to be entered online.

Selecting options

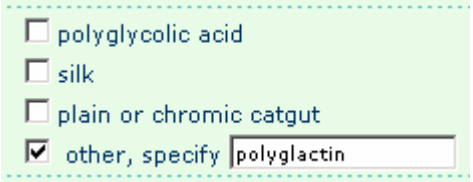
- selecting multiple options – **check boxes**: allows more than one option to be selected. To unselect an option tick the box again.



- selecting options – **radio buttons**: allows only one option to be selected. To unselect an option tick another option from the list.



- where there is an option to select **other** please remember to specify the answer in the text box.



Navigation

To move from one question to the next, you can either use the mouse or keystrokes (tab key, space bar and right/left arrows).

To move through the form without using a mouse, the following conventions apply:

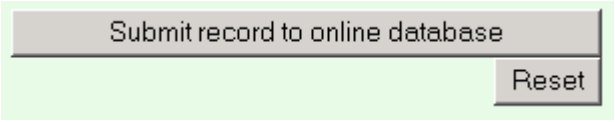
- use the **<tab>** key to move to the next question
- for check boxes use the **<space bar>** to select (and de-select) your option. To move down the list, use the **<tab>** key.
- for radio buttons use the **<space bar>** to select Yes or use the **<right/left arrow>** to select No or Unknown. (You can also use the **<up/down arrow>** to do the same thing.)

Verification

- before the data are submitted, the form will perform a verification of the data entered to check for errors or discrepancies. If data are missing, have been entered incorrectly or are invalid, an alert will appear indicating the error. Correcting the error(s) will allow the online submission to proceed.

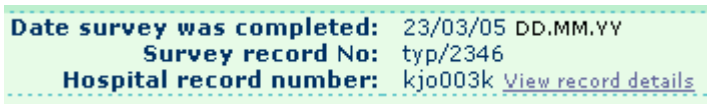
Submission of record to database

- when the data have been entered, click the **submit** button at the bottom of the page.
- warning! clicking the **reset** button will clear all data from the form.



- when you **submit** a record a new page will appear with the following:

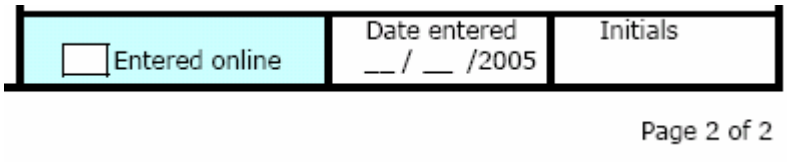
- to continue entering more records, click **Add another entry**
- to view entries that you have already submitted, click **View entries**. The most recent entry appears at the top of the list. If you wish to check the record, click on **View record details**.



Continued

The last step

- after each record has been successfully submitted to the database, remember to complete the details at the end of the data collection form.



- tick the box when the record has been successfully submitted.
- the **Date entered** corresponds to the date of online data entry.
- the name or initials of the person entering the data online should be recorded in the **Initials** box.

Editing records

- no edit facility is available. Once records are entered and submitted, changes can only be made centrally following a written request to the Project Co-ordinator (see below).

If there any difficulties with completing the form or submitting data, please contact Steve.
steve.mcdonald@med.monash.edu.au