

# Resuscitation Patient Management Tool

## Cardiopulmonary Arrest (CPA) EVENT

January 2021

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<b>OPTIONAL:</b>	Local Event ID:	
Did patient receive chest compressions and/or defibrillation during this event?	<input type="radio"/> Yes	<input type="radio"/> No/ Not Documented (Does NOT meet inclusion criteria)
Date/Time the need for chest compressions (or defibrillation when initial rhythm was VF or Pulseless VT) was FIRST recognized:	<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u> (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented

**CPA 2.1 PRE-EVENT** *Pre-Event Tab*

**OPTIONAL**

Was patient discharged from an Intensive Care Unit (ICU) within 24 hours prior to this CPA event?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, date admitted to non-ICU unit (after ICU discharge):	<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u>	MM/DD/YYYY HH:MM
Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hours prior to this CPA event?	<input type="radio"/> Yes	<input type="radio"/> No
Was patient in the ED within 24 hours prior to this CPA event?	<input type="radio"/> Yes	<input type="radio"/> No
Did patient receive conscious/procedural sedation or general anesthesia within 24 hours prior to this CPA event?	<input type="radio"/> Yes	<input type="radio"/> No
Enter vital signs taken in the 4 hours prior to the CPA event (up to 4 sets)	<input type="checkbox"/> Pre-Event VS Unknown/Not Documented	

Date / Time	Heart Rate	Systolic / Diastolic BP	Respiratory Rate	SpO2	Temp	Units
<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u>	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<input type="radio"/> C <input type="radio"/> F
<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u>	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<input type="radio"/> C <input type="radio"/> F
<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u>	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<input type="radio"/> C <input type="radio"/> F
<u>   </u> / <u>   </u> / <u>   </u> <u>   </u> : <u>   </u>	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<u>          </u> <input type="checkbox"/> Not Documented	<input type="radio"/> C <input type="radio"/> F

**CPA 2.2 PRE-EXISTING CONDITIONS** *Pre-Event Tab*

Did patient have an out-of-hospital arrest leading to this admission?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
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**Pre-existing Conditions at Time of Event** (check all that apply):

<ul style="list-style-type: none"> <li><input type="checkbox"/> None (review options below carefully)</li> <li><input type="checkbox"/> Acute CNS non-stroke event</li> <li><input type="checkbox"/> Acute Stroke</li> <li><input type="checkbox"/> Baseline depression in CNS function</li> <li><input type="checkbox"/> Cardiac malformation/abnormality – acyanotic (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Cardiac malformation/abnormality – cyanotic (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Congenital malformation/abnormality (Non-Cardiac) (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Congestive heart failure (this admission)</li> <li><input type="checkbox"/> Congestive heart failure (prior to this admission)</li> <li><input type="checkbox"/> Diabetes mellitus</li> <li><input type="checkbox"/> Hepatic insufficiency</li> <li><input type="checkbox"/> History of vaping or e-cigarette use in the past 12 months?</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Myocardial ischemia/infarction (prior to admit)</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Recently delivered or currently pregnant (if selected, maternal in-hospital cardiac arrest section is required)</li> <li><input type="checkbox"/> Renal Insufficiency</li> <li><input type="checkbox"/> Respiratory Insufficiency</li> <li><input type="checkbox"/> Sepsis</li> <li><input type="checkbox"/> <b>Active or suspected bacterial or viral infection at admission or during hospitalization:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Bacterial Infection</li> <li><input type="checkbox"/> Emerging Infectious Disease                             <ul style="list-style-type: none"> <li><input type="checkbox"/> SARS-COV-1</li> <li><input type="checkbox"/> SARS-COV-2 (COVID-19)</li> <li><input type="checkbox"/> MERS</li> </ul> </li> </ul> </li> </ul>
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<input type="checkbox"/> Hypotension/Hypoperfusion <input type="checkbox"/> Major trauma <input type="checkbox"/> Metastatic or hematologic malignancy <input type="checkbox"/> Metabolic/electrolyte abnormality <input type="checkbox"/> Myocardial ischemia/infarction (this admission)	<input type="checkbox"/> Other Emerging Infectious Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Seasonal cold <input type="checkbox"/> Other Viral Infection <b>Additional Personal Protective Equipment (PPE) Donned by the responders?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/ND
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**CPA 2.2 INTERVENTIONS ALREADY IN PLACE** *Pre-Event Tab*

**Interventions ALREADY IN PLACE when need for chest compressions and/or defibrillation was first recognized (check all that apply):**

<b>Part A:</b> <input type="checkbox"/> Non-invasive assisted ventilation <input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Mask and/or Nasal CPAP <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Mouth-to-Mouth <input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> Other Non-Invasive Ventilation: (specify) _____	<input type="checkbox"/> None <input type="checkbox"/> Invasive assisted ventilation, via an: <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Tracheostomy Tube <input type="checkbox"/> Intra-arterial catheter <input type="checkbox"/> Conscious/procedural sedation <input type="checkbox"/> End Tidal CO <sub>2</sub> (ETCO <sub>2</sub> ) Monitoring <input type="checkbox"/> Supplemental oxygen (cannula, mask, hood, or tent)
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<b>Monitoring</b>	<input type="checkbox"/> Apnea	<input type="checkbox"/> Apnea/Bradycardia	<input type="checkbox"/> ECG	<input type="checkbox"/> Pulse Oximetry
Vascular Access	<input type="radio"/> Yes		<input type="radio"/> No/ Not Documented	
Any Vasoactive Agent in Place?	<input type="radio"/> Yes		<input type="radio"/> No/Not Documented	

**OPTIONAL**

<b>Part B:</b> <input type="checkbox"/> IV/IO continuous infusion of antiarrhythmic(s) <input type="checkbox"/> Dialysis/extracorporeal filtration therapy (ongoing)	<input type="checkbox"/> None <input type="checkbox"/> Implantable cardiac defibrillator (ICD) <input type="checkbox"/> Extracorporeal membrane oxygenation (ECMO)
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**CPA 3.1 EVENT** *Event Tab*

Date/Time of Birth:	____/____/____ : ____ (MM/DD/YYYY HH:MM)		
Age at Event (in yrs., months, weeks, days, hrs., or minutes):	<input type="radio"/> Years	<input type="radio"/> Days	<input type="checkbox"/> Estimated
	<input type="radio"/> Months	<input type="radio"/> Hours	<input type="checkbox"/> Age Unknown/Not Documented
	<input type="radio"/> Weeks	<input type="radio"/> Minutes	
Subject Type	<input type="radio"/> Ambulatory/Outpatient <input type="radio"/> Emergency Department <input type="radio"/> Hospital Inpatient – (rehab, skilled nursing, mental health wards)		<input type="radio"/> Rehab Facility Inpatient <input type="radio"/> Skilled Nursing Facility Inpatient <input type="radio"/> Mental Health Facility Inpatient <input type="radio"/> Visitor or Employee
	Illness Category	<input type="radio"/> Medical-Cardiac <input type="radio"/> Surgical-Cardiac <input type="radio"/> Obstetric <input type="radio"/> Other (Visitor/Employee)	
Event Location (Area)		<input type="radio"/> Ambulatory/Outpatient Area <input type="radio"/> Adult Coronary Care Unit (CCU) <input type="radio"/> Adult ICU <input type="radio"/> Cardiac Catheterization Lab <input type="radio"/> Delivery Suite <input type="radio"/> Diagnostic/Intervention Area (excludes Cath Lab) <input type="radio"/> Emergency Department (ED) <input type="radio"/> General Inpatient Area <input type="radio"/> Neonatal ICU (NICU) <input type="radio"/> Newborn Nursery	
	<input type="radio"/> Operating Room (OR) <input type="radio"/> Pediatric ICU (PICU) <input type="radio"/> Pediatric Cardiac Intensive Care <input type="radio"/> Post-Anesthesia Recovery Room (PACU) <input type="radio"/> Rehab, Skilled Nursing, or Mental Health Unit/Facility <input type="radio"/> Same-Day Surgical Area <input type="radio"/> Telemetry Unit or Step-Down Unit <input type="radio"/> Other <input type="radio"/> Unknown/Not Documented		

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Event Location (Name)	_____		
Event Witnessed?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
Was a hospital-wide resuscitation response activated?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
<b>CPA 4.1 INITIAL CONDITION</b> <span style="float: right;"><i>Initial Condition/Defibrillation/Ventilation Tab</i></span>			
Condition that best describes this event:	<input type="radio"/> Patient was PULSELESS when need for chest compressions and/or need for defibrillation of initial rhythm VF/Pulseless VT was first identified <input type="radio"/> Patient had a pulse (poor perfusion) requiring chest compressions PRIOR to becoming pulseless <input type="radio"/> Patient had a pulse (poor perfusion) requiring chest compressions, but did NOT become pulseless at any time during this event		
Did patient receive chest compressions (includes open cardiac massage)?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented <input type="radio"/> No, Per Advance Directive		
Compression Method(s) used (check all that apply):	<input type="checkbox"/> Standard Manual Compression <input type="checkbox"/> Open chest CPR (direct [internal] cardiac compression) <input type="checkbox"/> IAC-CPR (interposed abdominal compression cardiopulmonary resuscitation) <input type="checkbox"/> Automatic Compressor <input type="checkbox"/> Unknown/Not documented		
Date/Time compression started	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	
<b>If compressions provided while pulse present:</b> Rhythm when patient with pulse FIRST received chest compressions during event:	<input type="radio"/> Accelerated idioventricular rhythm (AIVR) <input type="radio"/> Bradycardia <input type="radio"/> Pacemaker <input type="radio"/> Sinus (including Sinus Tachycardia)	<input type="radio"/> Supraventricular Tachyarrhythmia (SVTarryh) <input type="radio"/> Ventricular Tachycardia (VT) with a pulse <input type="radio"/> Unknown/Not Documented	
<b>If pulseless at ANY time during event:</b> Date/Time pulselessness first identified:	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	
First documented pulseless rhythm:	<input type="radio"/> Asystole <input type="radio"/> Pulseless Electrical Activity (PEA) <input type="radio"/> Pulseless Ventricular Tachycardia	<input type="radio"/> Ventricular Fibrillation <input type="radio"/> Unknown/Not Documented	
<b>CPA 4.2 AED AND VF/PULSELESS VT</b> <span style="float: right;"><i>Initial Condition/Defibrillation/Ventilation Tab</i></span>			
Was automated external defibrillator (AED) applied or manual defibrillator in AED/Shock Advisory mode applied?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	<input type="radio"/> Not Applicable (not used by facility)
Date/Time AED or manual defibrillator in AED/Shock Advisory mode applied?	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	
Did the patient have Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia ANY time during this event?	<input type="radio"/> Yes		<input type="radio"/> No/Not Documented
Date/Time of Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia?	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	
Was Defibrillation shock provided for Ventricular Fibrillation (VF) OR Pulseless Ventricular Tachycardia?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	<input type="radio"/> No, Per Advance Directive
Total # of Shocks	_____	<input type="checkbox"/> Unknown/Not Documented	
Date/Time	____/____/____ : ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Not Documented	
Energy (Joules)	_____	<input type="checkbox"/> Not Documented	
<b>Details of Each Shock (maximum of 4):</b>			

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Date/Time		Energy (joules)	
/ /	: <input type="checkbox"/> Not Documented		<input type="checkbox"/> Not Documented
/ /	: <input type="checkbox"/> Not Documented		<input type="checkbox"/> Not Documented
/ /	: <input type="checkbox"/> Not Documented		<input type="checkbox"/> Not Documented
/ /	: <input type="checkbox"/> Not Documented		<input type="checkbox"/> Not Documented

  

Documented reason (s) (patient, medical, hospital related or other) for not providing defibrillation shock for Ventricular Fibrillation (VF) or Pulseless Ventricular Tachycardia (VT) in first two minutes?	<input type="radio"/> Yes	<input type="radio"/> No
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Patient Reason(s):	<input type="checkbox"/> Initial Refusal (e.g. family refused)
Medical Reason(s)	<input type="checkbox"/> ICD in place which shocked patient within first 2 minutes of identification of VF or Pulseless VT <input type="checkbox"/> LVAD or BIVAD in place <input type="checkbox"/> Rhythm change to non-shockable rhythm within 2 minutes of identification of VF or Pulseless VT <input type="checkbox"/> Spontaneous Return of Circulation within first 2 minutes of identification of VF or Pulseless VT
Hospital Related or Other Reason(s)	<input type="checkbox"/> Equipment related delay (e.g., defibrillator not available, pad not attached) <input type="checkbox"/> In-hospital time delay (e.g. code team delays, personnel not familiar with protocol or equipment, unable to locate hospital defibrillator) <input type="checkbox"/> Other → (Please Specify)

  

CPA 4.3 VENTILATION	Initial Condition/Defibrillation/Ventilation Tab		
Types of Ventilation/Airways used	<input type="checkbox"/> None	<input type="checkbox"/> Unknown/Not Documented	
Ventilation/Airways Used (Select all that apply)	<input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Mask and/or Nasal CPAP/BiPAP <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Mouth-to-Mouth	<input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Supraglottic Airway <input type="checkbox"/> Tracheostomy Tube <input type="checkbox"/> Other Non-Invasive Ventilation, Specify	
Was Bag-Valve-Mask ventilation initiated during the event?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Date/Time	____/____/____ ____:____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented
Was any Endotracheal Tube (ET) or Tracheostomy Tube inserted/re-inserted during event?	<input type="radio"/> Yes	<input type="radio"/> No	
Date/Time Endotracheal Tube (ET) or Tracheostomy Tube inserted if not already in place and/or re-inserted during event:	____/____/____ ____:____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented
Method(s) of confirmation used to ensure Endotracheal Tube (ET) or Tracheostomy Tube placement in trachea (check all that apply):	<input type="checkbox"/> Waveform capnography (waveform ETCO2) <input type="checkbox"/> Capnometry (numeric ETCO2) <input type="checkbox"/> Exhaled CO2 colorimetric monitor (ETCO2 by color change) <input type="checkbox"/> Esophageal detection devices	<input type="checkbox"/> Revisualization with direct laryngoscopy <input type="checkbox"/> None of the above <input type="checkbox"/> Not Documented	

  

CPA 5.1 EPINEPHRINE	Other Interventions Tab		
Was IV/IO Epinephrine BOLUS administered?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Date/Time	____/____/____ ____:____ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented
Total Number of Doses	_____		<input type="checkbox"/> Unknown/Not Documented

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If IV/IO Epinephrine was not administered within the first five minutes of the event, was there a documented patient, medical, hospital related or other reason for not providing Epinephrine bolus?		<input type="radio"/> Yes	<input type="radio"/> No
Patient Reason(s)	<input type="checkbox"/> Initial Refusal (e.g. family refused)		
Medical Reason(s)	<input type="checkbox"/> Patient already receiving vasopressor (e.g. Epinephrine) as a continuous IV infusion prior to and during arrest <input type="checkbox"/> Spontaneous Return of Circulation within first 5 minutes of the date/time pulselessness was first identified (or the need for chest compressions was first recognized (pediatric only)) <input type="checkbox"/> Medication allergy		
Hospital Related or Other Reason(s)	<input type="checkbox"/> In-hospital time delay (e.g., delay in locating medication) <input type="checkbox"/> No route to deliver medication (e.g. no IV/IO access) <input type="checkbox"/> Other → (Please Specify)		

### CPA 5.2 OTHER DRUG INTERVENTIONS Other Interventions Tab

Select all either initiated, or if already in place immediately prior to, continued during event.

<input type="checkbox"/> <b>None</b> (select only after careful review of options below) <input type="checkbox"/> <b>Antiarrhythmic medication(s):</b> <input type="checkbox"/> Adenosine/Adenocard <input type="checkbox"/> Amiodarone/Cordarone <input type="checkbox"/> Lidocaine <input type="checkbox"/> Procainamide <input type="checkbox"/> Other antiarrhythmics: _____	<input type="checkbox"/> <b>Vasopressor(s) other than epinephrine bolus:</b> <input type="checkbox"/> Dobutamine <input type="checkbox"/> Dopamine > 3mcg/kg/min <input type="checkbox"/> Epinephrine, IV/IO continuous infusion <input type="checkbox"/> Norepinephrine <input type="checkbox"/> Phenylephrine <input type="checkbox"/> Other Vasopressors: _____	<input type="checkbox"/> Atropine <input type="checkbox"/> Calcium Chloride/Calcium Gluconate <input type="checkbox"/> Dextrose Bolus <input type="checkbox"/> Magnesium Sulfate <input type="checkbox"/> Reversal agent (e.g., naloxone/Narcan, flumazenil/Romazicon, neostigmine/Prostigim) <input type="checkbox"/> Sodium Bicarbonate <input type="checkbox"/> Other Drug Interventions: _____
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### CPA 5.3 NON-DRUG INTERVENTIONS Other Interventions Tab

Select each intervention that was employed during the resuscitation event.

<input type="checkbox"/> None (review options below carefully) <input type="checkbox"/> Cardiopulmonary bypass / extracorporeal CPR (ECPR) <input type="checkbox"/> Chest tube(s) inserted <input type="checkbox"/> Needle thoracostomy	<input type="checkbox"/> Pacemaker, transcutaneous <input type="checkbox"/> Pacemaker, transvenous or epicardial <input type="checkbox"/> Pericardiocentesis <input type="checkbox"/> Other non-drug interventions _____
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### CPA 6.1 EVENT OUTCOME Event Outcome Tab

Was ANY documented return of adequate circulation [ROC] (in the absence of ongoing chest compressions return of adequate pulse/heart rate by palpation, auscultation, Doppler, arterial blood pressure waveform, or documented blood pressure) achieved during the event?		<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time of FIRST adequate return of circulation (ROC):	___/___/___ :___ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	
Reason resuscitation ended	<input type="radio"/> Survived – ROC	<input type="radio"/> Died – Efforts terminated, no sustained ROC	
Date and time sustained ROC <b>lasted &gt; 20 min</b> OR resuscitation efforts were terminated (End of event)	___/___/___ :___ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	

### CPA 6.2 POST-ROC CARE Event Outcome Tab

Highest patient temperatures during first 24 hrs. after ROC: Temperature	<input type="radio"/> _____ C	<input type="radio"/> _____ F	<input type="checkbox"/> Temperature Not Documented		
Site	<input type="radio"/> Axillary <input type="radio"/> Bladder	<input type="radio"/> Blood <input type="radio"/> Brain	<input type="radio"/> Oral <input type="radio"/> Rectal	<input type="radio"/> Surface (skin, temporal) <input type="radio"/> Other	<input type="radio"/> Unknown <input type="radio"/> Tympanic

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Date/Time Recorded:	<u>    </u> / <u>    </u> / <u>    </u> <u>    </u> : <u>    </u> (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
<b>CPA 7.1 CPR QUALITY</b>		<b>CPR Quality Tab</b>
Was performance of CPR monitored or guided using any of the following? (Check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Waveform Capnography/End Tidal CO2 (ETCO2) <input type="checkbox"/> Arterial Wave Form/Diastolic Pressure <input type="checkbox"/> CPR mechanics device (e.g. accelerometer, force transducer, TFI device)	<input type="checkbox"/> CPR Quality Coach <input type="checkbox"/> Metronome <input type="checkbox"/> Other, Specify: _____
<b>If CPR mechanics device (e.g. accelerometer, force transducer, TFI device) used:</b>		
Average Compression Rate	<u>    </u> (Per Minute)	<input type="checkbox"/> Not Documented
Average Compression Depth	<input type="radio"/> <u>    </u> mm <input type="radio"/> <u>    </u> cm <input type="radio"/> <u>    </u> inches	<input type="checkbox"/> Not Documented
Compression Fraction	<u>    </u> (Enter number between 0 and 1)	<input type="checkbox"/> Not Documented
Percent of chest compressions with complete release	<u>    </u> (%)	<input type="checkbox"/> Not Documented
Average Ventilation Rate	<u>    </u> (Per Minute)	<input type="checkbox"/> Not Documented
Longest Pre-shock pause	<u>    </u> (Seconds)	<input type="checkbox"/> Not Documented
Was a team debriefing on the quality of CPR provided completed after the event?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Not Documented
<b>CPA 7.2 RESUSCITATION-RELATED EVENTS AND ISSUES</b>		<b>CPR Quality Tab</b>
<b>OPTIONAL:</b> <input type="checkbox"/> No/Not Documented		
Universal Precautions	<input type="checkbox"/> Not followed by all team members (specify in comments section)	
Documentation	<input type="checkbox"/> Signature of code team leader not on code sheet <input type="checkbox"/> Missing other signatures <input type="checkbox"/> Initial ECG rhythm not documented	<input type="checkbox"/> Medication route(s) not documented <input type="checkbox"/> Incomplete documentation <input type="checkbox"/> Other (specify in comments section)
Alerting Hospital-Wide Resuscitation Response	<input type="checkbox"/> Delay <input type="checkbox"/> Pager Issues	<input type="checkbox"/> Other (specify in comments section)
Airway	<input type="checkbox"/> Aspiration related to provision of airway <input type="checkbox"/> Delay <input type="checkbox"/> Delayed recognition of airway misplacement/displacement <input type="checkbox"/> Intubation attempted, not achieved	<input type="checkbox"/> Multiple intubation attempts → Number of Attempts <u>    </u> <input type="checkbox"/> Unknown/ Not Documented <input type="checkbox"/> Other (specify in comments section)
Vascular Access	<input type="checkbox"/> Delay <input type="checkbox"/> Inadvertent arterial cannulation	<input type="checkbox"/> Infiltration/Disconnection <input type="checkbox"/> Other (specify in comments section)
Chest Compression	<input type="checkbox"/> Delay <input type="checkbox"/> No back board	<input type="checkbox"/> Other (specify in comments section)
Defibrillations	<input type="checkbox"/> Energy level lower/higher than recommended <input type="checkbox"/> Initial delay, personnel not available to operate defibrillator <input type="checkbox"/> Initial delay, issues with defibrillator access to patient	<input type="checkbox"/> Initial delay, issue with paddle placement <input type="checkbox"/> Equipment Malfunction <input type="checkbox"/> Given, not indicated <input type="checkbox"/> Indicated, not given <input type="checkbox"/> Other (specify in comments section)
Medications	<input type="checkbox"/> Delay <input type="checkbox"/> Route <input type="checkbox"/> Dose	<input type="checkbox"/> Selection <input type="checkbox"/> Other (specify in comments section)
Leadership	<input type="checkbox"/> Delay in identifying leader <input type="checkbox"/> Knowledge of equipment <input type="checkbox"/> Knowledge of medications/protocols <input type="checkbox"/> Knowledge of roles	<input type="checkbox"/> Team oversight <input type="checkbox"/> Too many team members <input type="checkbox"/> Other (specify in comments section)

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Protocol Derivation	<input type="checkbox"/> ACLS/PALS	<input type="checkbox"/> NRP	<input type="checkbox"/> Other (specify in comments section)
Equipment	<input type="checkbox"/> Availability	<input type="checkbox"/> Function	<input type="checkbox"/> Other (specify in comments section)
Comments			
Was this cardiac arrest event the patient's index (first) event?	<input type="radio"/> Yes		<input type="radio"/> No

**Comments & Optional Fields:** Do not enter any Personal Health Information/Protected Health Information into this section.

Field 1	Field 2
Field 3	Field 4
Field 5	Field 6
Field 7	Field 8
Field 9	Field 10
Field 11	Field 12
Field 13 ____ / ____ / ____ : ____	Field 14 ____ / ____ / ____ : ____

### MATERNAL IN-HOSPITAL CARDIAC ARREST Research Tab

If Recently delivered or currently pregnant was selected under Pre-existing conditions, please select one of the following:	____ / ____ / ____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Not Documented
<input type="radio"/> Patient recently delivered fetus	If patient recently delivered a fetus, select delivery date: ____ / ____ / ____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Not Documented
<input type="radio"/> Patient is currently pregnant	If patient is currently pregnant, enter EDC/Due Date: ____ / ____ / ____ (MM/DD/YYYY)	<input type="checkbox"/> Not Documented Gestational Age ____
Select Number of Fetuses (Single Select)	<input type="radio"/> Single <input type="radio"/> Multiple	<input type="radio"/> Unknown <input type="radio"/> Not Documented
The patient had the following delivery or pregnancy complications	<input type="checkbox"/> Not Documented <input type="checkbox"/> None <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Cocaine/Crack use <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Diabetes <input type="checkbox"/> Eclampsia <input type="checkbox"/> GHTN (Pregnancy induced/gestational hypertension) <input type="checkbox"/> Hypertensive Disease <input type="checkbox"/> Magnesium Exposure <input type="checkbox"/> Major Trauma	<input type="checkbox"/> Maternal Group B Strep (Positive) <input type="checkbox"/> Maternal Infection <input type="checkbox"/> Methamphetamine/ICE use <input type="checkbox"/> Narcotic given to mother within 4 hours of delivery <input type="checkbox"/> Narcotics addiction and/or on methadone maintenance <input type="checkbox"/> Obstetrical hemorrhage <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Prior Cesarean <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Other (specify) _____
Total # of pregnancies (gravida)	____ (Integer Field)	<input type="checkbox"/> Unknown/Not Documented
Total # of deliveries (parity)	____ (Integer Field)	<input type="checkbox"/> Unknown/Not Documented
Delivery Mode (Single Select):	<input type="radio"/> Vaginal/Spontaneous <input type="radio"/> Vaginal/Operative	<input type="radio"/> VBAC <input type="radio"/> C-Section/Scheduled <input type="radio"/> C-Section/Emergent <input type="radio"/> Unknown/Not Documented
Left Lateral Uterine Displacement:	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown/Not Documented Time recognized ____ : ____	Select Method(s) (select all that apply) <input type="checkbox"/> Manual Uterine Displacement <input type="checkbox"/> Left Lateral Tilt <input type="checkbox"/> Unknown/Not Documented

# Resuscitation Patient Management Tool

## Cardiopulmonary Arrest (CPA) EVENT

January 2021

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Neonatal Outcome (Single Select)	<input type="radio"/> Delivered ( <b>If delivered, enter Apgar Scores</b> ): <input type="checkbox"/> Enter 1 min. Apgar score (integer field range: 0-10) _____ <input type="checkbox"/> Enter 5 min Apgar score (integer field range: 0-10) _____ <input type="checkbox"/> Unknown/Not Documented		<input type="radio"/> Undelivered <input type="radio"/> IUFD (intrauterine fetal death) <input type="radio"/> Viable <input type="radio"/> Unknown/Not Documented
<b>Was a CPA event completed for the newborn?</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown/ Not Documented

**END OF FORM**