Guidelines for Completing the
Get With The Guidelines- Resuscitation (GWTG-R)
Neonatal Event Record

The following is a listing of general guidelines for completion of the GWTG-R Event Record. Individual institutions may choose to require additional information, such as the recording of the patient's actual spontaneous respiratory rate instead of indication only presence with yes/no.

1. The GWTG-R Event record should be completed for any patient, visitor or employee who requires emergency assisted ventilation (mouth to mask, mouth to barrier, bag/valve/mask or invasive airway), defibrillation or chest compressions.

2. Record the patient's name and medical record number and the mother's name and medical record number in the upper right hand corner of the record. The patient's label or the addressograph stamp should also be placed in this section prior to distribution.

3. The top section of the record should be completed immediately after the event.
   a. Birth date - Record the date of delivery
   b. Today's date - Record the date of the event
   c. Time - Record the time of the event
   d. Sex of the infant - Record whether the infant is male or female
   e. APGAR Scores - Record all documented APGAR scores
   f. Weight - Record the infant's weight. This could potentially be the birth weight or an estimated weight from sonogram or by practitioner.
   g. Estimated Gestational Age - Use LMP, sonogram/ultrasound or by exam
   h. Temperature - Record the infant's current immediately following the event
   i. Was a Hospital-wide resuscitation response activated? Indicate if a hospital-wide resuscitation response was activated
   j. Patient Conscious at Onset - Indicate "yes" if the patient was conscious when the need for chest compressions and /or defibrillation was recognized
   k. Area of resuscitation - Record the area in which the resuscitation occurred. Labor & Delivery, NICU (Neonatal ICU), NBN (Newborn Nursery), Emergency Department or Other areas within the hospital are all possibilities.
   l. Indicate all monitors that were present at onset:
      1. ECG – Cardiac monitoring in the form of telemetry (central and/or bedside) monitoring.
      2. Pulse Ox. – Pulse oximeter in the form of telemetry (central and/or bedside) monitoring
      3. Apnea – Apnea/bradycardia monitor in the form of telemetry (central and/or bedside) monitoring
   m. Witnessed: Indicate yes if the patient was directly observed and by someone (can be family, lay bystander, employee or health care professional) at onset of event (differs from monitored).

4. Airway/Ventilation Section - This section can also be completed immediately following the event
   a. Respiratory status at onset - Indicate the patient's respiratory status when the need for emergency assisted ventilation, chest compressions, and/or defibrillation was recognized
      1. Spontaneous – Breathing without mechanical assistance
      2. Apnea – Not breathing spontaneously
      3. Agonal – only agonal respirations present
      4. Assisted – Mechanical ventilation being provided
   b. Type(s) of ventilation:
      1. Bag/Mask – Bag/Mask ventilation provided (do not select if invasive airway was in place throughout event)

2. ET – Endotracheal Tube in place or placed during the event.
3. CPAP – Continuous Positive Airway Pressure in place or placed during this event.
4. LMA – Laryngeal Mask Airway in place or placed during this event.
5. Tracheostomy – Tracheostomy was in place or placed during this event.
6. Other – If "other" is selected, provide the name(s) of the other airways used.

c. Tracheal intubation during resuscitation - If an ET was successfully inserted during this event, enter the time, Number of attempts, tube size, and name of the person who successfully intubated the patient.

d. Confirmation method(s) used - Indicate all that apply:
   1. Auscultation – Indicate if the presence of bilateral breath sounds were auscultated.
   2. Expired CO_2 detector – Indicate if expired CO_2 detector such as capnography or colorimetric was used to confirm placement.
   3. X-ray – results of the x-ray must be prior to the end of the event.
   4. Other – if "other" is selected, specify confirmation method used.

e. Suction – Indicate if the infant was suctioned during the resuscitation by type used:
   1. Bulb – Indicate if a bulb syringe was used.
   2. Catheter – Indicated if a suction catheter was used.
   3. ET/Mec Aspirator – Indicate if the infant was intubated and a meconium aspirator was applied.
   Also, indicate what time this occurred, the size catheter used and what the results were from the procedure.

f. Patient received chest compressions and/or defibrillation during this event - If patient received chest compressions during this event select "yes" or "no".

g. Time initiated - Indicate the time chest compressions or defibrillation was initiated. If the time is not indicated write not documented.

5. Special Circumstances recognized at birth - Select all of the conditions that apply. If "other" is selected, provide the name(s) of the condition(s) noted.

6. Documentation of the Event - Accurate and complete resuscitation efforts will be documented in this section.
   a. Time- The time of each intervention/procedure/assessment will be recorded.
   b. Heart Rate - Indicate the auscultated, palpated or monitored heart rate.
   c. Chest compressions - Indicate with a check mark if chest compressions were started or continued.
   d. Ventilation Rate - If mechanical ventilation is being provided, indicate the rate of administration.
   e. PIP - Indicate the Peak Inspiratory Pressure provided.
   f. PEEP - Indicate the Positive End Expiratory Pressure provided. This will be the box utilized for CPAP.
   g. % Oxygen - Indicate the percent Oxygen delivered. This will include BVM, CPAP or free-flow oxygen administration.
   h. O_2 Sat - Indicate the Oxygen saturation.
   i. Breath Sounds L(left) and R (right) - Indicate the quality and presence of breath sounds bilaterally utilizing the following codes:
      1. **=** = Equal
      2. ↑ = Increased
      3. ↓ = Decreased
      4. **CL** = Clear
      5. **FC** = Fine Crackles
      6. **CC** = Coarse Crackles
   j. Color - Indicate the color utilizing the following codes:
      1. **P** = Pink

2. **B** = Cyanotic/Dusky
3. **W** = Pale
   - k. Cap refill - Indicate the time of Capillary Refill in seconds.
   - l. Boluses – All drugs administered, as a bolus should be documented with the dose and route. Any drug not listed but administered should be recorded in the available blank slots with dose and route documented.
   - m. Infusions – All continuous infusions should be documented when started with the rate(cc)per hour. The concentration of the infusion should be recorded under the drug name. Any infusion not listed but administered should be recorded in the available blank slots with the rate (cc) per hour and the concentration documented.
   - n. Comments – The comment section should be used to document any procedures, interventions, observations, lab results as well as the patient's response to procedures or interventions.
7. Event Outcome – This section will be completed immediately following the event.
   - a. Code event start time – Record the time the event was recognized.
   - b. Code event end time – Record the time of the return of circulation (>20 min.), efforts terminated, medical futility, advance directives, or restrictions by family.
   - c. Total duration of chest compressions – Record the total duration of chest compressions throughout the event.
   - d. Reason resuscitation ended – Select the reason that the resuscitation event ended from the list below:
     1. Restoration of circulation (ROC) – Return of spontaneous pulse with good perfusion that was sustained for >20 minutes.
     2. Efforts terminated, No sustained ROC (Died) – The patient did not respond to Advanced Life Support, unable to achieve sustained ROC
     3. Medical Futility – Advanced life support was terminated because of medical futility, e.g. organ failure
     4. Advanced Directives – There was an advanced directive (e.g. advanced directive of limited advanced life support.
     5. Restrictions by family – there were restriction placed by the family of the patient.

8. Signatures – The recorder, ICU/Code Team Nurse and Practitioner must sign or print name in the designated place.
9. Page___of___ - Record the page number and the total number of pages utilized for the event in the bottom left of the record.
10. Distribution – The original record will be placed in the patient's medical record. Other copies should be distributed as indicated on the right side of the record.