

**Resuscitation Patient Management Tool**  
**CPA Event Newly Born Delivery Event CRF**

January 2021

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<b>OPTIONAL:</b> Local Event ID:	_____	
Neonatal Delivery Event?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented (Does NOT meet inclusion criteria)
Did pt. 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:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
System Entry Date	____/____/____ : ____ (MM/DD/YYYY HH:MM)	

**CPA 2.3 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"/> None	
<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"/> 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	
Monitoring	<input type="checkbox"/> ECG	<input type="checkbox"/> Pulse Oximetry
Vascular Access	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
If Vascular Access in place, type:	<input type="checkbox"/> Umbilical Venous Catheter	<input type="checkbox"/> Peripheral IV
Any Vasoactive Agent in place?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented

**CPA 3.1 EVENT** **Event Tab**

Date/Time of Birth	____/____/____ : ____ (MM/DD/YYYY HH:MM)				
Age at Event	____ Age in:	<input type="radio"/> Years <input type="radio"/> Month s	<input type="radio"/> Week s <input type="radio"/> Days	<input type="radio"/> Hours <input type="radio"/> Minutes	<input type="checkbox"/> Estimated? <input type="checkbox"/> Age Unknown/Not Documented
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"/> Medical-Noncardiac <input type="radio"/> Surgical-Cardiac <input type="radio"/> Surgical-Noncardiac			<input type="radio"/> Obstetric <input type="radio"/> Trauma <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 Cardiac Intensive Care <input type="radio"/> Pediatric ICU (PICU) <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
If team activated, date/time of resuscitation team arrival:	___/___/___ :___		<input type="checkbox"/> Time Not Documented
<b>CPA 4.1 INITIAL CONDITION</b>		<b>Initial Condition/Defibrillation/Ventilation Tab</b>	
Did patient have a detectable Heart Rate?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
If there is a detectable heart rate, what was the heart rate?	<input type="radio"/> ≥ 60 BPM	<input type="radio"/> <60BP M	<input type="radio"/> Heart Rate Not Documented
First documented monitored rhythm:	<input type="radio"/> Bradycardia <input type="radio"/> Asystole	<input type="radio"/> Pulseless Electrical Activity (PEA) <input type="radio"/> Other	<input type="radio"/> Unknown – not placed on cardiac monitor <input type="radio"/> Not Documented
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 used (check all that apply):	<input type="checkbox"/> Two Thumb encircling hands	<input type="checkbox"/> Two Finger Technique	<input type="checkbox"/> Not Documented
Compression to ventilation ratio used (check all that apply):	<input type="checkbox"/> 3:1	<input type="checkbox"/> 15:2	<input type="checkbox"/> Asynchronous <input type="checkbox"/> Not Documented
Date/Time compressions started:	___/___/___ :___ (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented
<b>CPA 4.3 VENTILATION</b>		<b>Initial Condition/Defibrillation/Ventilation Tab</b>	
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
If Yes, enter Date and Time	___/___/___ :___		<input type="checkbox"/> Time Not Documented
Was Laryngeal Mask Airway (LMA) inserted/re-inserted initiated during the event?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
If Yes, enter Date and Time	___/___/___ :___		<input type="checkbox"/> Time Not Documented
Was any Endotracheal Tube (ET) or Tracheostomy Tube inserted/re-inserted during event?	Yes	No	<input type="radio"/> Not Documented
If Yes, enter Date and Time	___/___/___ :___		<input type="checkbox"/> Time Not Documented
Was any Pulse Oximetry initiated during the event?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
If Yes, enter Date and Time	___/___/___ :___		<input type="checkbox"/> Time Not Documented
Method(s) of confirmation used to ensure correct placement of Endotracheal Tube (ET) or Tracheostomy Tube (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 Services <input type="checkbox"/> Revisualization with direct Laryngoscopy <input type="checkbox"/> None of the above <input type="checkbox"/> Not Documented	
<b>CPA 5.1 EPINEPHRINE</b>		<b>Other Interventions Tab</b>	
Was any Epinephrine BOLUS administered?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented

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Date/Time	____/____/____ : ____	<input type="checkbox"/> Time Not Documented
Dose	_____	<input type="checkbox"/> Not Documented
Delivered via:	<input type="checkbox"/> Intravascular <input type="checkbox"/> Peripheral <input type="checkbox"/> Umbilical Venous Catheter <input type="checkbox"/> Intraosseous (IO)	<input type="checkbox"/> Endotracheal/Tracheostomy Tube <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown/Not Documented

**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"/> None (select only after careful review of options below)	<input type="checkbox"/> Fluid bolus for volume expansion <input type="checkbox"/> Albumin <input type="checkbox"/> Lactate Ringers <input type="checkbox"/> Normal Saline <input type="checkbox"/> O-negative Blood	<input type="checkbox"/> Reversal agent (e.g., naloxone/Narcan, flumazenil/Romazicon, neostigmine/Prostigim) <input type="checkbox"/> Sodium Bicarbonate <input type="checkbox"/> Other Drug Interventions:
<input type="checkbox"/> Atropine		

**CPA 5.3 OTHER 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"/> Paracentesis
<input type="checkbox"/> Chest tube(s) inserted	<input type="checkbox"/> Pericardiocentesis
<input type="checkbox"/> Needle thoracostomy	<input type="checkbox"/> Other non-drug interventions _____

**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
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Date/Time of FIRST adequate return of circulation (ROC):	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
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Reason resuscitation ended	<input type="radio"/> Survived – ROC	<input type="radio"/> Died – Efforts terminated, no sustained ROC
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Date and time sustained ROC <b>lasting &gt; 20 min</b> OR resuscitation efforts were terminated (End of event)	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
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**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
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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:	____/____/____ : ____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
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**CPA 7.2 RESUSCITATION-RELATED EVENTS AND ISSUES** **CPR Quality Tab**

**OPTIONAL:**

Events and Issues	<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"/> 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 Issue(s) <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"/> Multiple intubation attempts → Number of Attempts _____ <input type="checkbox"/> Unknown/ Not Documented

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	<input type="checkbox"/> Delayed recognition of airway misplacement/displacement <input type="checkbox"/> Intubation attempted, not achieved	<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)
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)
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		

**END OF FORM**