

Cardiac Arrest and Cardiopulmonary Resuscitation Outcome Reports

Update and Simplification of the Utstein Templates for Resuscitation Registries

A Statement for Healthcare Professionals From a Task Force of the International Liaison Committee on Resuscitation (American Heart Association, European Resuscitation Council, Australian Resuscitation Council, New Zealand Resuscitation Council, Heart and Stroke Foundation of Canada, InterAmerican Heart Foundation, Resuscitation Councils of Southern Africa)

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Abstract—Outcome after cardiac arrest and cardiopulmonary resuscitation is dependent on critical interventions, particularly early defibrillation, effective chest compressions, and advanced life support. Utstein-style definitions and reporting templates have been used extensively in published studies of cardiac arrest, which has led to greater understanding of the elements of resuscitation practice and progress toward international consensus on science and resuscitation guidelines. Despite the development of Utstein templates to standardize research reports of cardiac arrest, international registries have yet to be developed. In April 2002, a task force of the International Liaison Committee on Resuscitation (ILCOR) met in Melbourne, Australia, to review worldwide experience with the Utstein definitions and reporting templates. The task force revised the core reporting template and definitions by consensus. Care was taken to build on previous definitions, changing data elements and operational definitions only on the basis of published data and experience derived from those registries that have used Utstein-style reporting. Attention was focused on decreasing the complexity of the existing templates and addressing logistical difficulties in collecting specific core and supplementary (ie, essential and desirable) data elements recommended by previous Utstein consensus conferences. Inconsistencies in terminology between in-hospital and out-of-hospital Utstein templates were also addressed. The task force produced a reporting tool for essential data that can be used for both quality improvement (registries) and research reports and that should be applicable to both adults and children. The revised and simplified template includes practical and succinct

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operational definitions. It is anticipated that the revised template will enable better and more accurate completion of all reports of cardiac arrest and resuscitation attempts. Problems with data definition, collection, linkage, confidentiality, management, and registry implementation are acknowledged and potential solutions offered. Uniform collection and tracking of registry data should enable better continuous quality improvement within every hospital, emergency medical services system, and community. (*Circulation*. 2004;110:3385-3397.)

Key Words: AHA Scientific Statements ■ cardiopulmonary resuscitation ■ heart arrest ■ defibrillation ■ registries

The outcome of cardiac arrest and cardiopulmonary resuscitation (CPR) is dependent on critical interventions, particularly early defibrillation, effective chest compressions, and assisted ventilation. Despite considerable efforts to improve the treatment of cardiac arrest, most reported survival outcome figures are poor. If patient outcomes are to improve, then evaluation of the contribution of all of the potential risk factors and interventions is essential. Such evaluation has been hindered by the lack of accurate data on structure, process, and outcome of care, in part because of the lack of uniformity in defining and reporting results.

To improve this situation, the International Resuscitation Council Task Forces, now known as the International Liaison Committee on Resuscitation (ILCOR), published a series of guidelines for uniform reporting of adult out-of-hospital, pediatric, and adult in-hospital resuscitation and resuscitation education and animal research.¹⁻⁴ Utstein-style guidelines and templates also were prepared for reporting resuscitation outcomes after trauma and drowning.^{5,6}

The Utstein-style definitions and reporting templates have been used extensively in published outcome studies of cardiac arrest. The use of these tools has contributed to a greater understanding of the elements of resuscitation practice and has facilitated progress toward an international consensus on science and resuscitation guidelines.

Although the Utstein-style reporting template has many benefits, it also has several limitations. Fredriksson and colleagues⁷ recently reviewed published studies on outcomes after cardiac arrest that reported the use of Utstein-style templates. Many of these studies identified the complexity of the existing templates and logistical difficulties in collecting some of the recommended core and supplementary data elements. For example, it is difficult for rescuers to estimate and record specific intervals accurately during the resuscitation event. It is often not possible to ascertain elements such as time of collapse for unwitnessed arrests and survival outcomes at 6 months or 1 year after hospital discharge. Furthermore, inconsistencies in terminology between in-hospital and out-of-hospital Utstein templates prevent the adequate integration and comparison of individual research studies. In addition, the most recent international guidelines for resuscitation recommended important changes in the practice of resuscitation, some of which affect the validity of the existing Utstein definitions. Two examples of changes in practice that necessitate revision of the Utstein templates are the removal of the pulse check by non-healthcare providers as a criterion for defining cardiac arrest and the provision for attempted defibrillation by bystanders.⁸

In April 2002, an ILCOR task force met in Melbourne, Australia, to review and revise the Utstein definitions and reporting templates. To identify potential changes to data elements, the task force reviewed published data and experience from cardiac arrest registries that have used Utstein-style reporting templates. The task force used a modified Delphi methodology established by previous Utstein-style conferences to review data and achieve consensus on the following elements:

- Data registries
- Utstein templates
- Operational definitions
- Time issues
- Report elements and format
- Data linkage
- Data access, management, and confidentiality issues
- Registry implementation issues

Data on cardiac arrest outcomes are generally collected and reported in 2 different formats: a registry, which is used for quality improvement, and a research report, which examines specific interventions and outcomes. The objective of the task force was to develop a single, simple, and practical template for uniform collection and reporting of data on cardiac arrest. Uniform collection and tracking of data facilitate better continuous quality improvement within hospitals, emergency medical services (EMS) systems, and communities. They also enable comparisons across systems for clinical benchmarking to identify opportunities for improvement. The revised template includes practical and succinct operational definitions that synthesize what has been learned from the previous Utstein reporting guidelines and existing cardiac arrest registries. The revised template should lead to better and more accurate reporting of cardiac arrests and resuscitation attempts. The revised template will be suitable for recording resuscitation attempts in both adults and children.

Utstein Definitions

The authors of the 1991 Utstein publication wrote that “the nomenclature of cardiac arrest presents a classic problem in semantics,” and added that “the Utstein definitions and recommendations attempt to solve this problem by presenting consensus definitions.”¹ The task force reviewed the current definitions and updated them when appropriate to address challenges encountered with the use of these definitions and to conform with the recommendations of the *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care—An International Consensus on Science*.⁸ The definitions that were satisfactory and consistent with current practice were not changed. Following are definitions of the 29 core data elements as agreed on by consensus.

Arrest, Witnessed

A witnessed cardiac arrest is one that is seen or heard by another person or an arrest that is monitored.

Assisted Ventilation

Assisted ventilation is the act of inflating a patient's lungs by rescue breathing with or without a bag-mask device or any other mechanical device.

Attempted Defibrillation

Defibrillation can be attempted by means of an automated external defibrillator (AED), a semiautomated external defibrillator, an implantable cardioverter-defibrillator (ICD), or a manual defibrillator. The type of device used is not considered a core data element.

Bystander CPR

Bystander CPR is CPR performed by a person who is not responding as part of an organized emergency response system approach to a cardiac arrest. Physicians, nurses, and paramedics may be described as performing bystander CPR if they are not part of the emergency response system involved in the victim's resuscitation.

Cardiac Arrest

Cardiac arrest is the cessation of cardiac mechanical activity as confirmed by the absence of signs of circulation. If an EMS provider or physician did not witness the cardiac arrest, then the professional may be uncertain as to whether a cardiac arrest actually occurred.

Cause of Arrest (Etiology)

An arrest is presumed to be of cardiac etiology unless it is known or likely to have been caused by trauma, submersion, drug overdose, asphyxia, exsanguination, or any other non-cardiac cause as best determined by rescuers.

Chest Compressions

Chest compressions are performed by an individual or a mechanical device during CPR in an attempt to restore spontaneous circulation.

Cardiopulmonary Resuscitation

CPR is an attempt to restore spontaneous circulation by performing chest compressions with or without ventilations.

Date of Arrest

The date of arrest is the date the event was known to occur or the date on which a patient was found. This date should be recorded in a conventional format that is consistent for the region (eg, YYYY, MM, DD; DD, MM, YYYY; or MM, DD, YYYY).

Date of Birth/Age

If a patient's date of birth is known, it should be recorded in an acceptable format. If the date of birth is not known but the patient's age is known, then the age should be recorded. If the patient's age is not known, his or her age should be estimated and recorded.

Date of Discharge/Death

The date of discharge or death is the date on which the patient was discharged from the acute hospital or was certified dead. It should be recorded in an acceptable format.

Defibrillation Attempt Before EMS Arrival

When a bystander attempts defibrillation (eg, public access or layperson rescuer defibrillation), it is recorded as a defibrillation attempt before EMS arrival. AEDs are increasingly being made available to the public. In patients with an ICD, a shockable rhythm is likely to have triggered ≥ 1 shock by the device before the arrival of EMS personnel. This shock can be confirmed by analyzing the ICD memory. After extensive discussion, the task force agreed that defibrillation attempts via ICDs are important but difficult for EMS to track. Thus, ICD documentation is optional.

Drugs

The term "drugs" refers to the delivery of any medication (by intravenous cannula, intraosseous needle, or tracheal tube) during the resuscitation event.

Emergency Medical Services

EMS personnel respond to a medical emergency in an official capacity as part of an organized medical response team. By this definition, physicians, nurses, or paramedics who witness a cardiac arrest and initiate CPR but are not part of the organized rescue team are characterized as bystanders and are not part of the EMS system.

End of Event

A resuscitation event is deemed to have ended when death is declared or spontaneous circulation is restored and sustained for 20 minutes or longer. If extracorporeal life support is being provided, then the end of event is 20 minutes after extracorporeal circulation has been established.

First Monitored Rhythm

The first monitored rhythm is the first cardiac rhythm present when a monitor or defibrillator is attached to a patient after a cardiac arrest. If the AED does not have a rhythm display, then it may be possible to determine the first monitored rhythm from a data storage card, hard drive, or other device used by the AED to record data. If the AED has no data-recording device, then the first monitored rhythm should be classified simply as shockable or nonshockable. This data point can be updated later if the AED has data download capability.

Location of Arrest

Location of arrest is the specific location where the event occurred or the patient was found. Knowledge of where cardiac arrests occur may help a community to determine how it can optimize its resources to reduce response intervals. A basic list of predefined locations will facilitate comparisons. Local factors such as the following may make the creation of subcategories useful:

- Place of residence (eg, home, apartment, back yard of a home)

- Public place (eg, street, city park, shopping center, sports stadium, entertainment center, airport, railway station, church, beach, office building)
- Other (eg, hotel room, private office, long-term care facility)

Neurological Outcome at Discharge From Hospital

Documentation of a patient's neurological status at many specific points is desirable (eg, on discharge from the hospital, at 6 months, at 1 year); however, recording neurological outcomes after discharge has been difficult. Survival without higher neurological function is suboptimal; therefore, it is important to attempt to assess neurological outcome at discharge. A simple validated neurological score such as the Cerebral Performance Category (CPC) should be recorded, if available.⁹

Patient Identifier

A patient identifier is a unique numeric or alphanumeric sequence that identifies a specific patient and cardiac arrest event. Ideally, the patient identifier should stay with the patient from the resuscitation event to hospital discharge (recovery or death). Unfortunately, few systems have the ability to link individual patient care records for the out-of-hospital, in-hospital, and postdischarge phases of the event.

Resuscitation

A resuscitation attempt is defined as the act of attempting to maintain or restore life by establishing or maintaining airway (or both), breathing, and circulation through CPR, defibrillation, and other related emergency care techniques.

Resuscitation Attempt by EMS Personnel

When EMS personnel perform CPR or attempt defibrillation, it is recorded as a resuscitation attempt by EMS personnel.

Resuscitation Not Attempted by EMS Personnel

EMS personnel may not attempt resuscitation when a do-not-attempt-resuscitation (DNAR) order exists, a resuscitation attempt is considered futile, or resuscitation is not required (eg, the patient shows signs of circulation).

Return of Spontaneous Circulation

Signs of the return of spontaneous circulation (ROSC) include breathing (more than an occasional gasp), coughing, or movement. For healthcare personnel, signs of ROSC also may include evidence of a palpable pulse or a measurable blood pressure. For the purposes of the Utstein registry template, "successful resuscitation" or ROSC is defined for all rhythms as the restoration of a spontaneous perfusing rhythm that results in more than an occasional gasp, fleeting palpated pulse, or arterial waveform. Assisted circulation (eg, extracorporeal support such as extracorporeal membrane oxygenation or a biventricular assist device) should not be considered ROSC until "patient-generated" (ie, spontaneous) circulation is established. Previous reports that focused on outcomes from

ventricular fibrillation have variably defined "successful defibrillation" as the termination of fibrillation to any rhythm (including asystole) and the termination of fibrillation to an organized electrical rhythm at 5 seconds after defibrillation (including pulseless electrical activity [PEA]). Neither of these definitions of successful defibrillation would qualify as ROSC unless accompanied by evidence of restored circulation. By consensus, the phrase "any ROSC" is intended to represent a brief (approximately >30 seconds) restoration of spontaneous circulation that provides evidence of more than an occasional gasp, occasional fleeting palpable pulse, or arterial waveform. The time at which ROSC is achieved is a core data element.

Sex

Sex (male or female) may be an important risk factor for cardiac arrest and resuscitation interventions.

Shockable/Nonshockable Rhythm

Shockable/nonshockable rhythm refers to the first monitored rhythm, which when analyzed by the person interpreting the monitor/defibrillator or an AED, was found to be treatable by attempted defibrillation (ie, shockable or nonshockable). In general, shockable cardiac arrest rhythms are further divided into ventricular fibrillation and pulseless ventricular tachycardia. Nonshockable cardiac arrest rhythms can be categorized as either asystole or PEA. Although a specific definition of asystole is desirable, no consensus agreement was reached on either a specific duration (eg, 30 seconds) or heart rate (eg, <5 bpm) to define asystole versus bradycardia/PEA. In future iterations of the registry document, further consideration and additional research resources may need to be devoted to addressing the importance and ability of providers to differentiate between these initial cardiac rhythms.

Successful CPR Before EMS Arrival

Occasionally when a bystander witnesses a cardiac arrest and starts CPR, the patient will regain signs of circulation by the time EMS personnel arrive. If the bystander verifies that the patient had no signs of circulation and that CPR was performed, a registry record should be initiated. EMS personnel do not need to verify that a cardiac arrest occurred for this case to be included in the registry.

Survived Event

"Survived event" for the out-of-hospital setting means sustained ROSC with spontaneous circulation until admission and transfer of care to the medical staff at the receiving hospital. For the in-hospital setting, survived event means sustained ROSC for >20 minutes (or the return of circulation if extracorporeal circulatory support is applied).

Survival to Hospital Discharge

Survival to hospital discharge is the point at which the patient is discharged from the hospital's acute care unit regardless of neurological status, outcome, or destination.

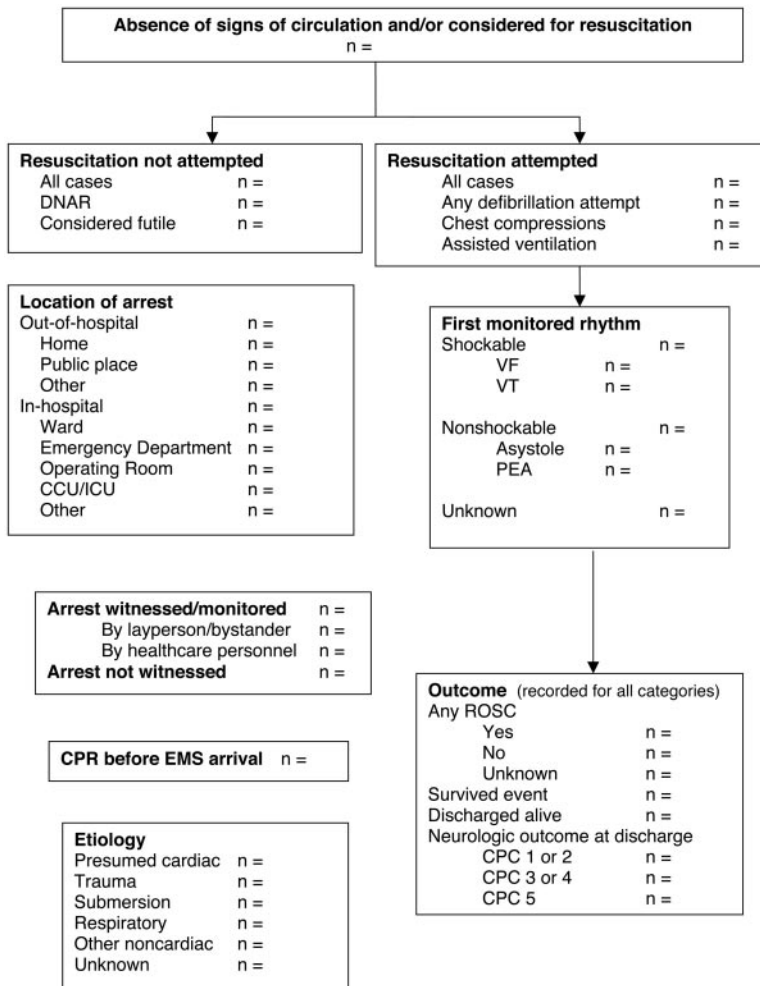


Figure 1. Utstein reporting template for core data elements. ED indicates emergency department; OR, operating room; CCU/ICU, critical care unit/intensive care unit; and PEA, pulseless electrical activity. Other abbreviations as in text.

Ideally, this should indicate survival to discharge from acute hospital care, including a possible rehabilitation period in a local hospital before long-term care, home care, or death.

Sustained ROSC

Sustained ROSC is deemed to have occurred when chest compressions are not required for 20 consecutive minutes and signs of circulation persist (or sustained ROSC if extracorporeal circulatory support is applied). Thus, after resuscitation from in-hospital cardiac arrest, sustained ROSC and survived event have the same definition.

Utstein Reporting Templates

The 1991 out-of-hospital and the 1997 in-hospital Utstein templates were comprehensive documents that were targeted mainly to the research community.^{1,2} The definitions in these documents have helped to standardize resuscitation terminology, although the capture of numerous data items is difficult for many individuals and institutions.

The task force discussed problems with the collection of resuscitation data extensively and assessed the usefulness of collecting data elements that were deemed important because of their potential impact on outcome but were difficult to collect or their accuracy was questionable (eg,

time of collapse). Of equal concern were data items deemed to have relatively little direct impact on outcome and yet were reliable and easy to collect (eg, time at which the EMS vehicle stopped).

The previous adult Utstein templates focused on witnessed ventricular fibrillation (VF) arrests. One reason to focus on witnessed VF was to provide a suitable comparator for judging the success of systems nationally and internationally. Unfortunately, a large and growing proportion of out-of-hospital arrests and the majority of in-hospital arrests present with a non-VF rhythm.^{10,11} The Utstein experts agreed that the revised template should include all initial cardiac arrest rhythms but retain the ability to analyze the witnessed VF subgroup for comparing systems. The 1991 Utstein document divided data into core and supplementary items, whereas the 1997 templates used slightly different terminology: essential and desirable. The revised Utstein template emphasizes only core data elements for registry use (Figure 1). The changes between earlier and revised Utstein templates are summarized in the Table.

Consensus Recommendation

Data should be classified as core or supplementary. Core data are the absolute minimum data required for continual

Utstein Data Templates: Summary of Changes

	1991 Name	2004 Name	2004 Definition	1991 Status	2004 Status
1.	Population served by EMS system	Removed	Total population of service area of EMS system	Core	Supplementary
2.	Confirmed cardiac arrests considered for resuscitation	Absence of signs of circulation and/or considered for resuscitation	Number of cardiac arrests defined by absence of signs of circulation	Core	Core
3.	Resuscitations not attempted	Unchanged	Total number of cardiac arrests in which resuscitation was not attempted and number of arrests in which resuscitation was not attempted because: <ul style="list-style-type: none"> • DNAR order was present • Attempt was considered futile (or meaningless) • Signs of circulation were present 	Core (total not attempted) None (DNAR and futile status)	Core
4.	Resuscitations attempted	Unchanged	Total number of resuscitations attempted and number of these resuscitations that included <ul style="list-style-type: none"> • Any defibrillation attempt • Chest compressions • Ventilations 	Core (total attempted) None (defibrillation, chest compressions, and ventilations)	Core
5.	Cardiac etiology	Etiology	Number of resuscitations in which etiology of arrest was <ul style="list-style-type: none"> • Presumed cardiac • Trauma • Submersion • Respiratory • Other noncardiac • Unknown 	Core	Core
6.	Noncardiac etiology	Merged with Etiology	See Etiology	Core	See Etiology
		Arrest witnessed/monitored	Total number of resuscitation attempts and number of arrests witnessed by <ul style="list-style-type: none"> • Laypersons • Healthcare providers 	None	Core
7.	Arrest witnessed by bystanders	See Arrest witnessed/monitored	Number of resuscitation attempts in which arrest was witnessed by laypersons	Core	Core
8.	Arrest not witnessed	See Arrest witnessed/monitored	Number of resuscitation attempts in which arrest was not witnessed by anyone	Core	Core
9.	Arrest witnessed by EMS personnel	See Arrest witnessed/monitored	Number of resuscitation attempts in which arrest was witnessed by healthcare personnel	Core	Core
		First monitored rhythm shockable	Total number of resuscitation attempts in which first monitored rhythm was shockable and identified as <ul style="list-style-type: none"> • VF • VT • Unknown AED-shockable rhythm 	None	Core
10.	Initial rhythm VF	See Monitored rhythm shockable	Number of resuscitation attempts in which first monitored rhythm after arrest was VF	Core	Core
11.	Initial rhythm VT	See Monitored rhythm shockable	Number of resuscitation attempts in which first monitored rhythm after arrest was VT	Core	Core
		First monitored rhythm nonshockable	Total number of resuscitation attempts in which first monitored rhythm was nonshockable and rhythm was identified as <ul style="list-style-type: none"> • Asystole • PEA • Bradycardia • Other • Unknown AED-nonshockable rhythm 	None	Core

Continued

	1991 Name	2004 Name	2004 Definition	1991 Status	2004 Status
12.	Initial rhythm asystole	See First monitored rhythm nonshockable	Number of resuscitation attempts in first monitored rhythm after arrest was asystole	Core	Core
13.	Other initial rhythms	See First monitored rhythm nonshockable	Number of resuscitation attempts in which first monitored rhythm after arrest was unshockable	Core	Core
14.	Determine presence of bystander CPR: yes or no for each subset	CPR before EMS	Number of resuscitation attempts in which CPR (chest compression) was performed before EMS arrival	Core	Core
		Rhythm analysis or defibrillation before EMS	Number of resuscitation attempts in which either AED rhythm analysis or defibrillation was performed before EMS arrival	None	Core
15.	Any ROSC	Any ROSC	Number of resuscitation attempts in which any ROSC was present: • Yes • No • Unknown	Core	Core
16.	Never achieved ROSC	See Any ROSC	See Any ROSC	Core	See Any ROSC
17a.	Efforts stopped: patient died en route to hospital	Removed	Number of resuscitation attempts in which all resuscitative efforts were discontinued and patient died before arriving at hospital	Core	Supplementary
17b.	Efforts stopped: patient died in ED	Removed	Number of resuscitation attempts in which all resuscitative efforts were discontinued and patient died in ED	Core	Supplementary
18.	Admitted to ICU/ward	Survived event to ED/ICU	Number of resuscitation attempts in which patient regained signs of circulation and was admitted to ED or ICU	Core	Core
19a.	Died in-hospital total	Removed	Number of resuscitation attempts in which patient regained signs of circulation and was admitted to ED/ICU but died in hospital	Core	Supplementary
19b.	Died in hospital within 24 h	Removed	Number of resuscitation attempts in which patient regained signs of circulation and was admitted to ED/ICU but died in hospital within 24 h	Core	Supplementary
20.	Discharged alive	Unchanged	Number of resuscitation attempts in which patient regained signs of circulation, was admitted to ED/ICU, and was discharged from hospital alive	Core	Core
21.	Died within 1 year after hospital discharge	Removed	Number of resuscitation attempts in which patient regained signs of circulation, was discharged alive from hospital but died within 1 year after hospital discharge	Core	Supplementary
22.	Alive at 1 year	Removed	Number of resuscitation attempts in which patient regained signs of circulation, was discharged alive from hospital, and was alive at 1 year after hospital discharge	Core	Supplementary
		Neurological outcome at discharge	Number of resuscitation attempts in which patient regained signs of circulation, was discharged alive from hospital, and had CPC score of • 1 or 2 • 3 or 4 or unknown	None	Core
		Location of arrest: out of hospital	Total number of resuscitations that took place out of hospital and number of resuscitation attempts that took place within • Home/residence • Industrial/workplace • Sport/recreation event • Street/highway • Public building • Assisted living/long-term care facility • Educational institution • Other • Unspecified/unknown	None	Core (EMS only)
		Location of arrest: in hospital	Total number of resuscitation attempts that took place in hospital and number of resuscitation attempts that took place within • Ward • Emergency Department • Operation Room • Intensive or Coronary Care Unit • Other • Unknown	None	Core (hospital only)

Cardiac Arrest Data Collection Form

Date of arrest YYYY/MM/DD

Patient identifier (first name, last name, or ID number)

Sex

Age years (estimated) **OR** Date of birth YYYY/MM/DD

Cardiac arrest determined by

Cause of arrest

Treatment before EMS arrival

Bystander CPR
Defibrillation by bystander <input type="checkbox"/> or implanted defibrillator <input type="checkbox"/>

Resuscitation attempted by EMS

Location of arrest out of hospital in hospital

Witnessed If witnessed, time of arrest HH:MM

Initial rhythm

Chest compressions

Defibrillation attempt

Ventilation Drugs

Time of collapse HH:MM (estimated)

Time of call receipt HH:MM

Time vehicle stopped HH:MM

Time of first rhythm analysis HH:MM

Spontaneous circulation (on arrival in ED)

Hospital admission

Hospital discharge

Date of hospital discharge (or death) YYYY/MM/DD

Neurologic status at discharge (CPC)

Figure 2. Revised Utstein cardiac arrest data collection form.

quality improvement. These data form the data set for CPR registries at local, state/provincial, national, and international levels. They should be relatively easy to collect and reliable and include patient, event (process), and outcome data. Collection of these data elements should be sufficient to enable comparisons of process and outcomes among different institutions and countries. Supplementary data are required for resuscitation research. The standardized definitions enable comparative analysis between resuscitation studies. The task force agreed that a single data collection form should be used for both out-of-hospital and in-hospital cardiac arrest; an example is given in Figure 2.

Dates, Time Points, and Intervals

The 2 most important intervals affecting patient survival are the collapse-to-first CPR attempt interval and collapse-to-first defibrillatory shock interval.^{12–18} In the original Utstein document, many other time points and intervals

were recommended as core items for research and quality assurance purposes. Several of these time elements were included because of their known association with outcomes; others were included because they are relatively easy to document accurately and may be useful for quality assurance. These other times include when the emergency vehicle stops at the scene, the resuscitation team arrives at the patient's side, intravenous access is obtained, medications are given, and sustained ROSC is first attained.

The use of these clearly defined resuscitation intervals has improved resuscitation research as well as hospital and EMS quality assurance programs; however, few epidemiological studies and even fewer EMS and hospital systems have included the entire recommended list of core time elements. The supplementary list is used rarely. Time points such as estimated time of collapse when the arrest was not witnessed are impossible to obtain, and others are inherently unclear, such as when the hospital resuscitation team arrives (members arrive at different times).

Clock inaccuracy and lack of clock synchronization continue to be a problem. To minimize timing errors, the task force recommends that one clock (or one synchronized to the initial clock) be used to determine all times throughout the resuscitation attempt. It is more important to record intervals than specific times accurately.

The goal of the task force was to distinguish the time points and intervals that constitute core elements from those that represent supplementary data elements. Comparison of these elements enables comparison among research investigations and quality assurance programs. The following sections name the recommended time point/intervals to be collected and recorded in an acceptable format (HH:MM or similar).

Recommended Core Time Events to Be Recorded

Date of Death

The date of death should be recorded in a conventional format.

Time of Witnessed/Monitored Arrest

An arrest is witnessed if the collapse was seen (or heard) by an identifiable witness and monitored if a medical professional or electronic monitoring device detects and documents apparent cardiac arrest or the potential need for resuscitation.

Time When Call Received

The time that the first EMS operator was contacted should be listed as the time that the call was received. In the hospital the comparable time is when the resuscitation team is called after initial determination of the potential need for resuscitation. In some hospital settings (eg, intensive care unit, emergency department, operating room), this time may be when the bedside practitioner notes an arrest or the potential need for resuscitation and shouts for help. In other hospital settings, it may be when a nurse, ward clerk, or physician calls the operator to notify the cardiac arrest team. If a resuscitation team is called to evaluate a critically ill patient before an arrest or the need for resuscitation and the patient has an arrest in the presence of the team, then the time of call receipt is the same as the time of witnessed collapse/arrest.

Time of First Rhythm Analysis/Assessment of Need for CPR

This time is defined as when (1) cardiac rhythm is analyzed for a shockable rhythm or when (2) a provider clinically assesses the need for CPR (eg, no signs of circulation in the setting of a respiratory arrest or drowning). Under most circumstances this is the time when an AED or other defibrillator is attached to the patient and turned on. For in-hospital patients undergoing continuous ECG monitoring, this is the time when a provider attempts to interpret the ECG for evidence of a shockable rhythm.

Several reasons exist for adding this element to the previous core element of time to defibrillation. Evidence is accumulating that for prolonged VF, rhythm analysis and CPR before defibrillation may be preferable to immediate defibrillation.^{19,20} Moreover, many patients in cardiac

arrest or in need of CPR are not in VF. Under each circumstance, time of first rhythm analysis/assessment of CPR need is more meaningful than time to defibrillation.

Time of First CPR Attempts

The time of first CPR attempts (ie, chest compressions or defibrillation attempts) should be recorded both for bystander-initiated CPR and CPR initiated by EMS personnel/healthcare providers.

Time of First Defibrillation Attempt If Shockable Rhythm

This time should be recorded in real time when the first shock is delivered. The best way to obtain this information is through an AED or conventional defibrillator with automated event documentation. These devices provide precise details about initial rhythm, times, and responses of heart rhythm to therapy. In the hospital, the time interval from collapse/arrest to first defibrillation attempt may be the most important process indicator of effective response when VF is the initial cardiac arrest rhythm.

Recommended Supplementary Time Events to Be Recorded

These time points are useful for internal quality assurance or research but are not deemed core time elements. They are either not considered as important in assessing process or outcome or problems are inherent in their accuracy and reproducibility.

Time When First Emergency Response Vehicle Is Mobile

This is the time when the emergency response vehicle begins to move. The interval between the time that the call was received and the time that the vehicle began to move usually is documented precisely and is important for quality assurance (eg, prolonged intervals may be the result of prolonged call processing or slowness of ambulance personnel).

Time When Vehicle Stops

This is the time when the emergency response vehicle stops moving at a location as close as possible to the patient. This time is documented precisely and is an important quality assurance measure.

Time of Return of Spontaneous Circulation

This time marks the return of any palpable pulse in the absence of ongoing chest compressions. If invasive intraarterial blood pressure is being monitored, then systolic blood pressure >60 mm Hg can be used as the surrogate for a palpable pulse.

Time When Vascular Access Achieved and Time When Medications Given

The value of intravascular or tracheal medications used in cardiac resuscitation has yet to be determined^{15,21}; nevertheless, their effectiveness may be time dependent. For this reason, the time of medication administration may be useful.

Time When CPR Stopped/Death

Numerous psychological and situational factors influence the time at which CPR is stopped, and this time point often

is imprecise. Nevertheless, this information may be useful (eg, for developing guidelines on when to stop CPR). Duration of CPR is an important quality assurance issue (eg, provision of CPR for 1 to 2 hours may be inappropriate) and is a supplementary data item.

Previously Recommended Time Points That Are No Longer Recommended

Departure from Scene and Arrival at Emergency Department

This time point was deleted because it differs greatly among EMS systems, especially when distances from the scene to the emergency department vary greatly.

Time When Tracheal Intubation Achieved

The importance of this time is unclear, especially in light of increasing evidence that effective airway control and adequate ventilation of the lungs are more important than the specific intervention of tracheal intubation.

Time When Arrest Confirmed, Time of End of ROSC, and Time of Awakening

These time points were deleted because of their imprecise definitions and the practical difficulties encountered in documenting the times accurately.

Time of Arrival at Patient's Side

This time point also was deleted because of imprecise definition and practical difficulties documenting this time accurately, especially in hospitals, because team members arrive at different times.

Potential Problems and Solutions for Reporting Times

The accurate recording of resuscitation times is difficult because of the psychological stress and intensive work generated during resuscitation attempts and because clock accuracy is unreliable. Despite these problems, quality assurance and medicolegal requirements make such documentation a high priority. Well-constructed forms for reporting cardiac arrest and CPR can and should facilitate good record keeping.

Postresuscitation Phase

The original Utstein reporting templates for both out-of-hospital and in-hospital cardiac arrest include factors up until ROSC and thereafter jump to outcome measurements (ie, died in the hospital, was discharged alive, status of functional outcome) without designating specific postresuscitation factors during the in-hospital phase after ROSC. At the time this was logical because information on postresuscitation factors that affect outcome was limited.

It is now known that several postresuscitation variables influence outcome dramatically. Two randomized controlled studies of adults with out-of-hospital VF cardiac arrest report a significant improvement in outcome when hypothermia was induced after ROSC.^{22,23} Two other studies reported significant differences between hospitals in the survival of patients admitted after prehospital cardiac arrest. These differences were not explained by

prehospital factors.^{24,25} In addition to body temperature, a negative association was found between survival and each of the following: high blood glucose levels, seizure activity, and low pH.²⁴ These observational studies do not prove that treatment of these factors improves outcome, but they should provoke further research. Cardiovascular and respiratory dysfunction also are present to a variable degree during the first 24 hours after resuscitation, and interhospital variations in monitoring and treatment are likely to influence outcomes. More important, regional and local differences in approaches to limitation and withdrawal of technological support can dramatically influence the length of stay and survival.²⁵

In many communities, the difficulty of linking prehospital and hospital data is insurmountable. As a minimum, the experts agree that whether hypothermia was induced should be included in reports as a core element. Additional desirable postresuscitation factors such as body temperature (both hyperthermia and hypothermia), blood glucose values, seizure activity, and some hemodynamic and ventilatory/blood gas variables may be important supplementary elements for specific research reports.

Data Access and Management

The collection and collation of sudden cardiac arrest registry data pose several challenges for EMS providers and researchers. A person who experiences a sudden out-of-hospital cardiac arrest often is treated by lay rescuers, public safety responders, or EMS responders, as well as a range of healthcare providers in the emergency department, coronary care or intensive care unit, and general ward. Information about the structure, process, and outcome associated with each of these settings may be collected sequentially by a single individual or multiple individuals representing each setting. If the latter occurs, then it may be difficult to track the care provided for each patient.

Collation of cardiac arrest data for entry into a registry may be done locally, regionally, nationally, or internationally. A significant advantage of collating data in a regional or larger database is that doing so enables individual clinicians or EMS systems to compare their own patient populations, interventions, and outcomes with those of other systems. This then enables clinicians and EMS providers to identify opportunities to improve quality of care and ascertain whether resuscitation is being provided according to evidence-based guidelines.

The task force was aware that some investigators are reluctant to contribute data to a central registry. Their reasons include concerns about ownership, data security, confidentiality, and resources. These concerns can be resolved by collaboration and the open exchange of ideas. The application of new computer technology can ensure data security through the use of firewalls, encrypted passwords, and deidentifying individual patient records. The concerns about data ownership and intellectual/academic recognition could be addressed through written understandings with each of the key stakeholders.

In most jurisdictions, local privacy laws and provisions will govern the collection of cardiac arrest data for a registry. The task force recommends that sites participating in a registry seek review and approval from their institutional review board or ethics committee to ensure compliance with local standards for health data registries and informed consent.

The task force also considered data accuracy defined by the ability of a measurement to match the true value of the quantity being measured. This is a particular challenge with sudden cardiac arrest data for several reasons: Intervals often are underestimated or reported in convenient numbers, such as even numbers or multiples of 5; patient factors are difficult to verify because most patients are not available for interview after the event; care processes are difficult to verify; and long-term outcomes, such as post-discharge status, often are difficult to obtain. Where resources are available, data should be reabstracted at each site to enable assessment of the quality of the registry data.

As with data accuracy, the reliability or similarity of results among different observations, experiments, or trials also presents a challenge for registries. Cardiac arrest data elements tend to be underreported and incomplete.²⁶ Every effort should be made to ensure completeness of data. Restricting data elements to the recommended core items listed in the present statement will facilitate completeness.

Data Linkage

Data linkage involves the collation of records for an individual from various sources into one cumulative file.²⁷ Increasing globalization, conversion from a paper-based to an electronic-based health record system, and development of increasingly user-friendly linkage software have strengthened opportunities for data linkage and global data integration.

Record linkage is a vital component of local, regional, national, and even international data and health information management.^{28,29} Through linkage it becomes possible to track fragmented health information, input missing or inconsistent data, and measure short- and long-term health outcomes while adjusting for covariate risk, demographics, and potentially confounding variables in health service evaluation and research. Linkage can help tie together structure, process, and outcome variables within large registries, which will facilitate benchmarking of cardiac resuscitation activities. For example, dispatch, prehospital, first responder, ambulance, defibrillator device, hospital, and death registry data could be incorporated into a single database. Linked registry data can support continual quality improvement within hospitals, communities, health networks, and countries. By virtue of its population-based approach, data linkage helps avoid selection bias. Because data are collected without any known purpose or outcome a priori, reporting and recall biases are minimized.

Concerns about privacy, confidentiality, and information security have led many countries to enact strict legislation to protect data (eg, in the United States, the Health Insurance Portability and Accountability Act). This sort of legislation has constrained the ability to link large registries across and within national boundaries.²⁹ Conflict between the rights of the individual to protect information about himself or herself

and the responsibility of health services to improve healthcare delivery makes record linkage difficult.

Implementation

Global information sharing is difficult to implement. The scientific community needs to address state/provincial, regional, and national regulations that limit sharing of data related to individual patient outcomes after resuscitation. Barriers exist among

- Prehospital and in-hospital systems to determine specific patient outcomes at hospital discharge
- Data repositories to determine specific patient outcomes at 30 days, 6 months, and 1 year
- Registries to enable sharing of minimally identified data into an international resuscitation database

The reports generated from existing registries should conform to the Utstein template, enabling communication and comparison among registries.

The importance of collecting and sharing resuscitation data must be made clear to the public and to relevant regulators. Protecting patient confidentiality is paramount, but with the appropriate safeguards, it should still be possible for key organizations to share data. Examples include public health databases and population-specific registries such as those established for cancer. Cardiac arrest registries should be no different. Patient advocates, national resuscitation organizations, and ILCOR should actively engage the appropriate legislative and regulatory bodies to facilitate the development and sharing of registry information.

Summary

Outcome after cardiac arrest and CPR is dependent on critical interventions, particularly early defibrillation, effective chest compressions, and advanced life support. Utstein-style definitions and reporting templates have been used extensively in published studies of cardiac arrest, which has led to greater understanding of the elements of resuscitation practice and progress toward international consensus on science and resuscitation guidelines.⁷ Despite the development of Utstein templates to standardize research reports of cardiac arrest, international registries have yet to be developed.

In April 2002, an ILCOR task force met in Melbourne, Australia, to review worldwide experience with the Utstein definitions and reporting templates. The task force revised the core reporting template and definitions by consensus. Care was taken to build on previous definitions, changing data elements and operational definitions only on the basis of published data and experience derived from those registries that have used Utstein-style reporting. Attention was focused on decreasing the complexity of the existing templates and addressing logistical difficulties in collecting specific core and supplementary (ie, essential and desirable) data elements recommended by previous Utstein consensus conferences.¹⁻³ Inconsistencies in terminology between in-hospital and out-of-hospital Utstein templates also were addressed.

The task force produced a reporting tool for essential data that can be used for both quality improvement (registries) and research reports and that should be applicable to both adults and children. The revised and simplified template includes practical and succinct operational definitions. It is anticipated that the revised template will enable better and more accurate completion of all reports of cardiac arrest and resuscitation attempts. Problems with data definition, collection, linkage, confidentiality, management, and registry implementation are acknowledged, and potential solutions were offered. Uniform collection and tracking of registry data should enable better

continuous quality improvement within every hospital, EMS system, and community.

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