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Cardiac Arrest and Cardiopulmonary Resuscitation Outcome Reports: Update of the Utstein Resuscitation Registry Template for In-Hospital Cardiac Arrest

A Consensus Report From a Task Force of the International Liaison Committee on Resuscitation (American Heart Association, European Resuscitation Council, Australian and New Zealand Council on Resuscitation, Heart and Stroke Foundation of Canada, InterAmerican Heart Foundation, Resuscitation Council of Southern Africa, Resuscitation Council of Asia)

ABSTRACT: Utstein-style reporting templates provide a structured framework with which to compare systems of care for cardiac arrest. The 2004 Utstein reporting template encompassed both out-of-hospital and in-hospital cardiac arrest. A 2015 update of the Utstein template focused on out-of-hospital cardiac arrest, which makes this update of the in-hospital template timely. Representatives of the International Liaison Committee on Resuscitation developed an updated in-hospital Utstein reporting template iteratively by meeting face-to-face, by teleconference, and by online surveys between 2013 and 2018. Data elements were grouped by hospital factors, patient variables, pre-event factors, cardiac arrest and postresuscitation processes, and outcomes. Elements were classified as core or supplemental by use of a modified Delphi process. Variables were described as core if they were considered essential. Core variables should enable reasonable comparisons between systems and are considered essential for quality improvement programs. Together with core variables, supplementary variables are considered useful for research.

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The first Utstein-style guideline for the reporting of data from cardiac arrest was published in 1991 and represented the output from an international multidisciplinary meeting held at the Utstein Abbey near Stavanger, Norway, in June 1990.[1] This first Utstein reporting guideline focused on out-of-hospital cardiac arrest (OHCA) and aimed to standardize definitions and data items, thus enabling comparison of cardiac arrest epidemiology and outcomes between emergency medical services systems. It was anticipated that this would also drive quality improvement, identify knowledge gaps, and facilitate clinical research by standardizing reporting and definitions for use by investigators. The first Utstein reporting guideline for in-hospital cardiac arrest (IHCA) was published in 1997 and included 4 categories of variables for documenting in-hospital resuscitation: hospital, patient, arrest, and outcome.[2] Other Utstein reporting guidelines include pediatric advanced life support,[3] laboratory research,[4] education,[5] drowning,[6] postresuscitation care,[7] and emergency medical dispatch.[8] In 2004, the Utstein guidelines for reporting cardiac arrest were updated to incorporate definitions and data elements for both OHCA and IHCA, reduce complexity of data collection, and address advances in resuscitation science.[9] The Utstein reporting guidelines for cardiac arrest were revised again in 2015, but this update was confined to OHCA because of substantial differences between IHCA and OHCA epidemiology, process of care, and treatments.[10] This article, therefore, is an update to Utstein reporting guidelines for IHCA.

Key Words: AHA Scientific Statements ■ cardiac arrest ■ cardiopulmonary resuscitation ■ death, sudden, cardiac ■ in-hospital cardiac arrest

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https://www.ahajournals.org/journal/circ

Circulation. 2019;140:e746–e757. DOI: 10.1161/CIR.0000000000000710

Although there are numerous national and regional registries for OHCA,[11–17] there are relatively few for IHCA.[17–20] The American Heart Association Get With The Guidelines–Resuscitation (GWTG-R) registry has been a particularly valuable source of data on all aspects of IHCA,[21] and more recently, the UK National Cardiac Arrest Audit has also reported on the incidence and outcome from cardiac arrest in hospitals in the United Kingdom.[19] The experts involved in updating these Utstein IHCA reporting guidelines have drawn on the experience derived from GWTG-R and the UK National Cardiac Arrest Audit, and as with the recent revision of the OHCA reporting guideline, the proposals set out in this article aim to balance the desire for uniform collection of evidence-based factors associated with outcome and the practical challenges of real-life data collection and validation.

METHODS

The Utstein collaborator group met face-to-face on 4 occasions to discuss the revisions to the Utstein IHCA reporting template. The first meeting followed the International Liaison Committee on Resuscitation (ILCOR) meeting in Melbourne, Australia, in April 2013. The second meeting occurred during a 1-day ILCOR meeting in New Orleans, LA, in November 2016; the third meeting took place during a 3-day ILCOR meeting in Adelaide, Australia, in May 2017; and the final face-to-face meeting took place during a 3-day ILCOR meeting in Anaheim, CA, in November 2017. These face-to-face meetings were supplemented by 5 teleconferences that took place during 2016 to 2018.

The Utstein collaborator group agreed that whenever possible, there would be consistency with the definitions and data elements set out in the 2015 OHCA Utstein reporting guideline.[10] Thus, core elements were defined as elements that all registries should aim to capture and report; these are considered the minimum recommended standard for quality assurance/improvement purposes. A core element is one that is considered both important and reasonably practical to collect and validate. Supplemental elements were defined as elements that were desirable but not essential to capture and report; such elements are more likely to be relevant to research than to quality assurance.

After the final face-to-face meeting in 2017, members of the IHCA Utstein Working Group considered core and supplemental data elements under the 6 domains of hospital factors, patient variables, pre-event factors, cardiac arrest and postresuscitation processes, and outcomes. A 2-stage Delphi process was conducted using a web-based survey to achieve consensus for the recommendations for core and supplemental elements. During stage 1, the output from the IHCA Utstein Working Group was presented to the wider collaborator group comprising all members of the ILCOR Advanced Life Support, Basic Life Support, and Pediatric Task Forces. The ILCOR Neonatal Task Force was not included in this collaboration because this Utstein-style guideline does not include neonatal resuscitation, which is distinct from resuscitation of adults and children. Agreement for core and supplemental elements was sought using a 5-point Likert scale, with 1 representing "do not agree" and 5 representing "strongly agree." A score of 4 or 5 was deemed to be "agreement." Participants were also able to submit additional elements for consideration. New elements, or elements for which there was <85% agreement on designation as core or supplemental, were submitted to a second round of voting. For the second round the collaborator group were asked whether the remaining variables should be supplemental or not included. There was >85% agreement for designations for all elements by the end of the second round, so further rounds were not required. Data definitions were based where possible on 2004 and 2015 Utstein definitions; some were adapted from the GWTG-R registry.

The IHCA Utstein Working Group, on behalf of collaborators, summarized the output from this process in a draft of the manuscript that was circulated and approved by the Utstein IHCA collaborators. The final manuscript was approved by the coauthors and ILCOR.

RESULTS

IHCA Utstein Definitions

The Utstein elements were grouped into 6 domains (Figure). Each domain contained core and supplemental elements that are described in the Table.

Hospital Factors

Core hospital elements are the number of hospital admissions and the number of treated cardiac arrests per year. These data enable calculation of the incidence of cardiac arrest per 1000 admissions. There is variation in what constitutes a hospital admission; however, standardization is essential because changing the denominator will have a major impact on cardiac arrest incidence. The consensus definition of hospital admission is admission to an in-patient bed; day cases are included, whereas outpatients or visitors are not. Cardiac arrests in the emergency department can be included in the registry, but the IHCA Utstein Working Group recommends that they be excluded for the purposes of calculating incidence of IHCA per 1000 admissions. The emergency department cardiac arrest patients who are included in the registry are those who have a cardiac arrest de novo in this location and not those who arrive in cardiac arrest or who rearrest after initial resuscitation from an OHCA. A cardiac arrest is defined as the delivery of chest compressions or defibrillation.[22] In the pediatric population, this could include some patients who receive chest compressions for poor perfusion in the setting of severe bradycardia.

Supplemental hospital factors are the total number of deaths per year and a description of the number of

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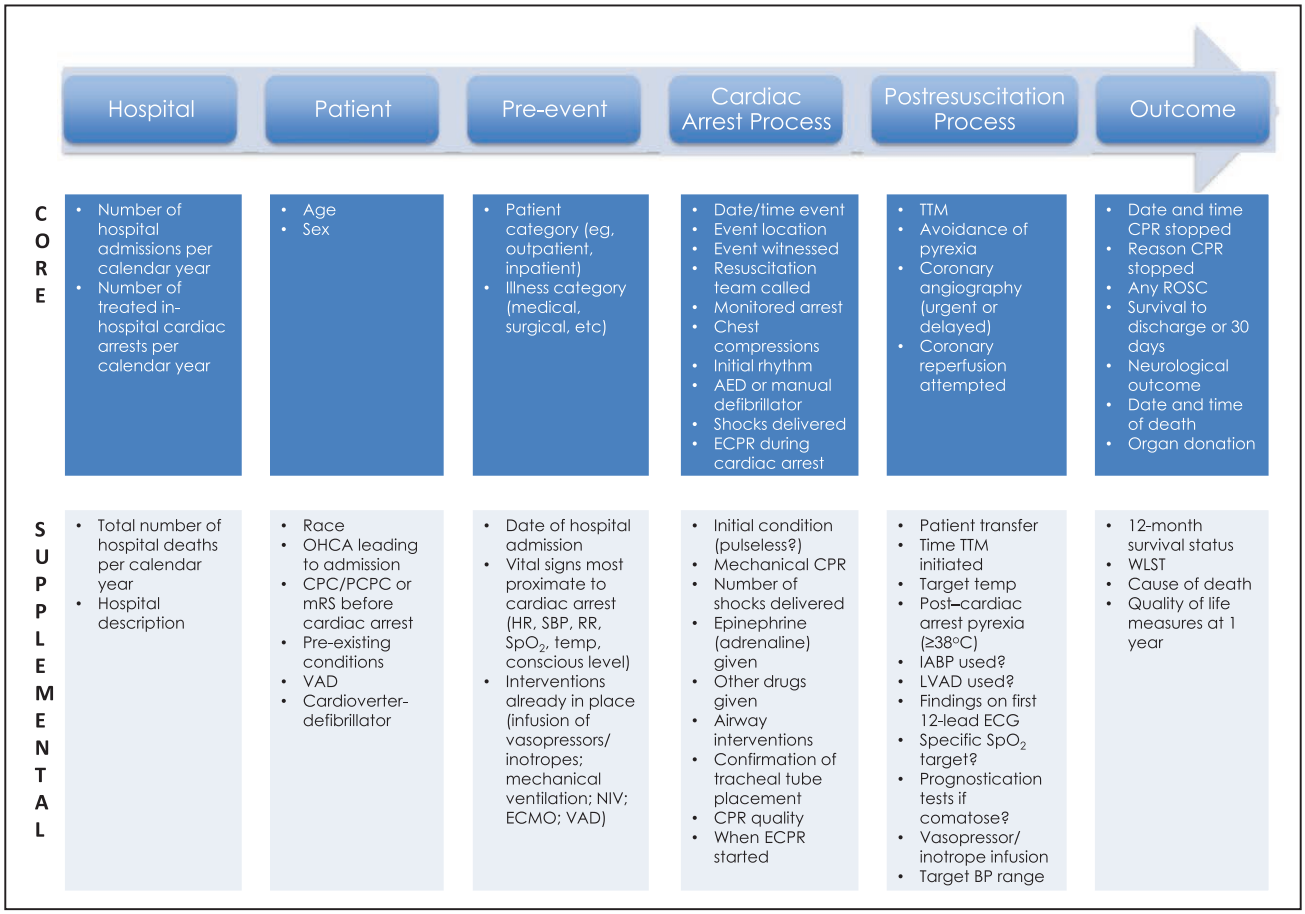


Figure. Data element domains.
Core and supplemental elements are shown for each of the 6 domains. AED indicates automated external defibrillator; BP, blood pressure; CPC, Cerebral Performance Category; CPR, cardiopulmonary resuscitation; ECMO, extracorporeal membrane oxygenation; ECPR, extracorporeal cardiopulmonary resuscitation; HR, heart rate; IABP, intra-aortic balloon pump; ICU, intensive care unit; LVAD, left ventricular assist device; mRS, modified Rankin Scale; NIV, noninvasive ventilation; OHCA, out-of-hospital cardiac arrest; PCPC, Pediatric Cerebral Performance Category; ROSC, return of spontaneous circulation; RR, respiratory rate; SBP, systolic blood pressure; temp, temperature; SpO_2, peripheral oxygen saturation; TTM, targeted temperature management; VAD, ventricular assist device; and WLST, withdrawal of life-sustaining treatment.

hospital beds and facilities relevant to cardiac arrest (eg, 24/7 access to a cardiac catheterization laboratory). An estimate of the number of deaths in patients with do-not-attempt cardiopulmonary resuscitation (DNACPR) decisions is provided by the difference between the total number of hospital deaths and the number of deaths after a cardiopulmonary resuscitation (CPR) attempt. We accept that there are limitations to this method for estimating the number of DNACPR decisions, not least because of double counting; for example, a patient may have a cardiac arrest with return of spontaneous circulation (ROSC) and then die with a subsequent DNACPR decision.

Patient Variables

Core patient variables are date of birth and sex. Among the supplemental patient variables, there was consensus for following national guidelines for defining categories of race, because there is inevitable international variation in nomenclature. Ideally, baseline neurological status would reflect the status before the index acute illness, but it was agreed that pre–cardiac arrest Cerebral Performance Category (CPC),[23] Pediatric CPC,[3] or modified Rankin Scale (mRS) score[24] was more likely to be collected at admission. Comorbidities influence outcome after IHCA, and the following have been evaluated previously for inclusion in the risk-standardization model derived from the GWTG-R registry: heart failure, myocardial infarction, or diabetes mellitus; renal, hepatic, or respiratory insufficiency; baseline evidence of motor, cognitive, or functional deficits (central nervous system depression); acute stroke; acute nonstroke neurological disorder; pneumonia; hypotension; sepsis; major trauma; metabolic or electrolyte abnormality; and metastatic or hematologic malignancy.[25] There was agreement to include as supplemental data the preexisting conditions that were included in the final GWTG-R registry model: sepsis, hypotension, metastatic or hematologic malignancy, hepatic insufficiency, and renal insufficiency.[25] The following factors from the GWTG-R pediatric model were not included in the Delphi survey: pre-event characteristics (heart failure this admission, heart failure

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Table. Utstein Data Definitions for IHCA

Utstein IHCA Elements	Consensus Definition 2018	Data Options
Hospital – core		
Number of hospital admissions per calendar year	Total hospital admissions. Admission is physical admission and recording of that admission to an in-patient bed. Day cases are included as admissions, but not outpatients or visitors.	Number of admissions/unknown
Number of treated in-hospital cardiac arrests per calendar year	Number of cardiac arrests. Cardiac arrest is defined by delivery of chest compressions and/or defibrillation.	Number of cases/unknown
Hospital – supplemental		
Total number of hospital deaths per calendar year		Number of cases/unknown
Hospital description	To include total number of beds, number of ICU beds, number of pediatric beds, 24/7 cardiac catherization laboratory, use of rapid response system	Free text
Patient – core		
Age	Date of birth	DD/MM/YYYY or MM/DD/YYYY or unknown
Sex	Sex	Male/female/unknown
Patient – supplemental		
Race	Race	Follow national guidelines to define race categories
Out-of-hospital cardiac arrest	Did patient have an out-of-hospital arrest leading to this admission?	Yes/no/unknown
CPC/PCPC or mRS before cardiac arrest	CPC (or PCPC) or mRS score at baseline before acute illness or at admission to hospital	CPC 1–4, PCPC 1–5, or mRS 0–5/unknown
Preexisting conditions	Did the patient have preexisting conditions at time of event from following list: sepsis; hypotension; metastatic or hematological malignancy; hepatic insufficiency; renal insufficiency?	Yes/no/unknown
VAD	At the time of cardiac arrest, the patient is supported by any form of VAD to augment cardiac output and coronary perfusion.	Yes/no/unknown
Cardioverter-defibrillator	At the time of cardiac arrest, the patient has an internal or external cardioverter-defibrillator.	Internal/external/no/unknown
Pre-event data – core		
Subject type	Patient category (eg, outpatient, inpatient)	Ambulatory/outpatient, emergency department, hospital inpatient, mental health facility inpatient, visitor or employee, unknown
Illness category	Medical, surgical, etc	Medical-cardiac, medical-noncardiac, surgical-cardiac, surgical-noncardiac, obstetric, trauma, other (visitor/employee), unknown
Pre-event data – supplemental		
Date of hospital admission	Date and time of hospital admission	Documented date on which the individual who had the cardiac arrest was admitted to hospital/unknown
Vital signs most proximate to cardiac arrest	Enter vital signs most proximate to the cardiac arrest	Date/time; heart rate; systolic BP; respiratory rate; Spo_2; temperature; conscious level; unknown
Interventions already in place	Continuous infusion of vasopressors/inotropes or mechanical ventilation or noninvasive ventilation (including HFNC oxygen) or VV ECMO already in place when need for chest compressions and/or defibrillation was first recognized	Vasopressors/inotropes/mechanical ventilation /noninvasive ventilation/VV ECMO/none/unknown
Cardiac arrest process – core		
Date/time of event	Date/time of event	Date/time the need for chest compressions (or defibrillation when initial rhythm was VF or pulseless VT) was first recognized/unknown
Event location	Event location (area)	Ambulatory/outpatient area; adult CCU; adult ICU; cardiac catheterization laboratory; delivery suite; diagnostic/intervention (other than catheterization laboratory); emergency department; general inpatient area; high-dependency unit; neonatal ICU; newborn nursery; operating room; pediatric ICU; pediatric cardiac intensive care; postanesthesia recovery room; rehabilitation, skilled nursing, or mental health unit/facility; same-day surgical area; telemetry unit or step-down unit; other (state); unknown

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Table. Continued

Utstein IHCA Elements	Consensus Definition 2018	Data Options
Event witnessed	A cardiac arrest that is seen or heard by another person or is monitored.	Yes/no/unknown
Resuscitation team called	Was a hospital-wide resuscitation response activated? Excludes a local response by the emergency department, operating room, or ICU teams, etc	Yes/no/unknown
Monitored cardiac arrest	Monitoring already in place when need for chest compressions and/or defibrillation was first recognized	ECG/other (specify)/unknown
Chest compressions	Did patient receive chest compressions (includes open cardiac massage)?	Yes/no/unknown
Initial rhythm	The first documented rhythm is the cardiac rhythm present at onset of cardiac arrest if monitored, or when the monitor or defibrillator is attached to the patient after onset of chest compressions.	VF/pulseless VT/PEA/asystole/bradycardia/shockable (AED)/unknown
AED used	Was AED applied or manual defibrillator in AED/shock advisory mode applied?	Yes/no/unknown + date/time AED or manual defibrillator in AED/shock advisory mode applied: ____/____/_____
Defibrillatory shocks delivered	Was defibrillation shock provided for VF or pulseless VT?	Yes/no/unknown/manual defibrillator shocks applied: unknown
ECPR	Venoarterial extracorporeal membrane oxygenation started during cardiac arrest	Yes/no/unknown
Cardiac arrest process – supplemental		
Initial condition	Condition that best describes event (pulseless or had a pulse)	Pulseless/pulse but poor perfusion/systolic arterial pressure <50 mm Hg (only if pulse assessment not documented and arterial line in place)/unknown
Mechanical CPR	A mechanical chest compression device was used.	Yes (specify device type)/no/unknown
Total number of shocks delivered	Number of defibrillatory shocks delivered	Number/unknown
Epinephrine/adrenaline given	Epinephrine/adrenaline given by intravenous cannula or intraosseous needle during the resuscitation event; includes total number of doses	Epinephrine/adrenaline/none given/unknown + number of doses + timing
Other drugs given	Amiodarone/lidocaine/vasopressin/atropine/bicarbonate/calcium/magnesium/dextrose	Amiodarone/lidocaine/vasopressin/atropine/bicarbonate/calcium/magnesium/dextrose/none given/unknown + timing
Airway interventions	Airway interventions used during the resuscitation and timing	None used/oropharyngeal airway/bag-mask/supraglottic airway/tracheal tube/surgical airway Indicate first device used/unknown + timing
Confirmation of correct tracheal tube placement	Method(s) of confirmation used to ensure correct placement of tracheal tube or tracheostomy tube	Waveform capnography (waveform $ETco_2$)/capnometry (numeric $ETco_2$)/exhaled CO_2 colorimetric monitor ($ETco_2$ by color change)/esophageal detection devices/ultrasound/revisualization with direct laryngoscopy (tick all that apply)/none of the above/unknown
CPR quality	Mechanisms or processes in place during the resuscitation to measure the quality of CPR being delivered	Yes/no/unknown Indicate whether used for real-time feedback or for quality assurance review Waveform capnography/end-tidal CO_2/arterial waveform/diastolic pressure/CPR mechanics device (eg, accelerometer, force transducer, TFI device)/CPR quality coach, metronome, other (specify) If CPR mechanics device (eg, accelerometer, force transducer, TFI device) used: average compression rate; average compression depth; compression fraction; chest compressions with complete release; average ventilation rate; longest preshock pause
If ECPR was used, when was it started?	If venoarterial extracorporeal membrane oxygenation was used, when was it started? ECPR start defined as initiation of extracorporeal flow to the patient after cannulation and circuit connection to cannulas	ECPR not used/time started/unknown
Postresuscitation process – core		
TTM	TTM is defined as an active therapy to achieve and maintain a specific target temperature for a defined duration.	Yes/no/unknown

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Table. Continued

Utstein IHCA Elements	Consensus Definition 2018	Data Options
Avoidance of pyrexia	Defined as an active therapy to prevent pyrexia (temperature >38.0°C)	Temperature at which active temperature management is started/unknown
Coronary angiography	Urgent coronary angiography defined as within 2 h of cardiac arrest; delayed coronary angiography defined as undertaken during the same hospital admission	Urgent coronary angiography/delayed coronary angiography/no coronary angiography/unknown
Coronary reperfusion attempted	Coronary reperfusion attempted using either PCI or thrombolysis	Type: PCI/thrombolysis/none/unknown Timing: Intra-arrest/within 24 h of ROSC/>24 h but before discharge/unknown
Postresuscitation process –supplemental		
Patient transfer	Was the patient transferred to a specialist hospital (eg, providing 24/7 PCI, TTM, post-arrest hemodynamic support) for further treatment?	Yes/no/unknown
Time TTM initiated	If TTM was used, when was active temperature management started?	Not used/intra-arrest/post-ROSC/unknown
Target temperature	If TTM was used, what was the target temperature?	Not used/target temperature or range (°C)/unknown
Post–cardiac arrest pyrexia	Was there ever a documented temperature ≥38°C within 72 h of cardiac arrest?	Yes/no/unknown Time pyrexia first documented
IABP	Was an IABP used?	Yes/no/unknown
LVAD	Was an LVAD used?	Yes/no/unknown
12-lead ECG interpretation	Interpretation of first 12-lead ECG after ROSC	STEMI/ischemic changes (not STEMI)/new LBBB/other
Oxygenation	After ROSC, was PaO_2 or SpO_2 targeted to a specific value?	Yes (state target range for Spo_2 or Pao_2)/no/unknown Duration
Neuroprognostic tests	Tests used to prognosticate outcome in comatose postarrest patients	Clinical examination: yes/no/unknown SSEP: yes/no/unknown EEG: yes/no/unknown NSE: yes/no/unknown CT brain: yes/no/unknown MRI brain: yes/no/unknown Other: Please specify Include timing for all tests
Vasopressors/inotropes	Did the patient receive any vasopressors/inotropes continuously by infusion in the 0- to 72-h period after ROSC?	Yes/no/unknown Specify vasopressor/inotrope
Targeted blood pressure management	What target blood pressure range was used?	Yes/no/target range/duration/unknown
Core outcomes		
Date/time CPR stopped	Date/time sustained ROSC (lasting >20 min) began OR resuscitation efforts were terminated	Date/time/unknown
Reason CPR stopped	Survived event (sustained ROSC with spontaneous circulation, or return of circulation supported by ECPR) or died (efforts terminated, no sustained ROSC)	Survived (ROSC >20 min)/died – efforts terminated (no sustained ROSC)/died – DNACPR in place before resuscitation attempt/unknown
Any ROSC	Was any documented return of adequate circulation 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 > 50 mm Hg systolic) achieved during the event?	Yes/no/unknown
30-d survival or survival to discharge	Was the patient alive at the point of hospital discharge/30 d?	Yes/no/unknown Record date of discharge if known
Neurological outcome at 30 d or hospital discharge	Record CPC/PCPC and/or mRS at 30 d or hospital discharge. Include a definition of how it was measured (face-to-face, extracted from notes, combination).	CPC score (1–5) or PCPC score (1–6)/unknown/not recorded; mRS (0–6)/unknown
Date and time of death if before hospital discharge	Recorded if patient dies before hospital discharge	Date and time/not applicable/unknown
Organ donation	Patients who had 1 or more solid organs donated for transplantation; DBD or DCD	Yes/DBD/DCD/no/unknown

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Table. Continued

Utstein IHCA Elements	Consensus Definition 2018	Data Options
Supplemental outcomes		
Survival status at 12 mo	The patient is alive at 12 mo after cardiac arrest.	Yes/no/unknown
Withdrawal of life-sustaining treatment (including timing)	A decision to withdraw life-sustaining treatment was made; record the time that this occurred after ROSC.	Yes/no/unknown: days/hours
Cause of death	Cause of death	Sudden cardiac death/refractory hemodynamic shock/respiratory failure/neurological withdrawal of life-sustaining treatment/comorbid withdrawal of life-sustaining treatment
HRQoL measurements (standardized questionnaires, eg, EQ5-D, SF-12)	A validated quality of life measure was used to assess health quality of life; best measured at 1 y	Yes/no/date/unknown List HRQoL instrument or instruments used and their outcomes/scores

Data definitions have been categorized as core and supplemental. 24/7 indicates 24 hours per day, 7 days per week; AED, automated external defibrillator; BP, blood pressure; CCU, coronary care unit; CPC, Cerebral Performance Category; CPR, cardiopulmonary resuscitation; CT, computed tomography; DBD, donation after brain death; DCD, donation after circulatory death; DNACPR, do not attempt cardiopulmonary resuscitation; ECMO, extracorporeal membrane oxygenation; ECPR, extracorporeal cardiopulmonary resuscitation; EEG, electroencephalogram; EQ5-D, 5-dimension EuroQoL Group assessment; $ETco_2$, end-tidal carbon dioxide; HFNC, high-flow nasal cannula; HRQoL, health-related quality of life; IABP, intra-aortic balloon pump; ICU, intensive care unit; IHCA, in-hospital cardiac arrest; LBBB, left bundle branch block; LVAD, left ventricular assist device; MRI, magnetic resonance imaging; mRS, modified Rankin Scale; NSE, neuron-specific enolase; PaO_2, partial pressure of oxygen in arterial blood; PCI, percutaneous coronary intervention; PCPC, Pediatric Cerebral Performance Category; PEA pulseless electrical activity; ROSC, return of spontaneous circulation; SF-12, Short-Form Health Survey (12 Items); SpO_2, peripheral oxygen saturation; SSEP, somatosensory evoked potentials; STEMI, ST-segment–elevation myocardial infarction; TFI, triaxial field induction; TTM, targeted temperature management; VAD, ventricular assist device; VF, ventricular fibrillation; VT, ventricular tachycardia; and VV ECMO, venovenous extracorporeal membrane oxygenation.

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before admission, metabolic or electrolyte abnormality, acute nonstroke central nervous system event, baseline depression in central nervous system function, pneumonia, septicemia, major trauma), and intravenous antiarrhythmic drug use in place at the time of cardiac arrest.[26]

Pre-event Factors

Pre-event core factors are the subject type (eg, outpatient, inpatient) and the illness category (eg, medical, surgical). It is well recognized that IHCAs are often not sudden, unexpected events; they are usually preceded by a period of deterioration evidenced by changes in vital signs.[27,28] It was agreed that the vital signs most proximate to the cardiac arrest would be valuable supplementary data but are difficult to collect and standardize; in the future, electronic data capture may make this easier.[29] Of the possible interventions in place at the time of cardiac arrest, there was consensus to include as supplementary data continuous infusions of vasopressors or inotropes, invasive ventilation, noninvasive ventilation (including high-flow nasal cannula oxygen), extracorporeal membrane oxygenation, or ventricular assist device.[30]

Cardiac Arrest Process Elements

Cardiac arrest core process elements include the date and time of cardiac arrest, event location (the predefined locations and the number of options can be determined locally), whether the event was witnessed, and whether the resuscitation team was called. Documentation of whether monitoring was in place at the time of cardiac arrest is also core data; this would typically be electrocardiographic monitoring, but it could also include pulse oximetry. The first documented rhythm, application of an automated external defibrillator or manual defibrillator, and whether shocks or chest compressions were given are also core data. The final core item is use of extracorporeal cardiopulmonary resuscitation (ECPR). It was agreed that the IHCA Utstein definition of ECPR should align with that proposed by the Extracorporeal Life Support Organization[31]: "ECPR is the application of rapid-deployment venoarterial extracorporeal membrane oxygenation, usually by peripheral cannulation, to provide circulatory support in patients in whom conventional CPR is unsuccessful in achieving sustained ROSC. Sustained ROSC is deemed to have occurred when chest compressions are not required for 20 consecutive minutes and signs of circulation persist. ECPR implies the application of [extracorporeal life support] during conventional CPR. Use of [extracorporeal life support] initiated for low cardiac output after sustained ROSC is considered venoarterial [extracorporeal membrane oxygenation]."

Nine supplemental cardiac arrest process elements are included. There was discussion on whether the airway intervention element should include the specific type of supraglottic airway used, but it was agreed that this would be left as a generic supraglottic airway. Ideally, the timing of these interventions (eg, drugs, airway) should be documented, because they are more likely to occur the longer the resuscitation attempt continues. The duration of resuscitation is strongly associated with worse outcome. In observational studies, this will bias the results toward a harmful effect of the intervention—an effect that has been termed *resuscitation time bias*.[32] The CPR quality element should include an indication of whether data are being used for real-time feedback or for quality assurance review. In

keeping with Extracorporeal Life Support Organization nomenclature, ECPR start is defined as initiation of extracorporeal flow after cannulation and circuit connection to the patient.[31]

Because quality of CPR is the most important determinant of myocardial and cerebral blood flow during CPR and resultant outcomes,[33] IHCA reports would optimally provide CPR hemodynamic data (eg, arterial diastolic blood pressure during CPR), potential proxies of CPR hemodynamics (eg, end-tidal carbon dioxide), or CPR mechanical data (eg, chest compression depth and rate, chest compression fraction).[33] However, practical issues relegate the consideration of these important data to future updates of this template.

Postresuscitation Process

Targeted temperature management is defined as an active therapy to achieve and maintain a specific target temperature for a defined duration and is 1 of 4 core postresuscitation process elements. The other core elements are avoidance of pyrexia, coronary angiography (divided into urgent [within 2 hours after cardiac arrest] and delayed), and attempted coronary reperfusion (percutaneous coronary intervention or thrombolysis). There are 11 supplemental postresuscitation process elements. After considerable discussion, post–cardiac arrest pyrexia was defined as a temperature ≥38°C within 72 hours after cardiac arrest. Documentation of vasopressor and inotrope infusions within the first 72 hours after ROSC is a supplemental element. Although the documentation of sedation and neuromuscular blocker use was also proposed, there was no consensus from the Delphi survey to include these items. The IHCA Utstein Working Group discussed this at length, because sedation is thought to be an important factor in delayed awakening after cardiac arrest.[34–36] Although we have been faithful to the Delphi process and excluded sedation and neuromuscular blockers as supplemental items, the IHCA Utstein Working Group is supportive of local decisions to collect these data. Documentation of neuroprognostic tests should include both the types of tests and their timing.

Outcome

Where possible, recommendations on the documentation of survival are consistent with those included in the 2015 OHCA Utstein update.[10] There are 7 core elements. It was agreed that the definition of "date and time CPR stopped" would be that used by the GWTG-R registry: "Date and time sustained ROSC (lasting >20 min) began or resuscitation efforts were terminated." For the core item "reason CPR stopped," there was considerable discussion on the use of the term *futility*, but it was eventually agreed not to include this. "Survived event" is defined as sustained ROSC or return of circulation supported by ECPR. The other option for "reason CPR stopped" is that the patient died (unable to achieve sustained ROSC). A DNACPR decision before the resuscitation attempt has also been added to the data options for this element. The working group noted that a previous American Heart Association consensus statement recommended that those resuscitation attempts that occur after a DNACPR decision has been made should not be counted in IHCA incidence or outcome measures.[22] Knowledge of the number of patients with a DNACPR decision who inadvertently receive CPR when they have an IHCA is a useful quality measure for local systems of care.

Any ROSC is a core outcome element and is defined by return of circulation 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 >50 mm Hg systolic). There was considerable discussion about the evidence for using systolic blood pressure >50 mm Hg as one of the criteria for any ROSC. The IHCA Utstein Working Group agreed that it was preferable to make a statement on this topic rather than stay silent, because many patients with IHCA have invasive arterial blood pressure monitoring. Systolic blood pressure >50 mm Hg is recommended by others to discriminate hypotension from a pulseless electrical activity cardiac arrest, and there are limited data indicating that a pulse is often not palpable once the blood pressure is <60 mm Hg.[37–40] Ultimately, it was agreed that this was, at best, "expert opinion" and is a knowledge gap. Neurological outcome at 30 days or hospital discharge is recorded as either CPC/Pediatric CPC or mRS score and can be measured by face-to-face or telephone interview, extraction from the medical record, or a combination of the two. The CPC is a 5-point scale ranging from 1 (good cerebral performance) to 5 (dead), and the Pediatric CPC is a 6-point scale ranging from 1 (good cerebral performance) to 6 (dead). The mRS is a 7-point scale ranging from 0 (no symptoms) to 6 (dead). In keeping with the 2015 OHCA Utstein update, survival with favorable neurological outcome is defined as a CPC 1 or 2 or mRS 0 to 3 or no change in CPC or mRS from the patient's baseline status.[10] The Core Outcome Set for Cardiac Arrest Collaborators recommend the mRS over the CPC because the latter lacks discrimination between scores and has the potential for ceiling effects and overestimation of function.[41]

The core outcome of organ donation includes documentation of either donation after brain death or donation after circulatory death. Date and time of death if before hospital discharge is the final core outcome; in some healthcare systems, date of death can be relatively easily tracked after hospital discharge. This should be included if possible.

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There are 4 supplemental outcome elements. The cause of death can be obtained from the medical records and death certificates; however, death certificates are generally considered to be an unreliable source for cause of death.[42–44] Investigators have recently proposed 5 categories for cause of death after cardiac arrest: sudden cardiac death, refractory hemodynamic shock, respiratory failure, neurological withdrawal of life-sustaining treatment, and comorbid withdrawal of life-sustaining treatment.[45] The IHCA Utstein Working Group agreed that these should be included as data options. Health-related quality of life measurements are a supplemental outcome. The Core Outcome Set for Cardiac Arrest Collaborators suggested that health-related quality of life could be assessed at 180 days or 1 year or both; however, they recognized that the longer duration of follow-up is likely to be logistically more challenging.[41] The consensus among the IHCA Utstein collaborators was that health-related quality of life measurements are ideally measured at 12 months.

IMPLEMENTATION

Implementation of the IHCA Utstein reporting guideline will facilitate comparison between IHCA registries throughout the world. Use of standardized definitions will enable consistent recording and reporting of IHCA data and will allow reliable documentation of trends in interventions and outcomes. Reliable documentation of the incidence of cardiac arrest is an important performance indicator, because this can be reduced by (1) early detection of the deteriorating patient and instigation of treatments to prevent cardiac arrest[28] and (2) implementation of DNACPR decisions when appropriate.[46] Thus, the incidence of cardiac arrest is a key performance indicator that can be used to track the effectiveness of rapid response systems in preventing cardiac arrest and the implementation of DNACPR decisions to ensure that CPR is attempted only when appropriate. There are challenges in using the incidence of cardiac arrest per 1000 hospital admissions to compare performance among hospitals, because this will be influenced significantly by external factors such as the proportion of elective admissions versus emergency admissions and the type of hospital, as well as by the variability in proportion of patients at each hospital with advanced directives. This can be mitigated to some extent by use of risk adjustment for hospital characteristics when hospitals are compared.[47]

As for the OHCA Utstein reporting guideline, there are substantial challenges in striking a balance between including as core data those factors that are deemed essential for quality assurance purposes while including only those data that can be collected relatively easily and reliably in different healthcare systems globally. If too many items are deemed core, or if they require considerable resources to enable reliable collection, only a few hospitals will comply with the IHCA Utstein reporting guideline, which will limit participation in a national registry. If only a small proportion of hospitals participate in the registry, the generalizability of the findings is limited. This, in turn, reduces the value of international comparisons. Although supplemental items are not deemed essential, the IHCA Utstein Working Group recognizes the importance of research in guiding and validating quality assurance/improvement and encourages collection of supplemental items when practicable.

CONCLUSIONS

Utstein-style guidelines standardize reporting of the process of care and outcomes for patients with cardiac arrest. This update of the IHCA Utstein reporting guideline includes 6 domains: hospital factors, patient variables, pre-event factors, cardiac arrest and postresuscitation processes, and outcomes. This consensus IHCA reporting template adopts the style of the recently updated OHCA version.

ARTICLE INFORMATION

The American Heart Association makes every effort to avoid any actual or potential conflicts of interest that may arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group are required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

This document was approved by the American Heart Association Science Advisory and Coordinating Committee on June 5, 2019; the American Heart Association Executive Committee on June 4, 2019.

The American Heart Association requests that this document be cited as follows: Nolan JP, Berg RA, Andersen LW, Bhanji F, Chan PS, Donnino MW, Lim SH, Ma MH-M, Nadkarni VM, Starks MA, Perkins GD, Morley PT, Soar J; on behalf of the Utstein Collaborators. Cardiac arrest and cardiopulmonary resuscitation outcome reports: update of the Utstein resuscitation registry template for in-hospital cardiac arrest: a consensus report from a Task Force of the International Liaison Committee on Resuscitation (American Heart Association, European Resuscitation Council, Australian and New Zealand Council on Resuscitation, Heart and Stroke Foundation of Canada, InterAmerican Heart Foundation, Resuscitation Council of Southern Africa, Resuscitation Council of Asia). *Circulation*. 2019;140:e746–e757. doi: 10.1161/CIR.0000000000000710.

This article has been copublished in *Resuscitation*.

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Acknowledgments

The writing group acknowledges the American Heart Association Emergency Cardiovascular Care staff, in particular Eileen M. Censullo, MBA, FAARC, RRT, for her dedication and support in the preparation of this manuscript.

JPN ran the Delphi surveys and prepared the first draft of the manuscript under the oversight of RAB, JS, and GDP. The draft manuscript was revised after input from a core writing group initially (JPN, RAB, LWA, FB, PSC, MWD, SHL, MH-MM, VMN, MAS, GDP, PTM, and JS). These outputs were then circulated and discussed in detail with coauthors who added important intellectual content to the manuscript's refinement. The final manuscript was approved by all authors and collaborators.

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This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit. A relationship is considered to be "significant" if (a) the person receives $10 000 or more during any 12-month period, or 5% or more of the person's gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns $10 000 or more of the fair market value of the entity. A relationship is considered to be "modest" if it is less than "significant" under the preceding definition.

*Modest.

†Significant.

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