# Sudden Cardiac Arrest (SCA)

## Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCA-01</td>
<td>Timeliness of First Defibrillation Attempt</td>
</tr>
<tr>
<td>SCA-02</td>
<td>Timely Confirmation of Correct Endotracheal Tube</td>
</tr>
<tr>
<td>SCA-03</td>
<td>Initiation of Therapeutic Hypothermia</td>
</tr>
<tr>
<td>SCA-04</td>
<td>Maintenance of Thermoregulation in Therapeutic Hypothermia</td>
</tr>
</tbody>
</table>

## General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Birthdate</td>
<td>All Records,</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>All Records, Not collected for HBIPS-2 and HBIPS-3</td>
</tr>
<tr>
<td>Discharge Disposition</td>
<td>All Records,</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>All Records,</td>
</tr>
<tr>
<td>Race</td>
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</tr>
<tr>
<td>Sex</td>
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</table>

## Measure Set Specific Data Elements

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>SCA-03, SCA-03, SCA-02, SCA-03, SCA-04,</td>
</tr>
<tr>
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<td>SCA-03,</td>
</tr>
<tr>
<td>Arrival Date</td>
<td>SCA-01, SCA-02, SCA-03, SCA-04, SCA-02, SCA-03,</td>
</tr>
<tr>
<td>Arrival Time</td>
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<tr>
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<td>Cardiac Arrest Time</td>
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<td>Endotracheal Intubation Confirmation Date</td>
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</tr>
<tr>
<td>Endotracheal Intubation Time</td>
<td>SCA-02,</td>
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<td>Endotracheal Tube Insertion</td>
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<td><strong>First Defibrillation Shock Date</strong></td>
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<tr>
<td><strong>Implanted Device</strong></td>
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</tr>
<tr>
<td><strong>Initial Rhythm</strong></td>
<td>SCA-01, SCA-03,</td>
</tr>
<tr>
<td><strong>Left Ventricular Assist, Device Biventricular Assist Device</strong></td>
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<tr>
<td><strong>Methods of Intubation Confirmation</strong></td>
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<tr>
<td><strong>Patient Location</strong></td>
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<tr>
<td><strong>Reason for Early Discontinuation of Therapeutic Hypothermia</strong></td>
<td>SCA-04,</td>
</tr>
<tr>
<td><strong>Reason for Not Administering Therapeutic Hypothermia</strong></td>
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</tr>
<tr>
<td><strong>Reason for Transfer</strong></td>
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<tr>
<td><strong>Return of Spontaneous Circulation</strong></td>
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<td><strong>Therapeutic Hypothermia Initiated</strong></td>
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<td><strong>Thermoregulation Maintained</strong></td>
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<td><strong>Time Therapeutic Hypothermia Ended</strong></td>
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</tr>
<tr>
<td><strong>Time Therapeutic Hypothermia Ordered</strong></td>
<td>SCA-03,</td>
</tr>
</tbody>
</table>
Measure Information Form

Measure Set: Sudden Cardiac Arrest (SCA)

Set Measure ID: SCA-01

Performance Measure Name: Timeliness of First Defibrillation Attempt

Description: In-hospital cardiac arrest with an initial rhythm of either ventricular fibrillation or pulseless ventricular tachycardia with first defibrillation shock delivered within 2 minutes of cardiac arrest time.

Rationale: Early defibrillation is critical in optimizing survival outcomes from sudden cardiac arrest (SCA) due to ventricular fibrillation (VF) or pulseless ventricular tachycardia because: (1) early defibrillation for these rhythms has been linked to improved survival, (2) the probability of successful defibrillation diminishes rapidly over time, and (3) VF will deteriorate to asystole if untreated. Therefore, the earlier defibrillation is attempted, the more likely the attempt will be successful and the greater the likelihood of survival to discharge. In the hospital setting, the goal for delivery of the first defibrillation shock is within 3 minutes from collapse. 1-2

The American Heart Association National Registry of Cardiopulmonary Resuscitation (NRCPR) Gold Standard for defibrillation is for delivery of the first shock should be under 3 minutes from ventricular fibrillation. The Gold Standard process intervals were determined by expert opinion with consensus of the NRCPR Scientific Advisory Board, and concurrence of the Emergency Cardiac Care Committee of American Heart Association, based on the 2010 American Heart Association Guidelines2.

In 2006, as noted in a joint statement3 of the American College of Cardiology, the American Heart Association, and the European Society of Cardiology, “Studies have suggested that immediate defibrillation is the preferred method within 1-2 minutes after the onset of cardiac arrest; a brief period of CPR to provide oxygenation of the victim improves survivability when time to defibrillation is longer.”

In the largest study sample to examine this issue, NRCPR investigators confirmed that, for patients who arrest in the hospital with an initial rhythm of ventricular fibrillation or pulseless ventricular tachycardia (VT), defibrillation within 2 minutes (compared to greater than 2 minutes) was associated with a higher likelihood of survival to discharge.4

Type of Measure: Process

Improvement Noted As:

Numerator Statement: First defibrillation shock delivered within 2 minutes (under 3 minutes) of cardiac arrest time.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:
Denominator Statement: Cardiac arrest events occurring after the time of arrival in patients with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1 in whom the initial rhythm is either ventricular fibrillation or pulseless ventricular tachycardia.

Included Populations:

- Inpatients described in Appendix A-1
- Emergency Department (ED) Patients

Excluded Populations:

- Cardiac arrest events occurring prior to hospital arrival in the ED
- Cardiac arrest events occurring wherein the initial rhythm is not ventricular fibrillation or pulseless ventricular tachycardia.
- Cardiac arrest events occurring in patients with a code status order
- Cardiac arrest events occurring during a specified ICD-9-CM principal or other procedure (during cardiac catheterization, during cardiac electrophysiology testing, while on cardiac bypass during open heart surgery, or while on extracorporeal membrane oxygenation (ECMO).
- Cardiac arrest events occurring in patients with left ventricular assist devices (LVADS) or bilateral ventricular assist devices (BIVADs).
- Events occurring in patients with any device implanted prior to cardiac arrest that is designed to deliver a defibrillation shock in the event of cardiac arrest (intra-cardiac defibrillators, defibrillator/pacemakers, etc.).
- Age <18 years

Data Elements:

- Arrival Date
- Arrival Time
- Birthdate
- Cardiac Arrest
- Cardiac Arrest Date
- Cardiac Arrest Event Number
- Cardiac Arrest Time
- Code Status Order
- Code Status Order Date
- Code Status Order Time
- Hispanic Ethnicity
- Implanted Device
- Initial Rhythm
- Left Ventricular Assist, Device Biventricular Assist Device
- Patient Location
- Race
- Sex

Risk Adjustment: No.

Data Accuracy:

Measure Analysis Suggestions:
**Sampling:** Yes.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


**Measure Algorithm:**
SCA–01: Timeliness of First Defibrillation Attempt

**Numerator:** First defibrillation shock delivered within 2 minutes (under 3 minutes) of cardiac arrest time.

**Denominator:** Cardiac arrest events occurring after the time of arrival in patients with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described Appendix A-1 in whom the initial rhythm is either ventricular fibrillation or pulseless ventricular tachycardia.

---

**Variable Key:**
- Age
- Cardiac Time
- Code Status Time I
- Defibrillation Time

---

**Begin Event Level Processing**
Measure Information Form

Measure Set: Sudden Cardiac Arrest (SCA)

Set Measure ID: SCA-02

Performance Measure Name: Timely Confirmation of Correct Endotracheal Tube

Description: Confirmation within one minute of initial placement via capnometry, electronic waveform capnography, esophageal detection devices, exhaled CO2 colorimetric monitor, or visualization with direct laryngoscopy that the endotracheal tube is correctly placed in the trachea, rather than in the esophagus.

Rationale: Unrecognized esophageal intubation is the most serious complication of tracheal intubation and is potentially catastrophic as it can lead to severe neurological injury and death. Chest X-Ray is not an acceptable method of verification; other methods, such as auscultation of the chest and fogging in the tube, likewise are not reliable³.

In a study of the National Registry for CPR (NRCPR) database, the records of 76,465 endotracheal intubations were examined; 18% of cases showed no documentation of confirmation, and in another 26% there was documentation of auscultation alone. Patients whose endotracheal tube placement was confirmed by capnography or esophageal detection device had a higher rate of return of spontaneous circulation (53.6% vs. 48.9%) and survival (18.2% vs 17.4%) than patients without documentation⁵.

Type of Measure: Process

Improvement Noted As:

Numerator Statement: Cardiac arrest events occurring after time of arrival during which an endotracheal tube is placed wherein confirmation of endotracheal tube placement is documented within one minute of intubation by a specified method of confirmation, which may be either:
A. Capnometry, or
B. Electronic waveform capnography, or
C. Esophageal detection devices, or
D. Exhaled CO2 colorimetric monitor, or
E. Revisualization with direct laryngoscopy

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Endotracheal Intubation Date
- Endotracheal Intubation Time
- Methods of Intubation Confirmation

Denominator Statement: Cardiac arrest events during which an endotracheal tube is placed.
**Included Populations:** Cardiac arrest, respiratory arrest, or cardiorespiratory arrest events occurring in patients with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1, during which an endotracheal tube is inserted.

- Inpatients
- ED Patients

**Excluded Populations:**

- Cardiac arrest events occurring while an endotracheal tube is in place
- Cardiac arrest events occurring prior to hospital arrival
- Age <18 years

**Data Elements:**

- **Arrival Date**
- **Arrival Time**
- **Birthdate**
- **Cardiac Arrest**
- **Cardiac Arrest Date**
- **Cardiac Arrest Event Number**
- **Cardiac Arrest Time**
- **Endotracheal Intubation Date**
- **Endotracheal Intubation Time**
- **Hispanic Ethnicity**
- **Race**
- **Sex**

**Risk Adjustment:** No.

**Data Accuracy:**

**Measure Analysis Suggestions:**

**Sampling:** Yes.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


5. Relationship Between Documentation of Confirmed Endotracheal Tube Placement and Patient Outcomes in the National Registry of Cardiopulmonary Resuscitation for the American Heart

Measure Algorithm:
SCA-02: Timely Confirmation of Correct Endotracheal Tube

Numerator: Cardiac arrest events occurring after time of arrival during which an endotracheal tube is placed wherein confirmation of endotracheal tube placement is documented within one minute of intubation by a specified method of confirmation, which may be either:

A. Capnometry, or
B. Electronic waveform capnography, or
C. Esophageal detection devices, or
D. Exhaled CO₂ colorimetric monitor, or
E. Revisualization with direct laryngoscopy

Denominator: Cardiac arrest events during which an endotracheal tube is placed.

---

Variable Key:

- Age
- Cardiac Time
- Endotracheal Intubation Time I
- Endotracheal Intubation Time II

---

Begin Event Level Processing

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Measure Information Form

Measure Set: Sudden Cardiac Arrest (SCA)

Set Measure ID: SCA-03

Performance Measure Name: Initiation of Therapeutic Hypothermia

Description: Initiation of therapeutic hypothermia after out-of-hospital sudden cardiac arrest.

Rationale: Therapeutic hypothermia has been demonstrated to be of benefit in overall survival rates and neurological outcome when used for survivors of out-of-hospital sudden cardiac arrest. Sagalyn and colleagues, in review of the results of published investigations that included randomized controlled trials, determined that the findings from landmark randomized controlled trials were confirmed; the use of therapeutic hypothermia demonstrated an approximate two- to three-fold improvement in both survival and neurological outcome for survivors of out-of-hospital cardiac arrest. The Advanced Life Support Task Force of the International Liaison Committee on Resuscitation (ILCOR) in 2003 recommended that unconscious adult patients with spontaneous circulation after out-of-hospital cardiac arrest should be cooled to within a range of 32° C- 34°C for 12 to 24 hours when the initial rhythm was ventricular fibrillation. This recommendation was repeated by the American Heart Association in the 2010 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Despite the many studies demonstrating the significant benefit of this treatment modality and long-standing recommendations, Merchant and colleagues determined that use of therapeutic hypothermia remains limited, with recent estimates suggesting that approximately 2300 (range 300 to 9500) additional comatose patients with cardiac arrest annually would achieve good neurological outcomes if hypothermia were fully implemented in US hospitals. Mild hypothermia is the only therapy applied in the post-cardiac arrest setting that has been shown to increase survival rates.

There are several possible mechanisms by which mild hypothermia might improve neurological outcomes when used after reperfusion. Mild hypothermia slows the cerebral metabolic rate and is thought to suppress many of the chemical reactions associated with reperfusion injury. Despite these potential advantages, hypothermia can also produce adverse effects, including arrhythmias, infection, and coagulopathy. Further studies are needed to support the use of hypothermia in patients under 18 years of age, and hypothermia may be beneficial after resuscitation from rhythms other than ventricular fibrillation/ventricular tachycardia and from in-hospital cardiac arrest.

Not all facilities have the capability to administer therapeutic hypothermia. In those facilities, patients should be transferred to another acute care facility with such capability.

Type of Measure: Process

Improvement Noted As:

Numerator Statement: Patients for whom therapeutic hypothermia is initiated either prior to or after hospital arrival, or who are transferred to another acute care facility for therapeutic hypothermia.

Included Populations: Not applicable
Excluded Populations: None

Data Elements:

- Arrival Date
- Arrival Time
- Date Therapeutic Hypothermia Initiated
- Discharge Disposition
- Therapeutic Hypothermia Initiated
- Time Therapeutic Hypothermia Initiated

Denominator Statement: Patients discharged with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1, who sustain a cardiac arrest prior to hospital admission, and who meet all of the following criteria:

- Ventricular fibrillation or pulseless ventricular tachycardia is the initial rhythm at cardiac arrest, and
- Return of spontaneous circulation, and
- Comatose

Included Populations: Not applicable

Excluded Populations:

- Patients without return of spontaneous circulation
- Patients not comatose
- Cardiac arrest occurring after hospital admission
- Expired after therapeutic hypothermia ordered but prior to initiation of hypothermia
- Age < 18 years
- Documented reason for not administering therapeutic hypothermia

Data Elements:

- Admission Date
- Admission Time
- Birthdate
- Cardiac Arrest
- Cardiac Arrest Date
- Cardiac Arrest Time
- Comatose
- Date Therapeutic Hypothermia Ordered
- Discharge Disposition
- Discharge Time
- Hispanic Ethnicity
- Initial Rhythm
- Race
- Reason for Not Administering Therapeutic Hypothermia
- Return of Spontaneous Circulation
- Sex
- Time Therapeutic Hypothermia Ordered

Risk Adjustment: No.

Data Accuracy:
Measure Analysis Suggestions:

Sampling: Yes.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
SCA-03: Initiation of Therapeutic Hypothermia

**Numerator:** Patients for whom therapeutic hypothermia is initiated either prior to or after hospital arrival, or who are transferred to another acute care facility for therapeutic hypothermia.

**Denominator:** Patients discharged with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1, who sustain a cardiac arrest prior to hospital admission, and who meet all of the following criteria:
- Ventricular fibrillation or pulseless ventricular tachycardia is the initial rhythm at cardiac arrest, and
- Return of spontaneous circulation, and
- Comatose

---

**Variable Key:**
- Age
- Cardiac Time II
- Expired Time I
- Expired Time II

---

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SCA-03

Data
Therapeutic
Hypothermia
Initiated

= UTD

Non-UTD

Time
Therapeutic
Hypothermia
Initiated

= UTD

Non-UTD

Expired Time II (in minutes) = Date and Time Therapeutic Hypothermia Initiated minus Discharge Date and Time

Expired Time II

=> 0

Case will be rejected

< 0

In Numerator Population

In Measure Population

STOP

SCA-03 Z
Measure Information Form

**Measure Set:** Sudden Cardiac Arrest (SCA)

**Set Measure ID:** SCA-04

**Performance Measure Name:** Maintenance of Thermoregulation in Therapeutic Hypothermia

**Description:** Assessment of the maintenance of the goal temperature of 32° - 34° C when therapeutic hypothermia is used for survivors of sudden cardiac arrest.

**Rationale:** Therapeutic hypothermia has been demonstrated to be of benefit in overall survival rates and neurological outcome when used for survivors of out-of-hospital sudden cardiac arrest. Sagalyn and colleagues, in review of the results of published investigations that included randomized controlled trials, determined that the findings from landmark randomized controlled trials were confirmed; the use of therapeutic hypothermia demonstrated an approximate two- to three-fold improvement in both survival and neurological outcome for survivors of out-of-hospital cardiac arrest¹. The Advanced Life Support Task Force of the International Liaison Committee on Resuscitation (ILCOR) in 2003 recommended that unconscious adult patients with spontaneous circulation after out-of-hospital cardiac arrest should be cooled to 32 degrees C to 34 degrees C for 12 to 24 hours when the initial rhythm was ventricular fibrillation². This recommendation was repeated by the American Heart Association in the 2010 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care³. Despite the many studies demonstrating the significant benefit of this treatment modality and long-standing recommendations, Merchant and colleagues determined that use of therapeutic hypothermia remains limited, with recent estimates suggesting that approximately 2300 (range 300 to 9500) additional comatose patients with cardiac arrest annually would achieve good neurological outcomes if hypothermia was fully implemented in US hospitals⁴. Mild hypothermia is the only therapy applied in the post-cardiac arrest setting that has been shown to increase survival rates⁵.

There are several possible mechanisms by which mild hypothermia might improve neurological outcomes when used after reperfusion. Mild hypothermia slows the cerebral metabolic rate and is thought to suppress many of the chemical reactions associated with reperfusion injury. Despite these potential advantages, hypothermia can also produce adverse effects, including arrhythmias, infection, and coagulopathy². Further studies are needed to support the use of hypothermia in patients under 18 years of age, and hypothermia may be beneficial after resuscitation from rhythms other than ventricular fibrillation/ventricular tachycardia and from in-hospital cardiac arrest².

**Type of Measure:** Process

**Improvement Noted As:**

**Numerator Statement:** Patients for whom thermoregulation is maintained. (There is at least one core temperature recording every hour between 34 and 32 degrees C for a minimum of 12 continuous hours.)

**Included Populations:** Not applicable

**Excluded Populations:**
Data Elements:

- *Thermoregulation Maintained*

**Denominator Statement:** Patients with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1 for whom therapeutic hypothermia is initiated after sudden cardiac arrest.

**Included Populations:** Not applicable

- As above, including patients transferred in from another facility

**Excluded Populations:**

- Code Status order enacted after initiation of therapeutic hypothermia
- Expired during therapeutic hypothermia
- Transferred out within 12 hours after initiation of therapeutic hypothermia
- Non-system reason for early discontinuance of therapeutic hypothermia

**Data Elements:**

- *Cardiac Arrest*
- *Cardiac Arrest Date*
- *Cardiac Arrest Time*
- *Code Status Order*
- *Code Status Order Date*
- *Code Status Order Time*
- *Date Therapeutic Hypothermia Ended*
- *Date Therapeutic Hypothermia Initiated*
- *Discharge Disposition*
- *Discharge Time*
- *Hispanic Ethnicity*
- *Race*
- *Reason for Early Discontinuation of Therapeutic Hypothermia*
- *Sex*
- *Therapeutic Hypothermia Initiated*
- *Time Therapeutic Hypothermia Ended*
- *Time Therapeutic Hypothermia Initiated*

**Risk Adjustment:** No.

**Data Accuracy:**

**Measure Analysis Suggestions:**

**Sampling:** Yes.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


Measure Algorithm:
SCA–04: Maintenance of Thermoregulation in Therapeutic Hypothermia

**Numerator:** Patients for whom thermoregulation is maintained. (There is at least one core temperature recording every hour between 34 and 32 degrees C for a minimum of 12 continuous hours.)

**Denominator:** Patients with an ICD-9-CM Principal or Other Diagnosis Code of cardiac arrest as described in Appendix A-1 for whom therapeutic hypothermia is initiated after sudden cardiac arrest.

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Variable Key:
- Code Status Time II
- Hypothermia Time I
- Hypothermia Time II
- Hypothermia Time III

---

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Sudden Cardiac Arrest Pilot

The Joint Commission - DO NOT CITE, QUOTE, REPRODUCE OR DISTRIBUTE

[Diagram image]

STOP

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Data Elements
Data Element Name: Admission Date

Collected For: ACHF-01, ACHF-02, ACHF-03, ACHF-07, ACHF-08, HBIPS, Osteo, PBM, PC, SCA-03, SUB, TOB.

Definition: The month, day, and year of admission for inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to inpatient care?

Format: Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2001-Current Year)

Notes for Abstraction:

• The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

• A patient of a hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.)

• For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

• For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date.

• For patients for whom there is no admission to inpatient status, enter 00-00-0000.

Suggested Data Sources: ONLY ALLOWABLE SOURCES
Physician orders
Face sheet
UB-04, Field Location: 12

Excluded Data Sources

UB-04, Field Location: 06

Additional Notes:

Guidelines for Abstraction:

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<thead>
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<th>Inclusion</th>
<th>Exclusion</th>
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<tbody>
<tr>
<td>None</td>
<td>Admit to observation</td>
</tr>
<tr>
<td></td>
<td>Arrival date</td>
</tr>
</tbody>
</table>
Data Element Name: Admission Time

Collected For: SCA-03

Definition: The time of admission to acute inpatient care.

Suggested Data Collection Question: What is the time the patient was admitted to acute inpatient care?

Format:

- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:

Enter the earliest documented time of admission

- HH = Hour (00-23)
- M = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

- Midnight = 00:00
- Noon = 12:00
- 5:31 am = 05:31
- 5:31 pm = 17:31
- 11:59 am = 11:59
- 11:59 pm = 23:59

Note:

00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Date should remain 11-24-20xx or if it should be converted to 11-25-20xx. When converting Midnight or 24:00 to 00:00, do not forget to change the Arrival Date.

Example: Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- The intent of this data element is to determine the time that the patient was actually admitted to acute inpatient care.
- For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the time that the determination was made to admit to acute inpatient care and the
order was written. Do not abstract the time that the patient was admitted to Observation.

- If there are multiple inpatient orders, use the order that most accurately reflects the time that the patient was admitted. The admission time should not be abstracted from the earliest admission order without regards to substantiating documentation, such as nurses notes. If documentation suggests that the earliest admission order does not reflect the time the patient was admitted to inpatient care, this time should not be used.
- The admission time used should correspond to the admission date used.
- For times that include "seconds", remove the seconds and record the time as is. Example: 15:00:35 would be recorded as 15:00
- If the time of arrival is unable to be determined from medical record documentation, select "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD”. Example:
  - Documentation indicates the Arrival Time was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the Arrival Time is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select “UTD”.
- Review only the acceptable sources to determine the earliest time the patient was admitted for inpatient care. This may differ from the arrival time.
  - Note: Medical record documentation from all of the “ONLY ACCEPTABLE SOURCES” should be carefully examined in determining the most correct time of admission. Admission time should NOT be abstracted simply as the earliest time in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest time in the acceptable sources does not reflect the time the patient was admitted to the hospital, this time should not be used.
- If the patient is in an observation status and is subsequently admitted to the hospital, use the time

**Suggested Data Sources:**
- Face sheet
- Physician orders

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>

The Joint Commission - DO NOT CITE, QUOTE, REPRODUCE OR DISTRIBUTE 33
<table>
<thead>
<tr>
<th>None</th>
<th>Sudden Cardiac Arrest Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Admit to observation</td>
</tr>
<tr>
<td></td>
<td>• Arrival date</td>
</tr>
</tbody>
</table>
Data Element Name: Arrival Date

Collected For: SCA-01, SCA-02, SCA-03.

Definition: The earliest documented month, day, and year the patient arrived at the hospital.

Suggested Data Collection Question: What was the earliest documented date the patient arrived at the hospital?

Format: Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values: Enter the earliest documented date
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-9999)
UTD = Unable to Determine

Notes for Abstraction:
• If the date of arrival is unable to be determined from medical record documentation, select “UTD.”
• The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the Discharge Date]) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Examples:
○ Documentation indicates the Arrival Date was 03-42-20xx. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the Arrival Date is outside of the range listed in the Allowable Values for “Day”, it is not a valid date and the abstractor should select “UTD.”
○ Patient expires on 02-12-20xx and all documentation within the ONLY ACCEPTABLE SOURCES indicates the Arrival Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the Arrival Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Arrival Date allows the case to be accepted into the warehouse.

• Review only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date.

Note: Medical record documentation from all of the “ONLY ACCEPTABLE SOURCES”...
SOURCES “should be carefully examined in determining the most correct date of arrival. Arrival date should NOT be abstracted simply as the earliest date in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest date in the acceptable sources does not reflect the date the patient arrived at the hospital, this date should not be used.

• When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation, which reflects processes that occurred in the ED or hospital.

• If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to the hospital, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date.

• If the patient is a “Direct Admit” to the cath lab, as a transfer from another ED or acute care hospital, use the date the patient presents to the cath lab as the arrival date.

• If the patient is in an observation status and is subsequently admitted to the hospital:
  ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presents to the ED or arrived on the floor for observation care as the arrival date.
  ◦ If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to the ED as the arrival date.
  ◦ If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital.

• For “Direct Admits” to the hospital, use the earliest date the patient arrives at the hospital.

• The source “Any ED documentation” includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.

• The source “Procedure notes” refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedures notes.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES

• Vital signs graphic record
• Procedure notes
• Any ED documentation
• Nursing admission assessment/admitting note
• Observation record

For “Direct Admits,” in addition to the above suggested data sources, the following may also be utilized:
- Face sheet

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• Addressographs/stamps</td>
</tr>
</tbody>
</table>
Data Element Name: Arrival Time

Collected For: SCA-01, SCA-02, SCA-03.

Definition: The earliest documented time (military time) the patient arrived at the hospital.

Suggested Data Collection Question: What was the earliest documented time the patient arrived at the hospital?

Format:

- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

Allowable Values:

Enter the earliest documented time of arrival:

- **HH** = Hour (00-23)
- **MM** = Minutes (00-59)
- **UTD** = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

- Midnight = 00:00
- Noon = 12:00
- 5:31 am = 05:31
- 5:31 pm = 17:31
- 11:59 am = 11:59
- 11:59 pm = 23:59

**Note:**

00:00 = midnight. If your electronic system documents time as 00:00 11-24-2007, review supporting documentation to determine if the Arrival Date should remain 11-24-2007 or if it should be converted to 11-25-2007. When converting 24:00 to 00:00 do not forget to change the Arrival Date.

Example:

Midnight or 24:00 on 11-24-2007 = 00:00 on 11-25-2007

**Notes for Abstraction:**

- For times that include “seconds”, remove the seconds and record the time as is.

Example:

15:00:35 would be recorded as 15:00
If the time of arrival is unable to be determined from medical record documentation, select “UTD.”

2. The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”

Example:
Documentation indicates the Arrival Time was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the Arrival Time is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

Note:
Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Arrival Time allows the case to be accepted into the warehouse.

3. Review only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time.

Note:
Medical record documentation from all of the “only acceptable sources” should be carefully examined in determining the most correct time of arrival. Arrival time should NOT be abstracted simply as the earliest time in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest time in the acceptable sources does not reflect the time the patient arrived at the hospital, this time should not be used.

4. When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.

5. If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to the hospital, use the time the patient presents to the ED or arrives on the floor as the arrival time.

6. If the patient is in an observation status and is subsequently admitted to the hospital:
   - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presents to the ED or arrived on the floor for observation care as the arrival time.
   - If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to the ED as the arrival time.
   - If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital.
   - If the patient is a “Direct Admit” to the cath lab, as a transfer from another ED or acute care hospital, use the time the patient presents to the cath lab as the arrival time.
• For “Direct Admits” to the hospital, use the earliest time the patient arrives at the hospital.
• The source “Any ED documentation” includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
• The source “Procedure notes” refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.

Suggested Data Sources:  

**ONLY ACCEPTABLE SOURCES**

• Vital signs graphic record
• Procedure notes
• Any ED documentation
• Nursing admission assessment/admitting note
• Observation record

For “Direct Admits,” in addition to the above suggested data sources, the following may also be utilized:

• Face sheet

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>• None</td>
<td>• Addressographs/stamps</td>
</tr>
</tbody>
</table>
Data Element Name: Birthdate

Collected For: All Records

Definition: The month, day, and year the patient was born.

Note:

- Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.
- For HBIPS discharge measures, i.e., HBIPS-1, 4, 5, 6, 7, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Suggested Data Collection Question: What is the patient’s date of birth?

Format:

- Length: 10 – MM-DD-YYYY (includes dashes)
- Type: Date
- Occurs: 1

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-Current Year)

Notes for Abstraction:

Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form
Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
Data Element Name: Cardiac Arrest


Definition: Absence of both pulse and breathing

Suggested Data Collection Question: Did the patient sustain a cardiac arrest (absence of both pulse and breathing)?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y The patient sustained a cardiac arrest
N The patient did not sustain a cardiac arrest

Notes for Abstraction:
• Equivalent terms for cardiac arrest include Code Blue or cardiorespiratory arrest
• The preferred source is the resuscitation (Code Blue) record. A resuscitation record is a document completed during and/or immediately after a resuscitation effort.

Suggested Data Sources:
• Resuscitation records
• Entire medical record
• Any EMS documentation

Additional Notes:

Guidelines for Abstraction:

<table>
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<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Cardiac Arrest Date


Definition: The month, day, and year of cardiac arrest.

Suggested Data Collection Question: What is the date the patient sustained a cardiac arrest (absence of both pulse and breathing)?

Format: Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1-5

Allowable Values:

<table>
<thead>
<tr>
<th>MM</th>
<th>Month (01-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD</td>
<td>Day (01-31)</td>
</tr>
<tr>
<td>YYYY</td>
<td>Year (2001-Current Year)</td>
</tr>
</tbody>
</table>

Notes for Abstraction:

- Review only the acceptable sources to determine the Cardiac Arrest Date.
- The preferred source is the resuscitation (Code Blue) record. A resuscitation record is a document completed during and/or immediately after a resuscitation effort.
- If there are multiple cardiac arrests in rapid succession in the same resuscitation effort, only select the first arrest (and defibrillation dates).
- The source “Procedure notes” refers to formal documents that describe a procedure that was done (e.g., cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.
- The source “ECG rhythm strip interpretation” refers to a transcribed interpretation of an ECG. Abstractors should not interpret ECG tracings.

Suggested Data Sources:

- Nursing notes
- Progress notes
- Procedure notes
- Resuscitation record
- Any ED documentation
- Any EMS documentation
- ECG rhythm strip interpretation

Additional Notes:

Guidelines for Abstraction:

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</tbody>
</table>
Data Element Name: **Cardiac Arrest Event Number**

Collected For: **SCA-01, SCA-02.**

Definition: The number used to identify the numerical sequence of the cardiac arrest event for which data are being abstracted.

Suggested Data Collection Question: For which cardiac arrest event are data being abstracted?

Format: Length: 1  
Type: Numeric  
Occurs: 1-5

Allowable Values:

1 – First cardiac arrest event  
2 – Second cardiac arrest event  
3 – Third cardiac arrest event  
4 – Fourth cardiac arrest event  
5 – Fifth cardiac arrest event

Notes for Abstraction:

Suggested Data Sources:  
- Entire medical record

Additional Notes:

- A cardiac arrest event may be a single instance of cardiac arrest, or multiple arrests occurring within minutes of each other. For example, a patient may have a cardiac arrest, receive defibrillation, and recover; that is one cardiac arrest event. However, a patient may have a cardiac arrest at 10:00, be defibrillated, and arrest again four minutes after the first arrest at 10:04; that is also one cardiac arrest event.
- If the time elapsed between cardiac arrests is more than one hour, they are separate **Cardiac Arrest Event Numbers.** If the time elapsed between arrests is less than one hour, both arrests are part of the same **Cardiac Arrest Event Number.**
- Assign the number to the event based on the numeric sequence of the event within that episode of care. For example, patient is admitted on 3/1 and has a cardiac arrest on 3/3, from which he is resuscitated. He is sent to the ICU where he sustains another cardiac arrest on 3/5 at 6:00 and a third arrest on 3/5 at 6:05. In that case, **Cardiac Arrest Event Number 1** occurred on 3/3, and **Cardiac Arrest Event Number 2** occurred on 3/5 at 6:00. The patient then arrested again on 3/5 at 11:15 and expired; **Cardiac Arrest Event Number 3** was on 3/5 at 11:15.
• Assign a number to any cardiac arrest event whether or not the event is included in either SCA-01 or SCA-02.
  ◦ **Example 1**: a patient is admitted on June 21 for heart failure and has a cardiac arrest the following day, on June 22, during which an endotracheal tube is inserted. You would assign *Cardiac Arrest Event Number 1* to this event and it would be included in both SCA-01 and SCA-02. Eight days later, on June 30, he has a left ventricular device inserted. On July 5, he has a second cardiac arrest event; you would assign *Cardiac Arrest Event Number 2* to the July 5 event, even though he would be excluded from SCA-01 because of the left ventricular assist device but since an endotracheal tube was inserted on July 5 he would be included in SCA-02. On July 9, the family signs a Do Not Resuscitate order. On July 12, while still intubated, the patient has a third cardiac arrest and expires; assign *Cardiac Arrest Event Number 3* to this event, even though this event is excluded from both measures due to *Treatment Directive* signed and endotracheal tube in place.
  ◦ **Example 2**: Patient is admitted for an MI on 4/2 and has electrophysiologic testing on 4/4, during which a cardiac arrest occurs. He is transferred to CCU and has another cardiac arrest on 4/6. Assign *Cardiac Arrest Event Number 2* to the arrest on 4/6, since the arrest on 4/4 is *Cardiac Arrest Event Number 1* but is excluded from SCA-01 and SCA-02 because it occurred during electrophysiologic testing.

• Do not abstract data for more than the first 5 cardiac arrest events in each patient episode of care.

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Cardiac Arrest Time


Definition: The documented time (military time) the patient sustained a cardiac arrest.

Suggested Data Collection Question: What was the documented time the patient sustained a cardiac arrest?

Format: Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1-5

Allowable Values: Enter the documented time of arrest

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

• If the time is in the a.m., conversion is not required
• If the time is in the p.m., add 12 to the clock time hour

Examples:
Midnight - 00:00
Noon - 12:00
5:31 am - 05:31
5:31 pm - 17:31
11:59 am - 11:59
11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Date should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00 do not forget to change the Arrival Date.

Example: Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
• The time of cardiac arrest for a patient NOT on a cardiac monitor, or on a monitor that is not recording, is the time a Code Blue is called.
• The time of cardiac arrest for a patient on a recording cardiac monitor is the time documented on the rhythm strip that the cardiac arrest
occurred. For patients on a recording monitor, this time supersedes the time a Code Blue was called.
• For times that include “seconds”, remove the seconds and record the time as is. Example: 15:00:35 would be recorded as 15:00
• If the time of arrest is unable to be determined from medical record documentation, select “UTD”.
• If there are multiple cardiac arrests in rapid succession in the same resuscitation effort, only select the first arrest and defibrillation times.
• The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD”.
  ◦ Example:
    ■ Documentation indicates the Cardiac Arrest Time was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the Cardiac Arrest Time is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”.
• The preferred source is the resuscitation (Code Blue) record. A resuscitation record is a document completed during and/or immediately after a resuscitation effort.
• The source “Procedure notes” refers to formal documents that describe a procedure that was done (e.g., cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.
• The source “ECG rhythm strip interpretation” refers to a transcribed interpretation of an ECG from a monitor or automated external defibrillator. Abstractors should not interpret ECG tracings.

If multiple inclusion terms are used, record the time of the first timed entry. If no entries are timed, record UTD.

Suggested Data Sources:
• Nursing notes
• Progress notes
• Procedure notes
• Resuscitation (Code Blue) record
• Any ED documentation
• Any EMS documentation
• ECG rhythm strip interpretation

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Code Blue called</td>
<td>Addressographs/stamps</td>
</tr>
<tr>
<td>• Code Team called</td>
<td></td>
</tr>
<tr>
<td>• Cardiac arrest</td>
<td></td>
</tr>
<tr>
<td>• V Fib on monitor</td>
<td></td>
</tr>
<tr>
<td>• V tach on monitor, no pulse</td>
<td></td>
</tr>
<tr>
<td>• Cardiac arrest occurred</td>
<td></td>
</tr>
</tbody>
</table>
• 911 summoned, 911 called (if arrest occurs prior to hospital arrival)
Data Element Name: Code Status Order


Definition: A code status order is a physician order directing actions to be taken or treatment approaches for a patient in the event that his or her condition deteriorates, in the event of cardiac or respiratory arrest, or for patients who are or will become terminal. Orders to terminate life support are also considered code status orders.

Suggested Data Collection Question: Was there a code status order documented by a physician/APN/PA?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1-5

Allowable Values:
Y (Yes) There is documentation of a code status order by a physician/APN/PA.
N (No) There is no documentation of code status order by a physician/APN/PA.

Notes for Abstraction:
- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, palliative care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice/palliative care service
  - Patient or family request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice/palliative care service
  - Determine the earliest date the physician/APN/PA DOCUMENTED any inclusion terms for a code status order in the ONLY ACCEPTABLE SOURCES.

Suggested Data Sources: PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:
- Discharge summary
- DNR/MOLST/POLST forms
- DNR-Comfort Care form
- Physician orders
- Progress notes

Additional Notes: Excluded Data Sources:
Restraint order sheet

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Brain dead</td>
<td>• Inclusion term clearly described as negative.</td>
</tr>
<tr>
<td>• Brain death</td>
<td>◦ Examples:</td>
</tr>
<tr>
<td>• Comfort care</td>
<td>■ “No comfort care”</td>
</tr>
<tr>
<td>• Comfort measures</td>
<td>■ “Not a hospice candidate”</td>
</tr>
<tr>
<td>• Comfort measures only (CMO)</td>
<td>■ &quot;Declines palliative care&quot;</td>
</tr>
<tr>
<td>• Comfort only</td>
<td>■ &quot;Not appropriate for hospice care&quot;</td>
</tr>
<tr>
<td>• DNR</td>
<td>■ “I offered palliative care consult to discuss end of life issues. Family did not show any interest.”</td>
</tr>
<tr>
<td>• DNR-CCA</td>
<td></td>
</tr>
<tr>
<td>• DNR-Comfort Care Arrest</td>
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<tr>
<td>• DNRCC-A</td>
<td></td>
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<tr>
<td>• DNRCC-Arrest</td>
<td></td>
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<tr>
<td>• DNR/Allow Natural Death</td>
<td></td>
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<tr>
<td>• DNR-CC</td>
<td></td>
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<tr>
<td>• End of life care</td>
<td></td>
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<tr>
<td>• Hospice</td>
<td></td>
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<tr>
<td>• Hospice care</td>
<td></td>
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<tr>
<td>• MOLST (Medical Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>• Organ harvest</td>
<td></td>
</tr>
<tr>
<td>• Palliative care</td>
<td></td>
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<tr>
<td>• Palliative measures</td>
<td></td>
</tr>
<tr>
<td>• POLST (Physician Orders for Life-Sustaining Treatment)</td>
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<tr>
<td>• State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient’s preferences about specific-end-of-life treatment decisions into portable medical orders.</td>
<td></td>
</tr>
<tr>
<td>• Terminal care</td>
<td></td>
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<tr>
<td>• Terminate life support</td>
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</tbody>
</table>
Data Element Name: Code Status Order Date


Definition: Date of physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of a code status order, as described in the inclusion terms.

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of a code status order?

Format:

- **Length:** 10 - MM-DD-YYYY (includes dashes) or UTD
- **Type:** Date
- **Occurs:** 1-5

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2010-Current Year)
- UTD = Unable to Determine

Notes for Abstraction:

- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, palliative care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice/palliative care service
  - Patient or family request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice/palliative care service
- Determine the earliest date the physician/APN/PA DOCUMENTED any inclusion terms for code status order in the ONLY ACCEPTABLE SOURCES. Do not factor in when the resuscitation order was actually instituted. E.g., “Discussed DNR with family on arrival”
  - In some cases, the code statusorder date will be in advance of the admission date, such as DNR/POLST/MOLST forms that are signed and dated prior to admission.

Suggested Data Sources:

- Discharge summary
- DNR/MOLST/POLST forms
- DNR-Comfort Care form
**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Brain dead</td>
<td>Inclusion term clearly described as negative.</td>
</tr>
<tr>
<td>• Brain death</td>
<td>• Examples:</td>
</tr>
<tr>
<td>• Comfort care</td>
<td>◦ &quot;No comfort care&quot;</td>
</tr>
<tr>
<td>• Comfort measures</td>
<td>◦ “Not a hospice candidate”</td>
</tr>
<tr>
<td>• Comfort measures only (CMO)</td>
<td>◦ &quot;Declines palliative care&quot;</td>
</tr>
<tr>
<td>• Comfort only</td>
<td>◦ &quot;Not appropriate for hospice care&quot;</td>
</tr>
<tr>
<td>• DNR</td>
<td>◦ &quot;I offered palliative care consult to discuss end of life issues. Family did not show any interest.&quot;</td>
</tr>
<tr>
<td>• DNR-CCA</td>
<td></td>
</tr>
<tr>
<td>• DNR-Comfort Care Arrest</td>
<td></td>
</tr>
<tr>
<td>• DNRCC-A</td>
<td></td>
</tr>
<tr>
<td>• DNR-Allow Natural Death</td>
<td></td>
</tr>
<tr>
<td>• DNR-CC</td>
<td></td>
</tr>
<tr>
<td>• End of life care</td>
<td></td>
</tr>
<tr>
<td>• Hospice</td>
<td></td>
</tr>
<tr>
<td>• Hospice care</td>
<td></td>
</tr>
<tr>
<td>• MOLST (Medical Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>• Organ harvest</td>
<td></td>
</tr>
<tr>
<td>• Palliative care</td>
<td></td>
</tr>
<tr>
<td>• Palliative measures</td>
<td></td>
</tr>
<tr>
<td>• POLST (Physician Orders for Life-Sustaining Treatment)</td>
<td></td>
</tr>
<tr>
<td>• State-authorized portable orders (SAPOs). SAPOs are specialized forms,</td>
<td></td>
</tr>
<tr>
<td>Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR)</td>
<td></td>
</tr>
<tr>
<td>orders, or identifiers authorized by state law, that translate a patient's preferences about specific-end-of-life treatment decisions into portable medical orders.</td>
<td></td>
</tr>
<tr>
<td>• Terminal care</td>
<td></td>
</tr>
<tr>
<td>• Terminate Life Support</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Code Status Order Time


Definition: Time of physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of a code status order, as described in the inclusion terms.

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of a code status order?

Format: Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1-5

Allowable Values:

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format with the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Notes for Abstraction:

- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, palliative care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice/palliative care service
  - Patient or family request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice/palliative care service
- Determine the earliest date the physician/APN/PA DOCUMENTED any inclusion terms for a code status order in the ONLY ACCEPTABLE SOURCES. Do not factor in when the code status order was actually instituted. E.g., “Discussed DNR with family on arrival”

Suggested Data Sources:

- PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:
  - Discharge summary
  - DNR/MOLST/POLST forms
  - DNR-Comfort Care form
### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
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<tbody>
<tr>
<td>• Brain dead</td>
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</tr>
<tr>
<td>• DNR</td>
<td>◦ “I offered palliative care consult to discuss end of life issues. Family did not show any interest.”</td>
</tr>
<tr>
<td>• DNR-CCA</td>
<td>◦ “Patient declines hospice care at this time but I feel this will be an important plan of care when his condition deteriorates further”</td>
</tr>
<tr>
<td>• DNR-Comfort Care Arrest</td>
<td>◦ “Palliative care would also be reasonable - defer decision for now”</td>
</tr>
<tr>
<td>• DNRCC-A</td>
<td>◦ “Patient refusing comfort measures only”</td>
</tr>
<tr>
<td>• DNR-Allow Natural Death</td>
<td>• Advance Directive signed by patient or family with no accompanying order</td>
</tr>
<tr>
<td>• DNR-CC</td>
<td>• Living Will signed by patient with no accompanying order</td>
</tr>
<tr>
<td>• End of life care</td>
<td></td>
</tr>
<tr>
<td>• Hospice</td>
<td></td>
</tr>
<tr>
<td>• Hospice care</td>
<td></td>
</tr>
<tr>
<td>• MOLST (Medical Orders for Life-Sustaining Treatment)</td>
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</tr>
<tr>
<td>• Organ harvest</td>
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<td></td>
</tr>
<tr>
<td>• Terminal care</td>
<td></td>
</tr>
<tr>
<td>• Terminante Life Support</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Comatose

Collected For: SCA-03

Definition: Comatose patients are those patients documented as lacking purposeful movement or lacking response to painful stimuli or those patients for whom the term “comatose” has been entered into the clinical record.

Suggested Data Collection Question: Was there documentation the patient was comatose?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) There was documentation that the patient was comatose.

N (No) There was no documentation that the patient was comatose.

Notes for Abstraction:

• Begin abstraction at the time the patient has a Return of Spontaneous Circulation following cardiac arrest and end 2 hours after cardiac arrest. If any inclusion term is found, choose “Yes”; however, if an Exclusion term is found subsequently within that time frame, choose “No”.
• If there is no Return of Spontaneous Circulation, choose “Yes”.

Suggested Data Sources:

• Emergency department record
• Nursing notes
• Physician’s notes
• Code (resuscitation) record
• Observation notes
• Glasgow Sheet

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comatose</td>
<td>Awake</td>
</tr>
<tr>
<td>Coma</td>
<td>Confused</td>
</tr>
<tr>
<td>Unresponsive</td>
<td>Disoriented</td>
</tr>
<tr>
<td>Glasgow Coma Scale 8 or less GCS 8 or less</td>
<td>Follows verbal commands</td>
</tr>
<tr>
<td>Glasgow verbal score 3 or less</td>
<td>Responding Equivalent terminology</td>
</tr>
<tr>
<td>Not responding to verbal commands</td>
<td></td>
</tr>
<tr>
<td>Equivalent terminology</td>
<td></td>
</tr>
<tr>
<td>Data Element Name:</td>
<td>Date Therapeutic Hypothermia Ended</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Definition:</td>
<td>Date of documentation that therapeutic hypothermia was ended.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>What date was there documentation that therapeutic hypothermia was ended?</td>
</tr>
</tbody>
</table>
| Format:            | **Length:** 10 - MM-DD-YYYY (includes dashes) or UTD  
|                    | **Type:** Alphanumeric  
|                    | **Occurs:** 1 |

**Allowable Values:**

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2010-Current Year)
- UTD = Unable to Determine

**Notes for Abstraction:**

- If the date therapeutic hypothermia was ended is unable to be determined from medical record documentation, enter “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”.
  - Example:
    - Documentation indicates the date hypothermia ended was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the *Date Therapeutic Hypothermia Ended* is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD”.
- The date that therapeutic hypothermia ends is the date that re-warming began. If the date re-warming began is not documented, use the date the catheter or probe was removed or the date in which “therapeutic hypothermia terminated/ended” is documented.
- Use the earliest date that re-warming began if there are multiple entries.
- If the patient was discharged prior to the end of therapeutic hypothermia, enter UTD.

**Suggested Data Sources:**

- Nursing notes
- Progress notes
- Physician orders
- Hypothermia flow sheet
Additional Notes:

## Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Date Therapeutic Hypothermia Initiated


Definition: Date of documentation that therapeutic hypothermia was begun.

Suggested Data Collection Question: What date was there documentation that therapeutic hypothermia was begun?

Format: Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2010-Current Year)
UTD = Unable to Determine

Notes for Abstraction:

• If the date therapeutic hypothermia was begun is unable to be determined from medical record documentation, enter “UTD”.
• The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) (and no other documentation is found that provides this information, the abstractor should select “UTD”.
  ▪ Example:
    - Documentation indicates the date hypothermia started was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the Date Therapeutic Hypothermia Initiated is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD”.
• The Date Therapeutic Hypothermia Started and the Arrival Date may be the same date or a different date. For example, therapeutic hypothermia may have been started by an EMS provider at 23:45 pm on 11/1/20xx, while the arrival date is 11/2/20xx at 00:10 am.
• If therapeutic hypothermia is being given via a machine that uses cooling catheters or endovascular probe attached to a machine, and the catheter or probe is inserted in advance of the machine being turned on or activated, use the date the machine was turned on. If the date the machine was turned on is not documented, use the date the catheter or probe was inserted.
• Use the earliest date that therapeutic hypothermia is documented.

Suggested Data Sources:

• Emergency department record
• History and physical
• Nursing notes
- Progress notes
- Admission Notes
- EMS Record
- Hypothermia flow sheet

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: *Date Therapeutic Hypothermia Ordered*

Collected For: SCA-03.

Definition: The month, date, and year that therapeutic hypothermia was ordered.

Suggested Data Collection Question: What is the date that therapeutic hypothermia was ordered?

Format: Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001-Current Year)
- UTD = Unable to Determine

Notes for Abstraction:
- Use the date at which therapeutic hypothermia was first ordered. If a discrepancy exists in date documentation from different sources, choose the earliest date.
- If the date therapeutic hypothermia was ordered is unable to be determined from medical record documentation, select “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”.
  - Example:
    - Documentation indicates the therapeutic hypothermia order date was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the therapeutic hypothermia order date is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD”.
- If therapeutic hypothermia was initiated by EMS and there is no order, use the date that therapeutic hypothermia was begun.

Suggested Data Sources:
- Emergency department record
- Progress notes
- Physician orders
- EMS record
- Nursing flow sheets

Additional Notes:
## Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Therapeutic Hypothermia</td>
<td>• Ice bag to (one specific body part)</td>
</tr>
<tr>
<td>• Start Cooling Protocol</td>
<td></td>
</tr>
<tr>
<td>• Begin TH Protocol</td>
<td></td>
</tr>
<tr>
<td>• Iced saline at xx gtts. per min.</td>
<td></td>
</tr>
<tr>
<td>• Ice bags to groin, armpits, neck</td>
<td></td>
</tr>
<tr>
<td>• Apply cooling blankets</td>
<td></td>
</tr>
<tr>
<td>• Equivalent terminology</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: *Discharge Date*

Collected For: All Records, Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format:
- **Length:** 10 – MM-DD-YYYY (includes dashes)
- **Type:** Date
- **Occurs:** 1

Allowable Values:

- **MM = Month (01-12)**
- **DD = Day (01-31)**
- **YYYY = Year (2001-Current Year)**

Notes for Abstraction:

Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04, Field Location: 6

Additional Notes:

**Guidelines for Abstraction:**
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
<tr>
<td>Data Element Name:</td>
<td>Discharge Disposition</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Collected For:</td>
<td>All Records</td>
</tr>
<tr>
<td>Definition:</td>
<td>The final place or setting to which the patient was discharged on the day of discharge.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>What was the patient’s discharge disposition on the day of discharge?</td>
</tr>
<tr>
<td>Format:</td>
<td>Length: 1 Type: Alphanumeric Occurs: 1</td>
</tr>
</tbody>
</table>

**Allowable Values:**

1. Home
2. Hospice - Home
3. Hospice – Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**

- Only use documentation from the day of or the day before discharge when abstracting this data element.
  **Example:**
  Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value “5”.

- Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.

- If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.
  **Example:**
  Nursing discharge note documentation reflects that the patient is being discharged to “XYZ” Hospital. The Social Service notes from
the day before discharge further clarify that the patient will be transferred to the rehab unit of “XYZ” Hospital, select value “5”.

• If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value “4”.

• To select value “7” there must be explicit documentation that the patient left against medical advice.

Examples:
- Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed, select value “7”.
- Physician order written to discharge to home. Nursing notes reflect that patient left before discharge instructions could be given, select value “1”.

**Suggested Data Sources:**
- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social service notes
- Transfer record

**Additional Notes:**

Excluded Data Sources:
- Any documentation prior to the day of or day before discharge
- UB-04

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusion Guidelines for Abstraction:</strong> For Value 1:</td>
<td>None</td>
</tr>
<tr>
<td>• Assisted Living Facilities</td>
<td></td>
</tr>
<tr>
<td>• Court/Law Enforcement – includes detention facilities, jails, and prison</td>
<td></td>
</tr>
<tr>
<td>• Home – includes board and care, foster or residential care, group or personal care homes, and homeless shelters</td>
<td></td>
</tr>
<tr>
<td>• Home with Home Health Services</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization.</td>
<td></td>
</tr>
<tr>
<td>Facility Type</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Hospice Care - General Inpatient and Respite</td>
<td></td>
</tr>
<tr>
<td>Hospice Care - Residential and Skilled Facilities</td>
<td></td>
</tr>
<tr>
<td>Hospice Care - Other Health Care Facilities (excludes home)</td>
<td></td>
</tr>
</tbody>
</table>

For Value 4:

<table>
<thead>
<tr>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Short Term General and Critical Access Hospitals</td>
</tr>
<tr>
<td>Cancer and Children’s Hospitals</td>
</tr>
<tr>
<td>Department of Defense and Veteran’s Administration Hospitals</td>
</tr>
</tbody>
</table>

For Value 5:

<table>
<thead>
<tr>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended or Immediate Care Facility (ECF/ICF)</td>
</tr>
<tr>
<td>Long Term Acute Care Hospital (LTACH)</td>
</tr>
<tr>
<td>Nursing Home or Facility including Veteran’s Administration Nursing Facility</td>
</tr>
<tr>
<td>Psychiatric Hospital or Psychiatric Unit of a Hospital</td>
</tr>
<tr>
<td>Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed</td>
</tr>
<tr>
<td>Transitional Care Unit (TCU)</td>
</tr>
</tbody>
</table>
Data Element Name: Discharge Time


Definition: Time of documentation of discharge

Suggested Data Collection Question: What time was the patient discharged?

Format: Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format with the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Notes for Abstraction:

- If the time the patient expired is unable to be determined from medical record documentation, enter “UTD”.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”.
- Example:
  - Documentation indicates the patient expired at 26-42-20xx. No other documentation in the medical record provides a valid date. Since the Time Expired is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”.
- If the patient expired and there are multiple times, use the time the patient was pronounced.
- If there are multiple times documented, use the latest time.
- If the patient was transferred, use the time the patient was actually transferred, not the time the order was written.

Suggested Data Sources:

- Nursing notes
- Progress notes
- Resuscitation records
- Death certificate
### Additional Notes:

#### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: *Endotracheal Intubation Confirmation Date*

Collected For: SCA-02

Definition: The month, day, and year of endotracheal intubation confirmation.

Suggested Data Collection Question: What is the date the endotracheal intubation was confirmed?

Format: Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1-5

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001-Current Year)
- UTD = Unable To Determine
- N = No intubation confirmation

Notes for Abstraction:
- The intent of this data element is to determine the date that the endotracheal intubation was confirmed. Confirmation is a separate activity occurring after endotracheal tube placement.
- If there are multiple dates documented, use the date that most accurately reflects the date that the patient was intubated during an episode of cardiac arrest, based on other documentation in the record.
- If unable to determine date of confirmation, enter UTD.
- If there is no confirmation of intubation, enter N.

Suggested Data Sources:
- Anesthesia record
- Nursing notes
- Physician’s notes
- Code sheet (arrest record)
- Respiratory Therapy records

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>“ET tube confirmed”</td>
<td>None</td>
</tr>
<tr>
<td>“ET tube re-visualized”</td>
<td>None</td>
</tr>
<tr>
<td>PetCO2 (plus any number)</td>
<td>None</td>
</tr>
<tr>
<td>ETCO2 (plus any number)</td>
<td>None</td>
</tr>
<tr>
<td>Esophageal detection device</td>
<td>None</td>
</tr>
</tbody>
</table>
• EDD
• Color Waveform
• Cords re-visualized
• ETT re-visualized
• Glottis seen
• Glidescope
• Laryflex
• McGrath
• Airtraq
• Macintosh
• Storz
• DCI
• Pentax-Airway Scope
• Bullard
• Bonfile
• Video laryngoscope
• Any other brand name video laryngoscope
• Chest OK
• Tube placed OK
• No gurgling
• Chest X-Ray (CXR) for tube placement
• Chest PA and lateral
Data Element Name: **Endotracheal Intubation Confirmation Time**

**Collected For:** SCA-02

**Definition:** The time of endotracheal intubation confirmation. Confirmation occurs following the original placement.

**Suggested Data Collection Question:** What is the time the endotracheal intubation was confirmed?

**Format:**

- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1-5

**Allowable Values:**

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine
- N = None

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**

- Midnight = 00:00
- Noon = 12:00
- 5:31 am = 05:31
- 5:31 pm = 17:31
- 11:59 am = 11:59
- 11:59 pm = 23:59

**Note:**

00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Endotracheal Intubation Date should remain 11-24-20xx or if it should be converted to 11-25-20xx. When converting Midnight or 24:00 to 00:00, do not forget to change the Endotracheal Intubation Date.

Example: Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- The intent of this data element is to determine the time that the endotracheal intubation was confirmed. Confirmation is a separate activity occurring after endotracheal tube placement.
- If there are multiple times documented, use the earliest time following the original intubation.
• If there is no confirmation time documented within 30 minutes of endotracheal tube placement, select N.
• If there is documentation of an inclusion term that is untimed, select UTD

### Suggested Data Sources:
- Nursing notes
- Physician’s notes
- Code sheet (arrest record)
- Respiratory Therapy records
- Anesthesia record

### Additional Notes:

#### Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ET tube confirmed</td>
<td>None</td>
</tr>
<tr>
<td>• ET tube re-visualized</td>
<td></td>
</tr>
<tr>
<td>• PetCO2 (plus any number)</td>
<td></td>
</tr>
<tr>
<td>• ETCO2 (plus any number)</td>
<td></td>
</tr>
<tr>
<td>• Esophageal detection device</td>
<td></td>
</tr>
<tr>
<td>• EDD</td>
<td></td>
</tr>
<tr>
<td>• Color Waveform</td>
<td></td>
</tr>
<tr>
<td>• Cords re-visualized</td>
<td></td>
</tr>
<tr>
<td>• TT re-visualized</td>
<td></td>
</tr>
<tr>
<td>• Glottis seen</td>
<td></td>
</tr>
<tr>
<td>• Glidescope</td>
<td></td>
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<tr>
<td>• Laryflex</td>
<td></td>
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<tr>
<td>• McGrath</td>
<td></td>
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<tr>
<td>• Airtraq</td>
<td></td>
</tr>
<tr>
<td>• Storz</td>
<td></td>
</tr>
<tr>
<td>• DCI</td>
<td></td>
</tr>
<tr>
<td>• Pentax-Airway Scope</td>
<td></td>
</tr>
<tr>
<td>• Bullard</td>
<td></td>
</tr>
<tr>
<td>• Bonfile</td>
<td></td>
</tr>
<tr>
<td>• Video laryngoscope</td>
<td></td>
</tr>
<tr>
<td>• Any other brand name video laryngoscope</td>
<td></td>
</tr>
<tr>
<td>• Bilateral breath sounds</td>
<td></td>
</tr>
<tr>
<td>• Chest OK</td>
<td></td>
</tr>
<tr>
<td>• Tube placed OK</td>
<td></td>
</tr>
<tr>
<td>• No gurgling</td>
<td></td>
</tr>
<tr>
<td>• Abdominal sounds OK</td>
<td></td>
</tr>
<tr>
<td>• Chest X-Ray (CXR) for tube placement</td>
<td></td>
</tr>
<tr>
<td>• Chest PA and lateral</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name:  
*Endotracheal Intubation Date*

Collected For:  
SCA-02,

Definition:  
The month, day, and year of endotracheal intubation.

Suggested Data Collection Question:  
What is the date the patient was intubated?

Format:  
Length: 10 – MM-DD-YYYY (includes dashes)  
Type: Date  
Occurs: 1-5

Allowable Values:

MM = Month (01-12)  
DD = Day (01-31)  
YYYY = Year (2001-Current Year)  
UTD

Notes for Abstraction:

• The intent of this data element is to determine the date that the patient was intubated relative to a cardiac arrest. In some cases, the intubation will have occurred prior to the cardiac arrest.
• If there are multiple dates documented, use the date that most accurately reflects the date that the patient was intubated during an episode of cardiac arrest, based on other documentation in the record. If intubation does not occur during an episode of cardiac arrest, use the date of intubation occurring prior to the cardiac arrest event.
Example:
  ◦ “Patient intubated on 3-14-20xx at 11:00 am. Unable to wean from ventilator.”
  ◦ “Code Blue called 3-16-20xx, 7:35 am”
  ◦ Abstract 03-14-20xx as the *Endotracheal Intubation Date*.

Suggested Data Sources:

• Anesthesia record  
• Nursing notes  
• Physician’s notes  
• Code sheet (arrest record)

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Patient intubated”</td>
<td>None</td>
</tr>
<tr>
<td>“ET tube inserted”</td>
<td></td>
</tr>
</tbody>
</table>
• “Tubed”
Data Element Name: *Endotracheal Intubation Time*

Collected For: SCA-02.

Definition: The time of endotracheal intubation.

Suggested Data Collection Question: What is the time the patient was intubated?

Format:

- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1-5

Allowable Values:

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

- Midnight = 00:00
- Noon = 12:00
- 5:31 am = 05:31
- 5:31 pm = 17:31
- 11:59 am = 11:59
- 11:59 pm = 23:59

**Note:**

00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *Endotracheal Intubation Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx. When converting Midnight or 24:00 to 00:00, do not forget to change the *Endotracheal Intubation Date*.

Example: Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- The intent of this data element is to determine the time that the patient was intubated relative to a cardiac arrest. In some cases, the intubation will have occurred prior to the cardiac arrest.
- If there are multiple times documented, use the time that most accurately reflects the time that the patient was intubated during an episode of cardiac arrest, based on other documentation in the
record. If intubation does not occur during an episode of cardiac arrest, use the time of intubation occurring prior to the cardiac arrest event.

- Example:
  - Patient intubated on 3-14-20xx at 11:00 am. Unable to wean from ventilator.” “Code Blue called 3-16-20xx, 7:35 am” Abstract 07:35 as the Endotracheal Intubation Time.
- The preferred data source is the code sheet (arrest record).

**Suggested Data Sources:**
- Anesthesia record
- Nursing notes
- Physician’s notes
- Code sheet (arrest record)

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Patient intubated”</td>
<td>None</td>
</tr>
<tr>
<td>“ET tube inserted”</td>
<td></td>
</tr>
<tr>
<td>&quot;Tubed&quot;</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Endotracheal Tube Insertion

Collected For: SCA-02.

Definition: Identification of whether an endotracheal tube was inserted during the cardiac arrest event number for which data is being abstracted.

Suggested Data Collection Question: Was there documentation that an endotracheal tube was inserted during the cardiac arrest event number for which data is being abstracted?

Format: Length: 1
Type: Alphanumeric
Occurs: 1-5

Allowable Values: Y (Yes) There was documentation that an endotracheal tube was inserted during the cardiac arrest event.

N (No) There was no documentation that an endotracheal tube was inserted during the cardiac arrest event.

Notes for Abstraction: Be sure to abstract information for the Cardiac Arrest Event Number that is being abstracted. The allowable value may be different from one event to another event.

Suggested Data Sources:
- Emergency department record
- Nursing notes
- Physician’s notes
- Observation notes
- Code (resuscitation) record

Additional Notes: Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: *First Defibrillation Shock Date*

Collected For: SCA-01.

Definition: Date of documentation of the first defibrillation shock administered following cardiac arrest.

Suggested Data Collection Question: When is the earliest date of documentation of a defibrillation shock administered?

Format:

<table>
<thead>
<tr>
<th>Length</th>
<th>10 - MM-DD-YYYY (includes dashes) or UTD or N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Date</td>
</tr>
<tr>
<td>Occurs</td>
<td>1-5</td>
</tr>
</tbody>
</table>

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2010-Current Year)
- UTD = Unable to Determine
- N = No defibrillation shock administered

Notes for Abstraction:

- Determine the earliest date, following Cardiac Arrest Date, that any inclusion terms are documented. In most cases, this will be the same date as the Cardiac Arrest Date.
- If there are multiple cardiac arrests in rapid succession in the same resuscitation effort, only select the first arrest and defibrillation dates. For example, a patient arrest at 6:00, is defibrillated, and arrests again at 6:04. That is to be counted as one Cardiac Arrest Event Number, and First Defibrillation Shock Time is to be measured only for the arrest at 6:00. Only abstract data for the first arrest in any Cardiac Arrest Event Number.
- If unable to determine the time of the first defibrillation shock, enter UTD
- If no defibrillation shock is administered, enter N.

Suggested Data Sources:

- Nursing notes
- Progress notes
- Procedure notes
- Resuscitation record
- Any ED documentation
- ECG rhythm strip interpretation

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Terms</td>
<td>None</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Defib.</td>
<td></td>
</tr>
<tr>
<td>Defibrillated</td>
<td></td>
</tr>
<tr>
<td>Shocked</td>
<td></td>
</tr>
<tr>
<td>Shock given</td>
<td></td>
</tr>
<tr>
<td>(Number) joules</td>
<td></td>
</tr>
<tr>
<td>First shock</td>
<td></td>
</tr>
<tr>
<td>Similar terminology</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: First Defibrillation Shock Time

Collected For: SCA-01

Definition: Time that the first defibrillation shock following cardiac arrest is administered.

Suggested Data Collection Question: When is the earliest administration of a defibrillation shock?

Format: Length: 5 - HH-MM (with or without colon) or UTD or N
Type: Time
Occurs: 1-5

Allowable Values:

<table>
<thead>
<tr>
<th>HH</th>
<th>MM</th>
<th>UTD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hour (00-23)</td>
<td>Minutes (00-59)</td>
<td>Unable to Determine</td>
<td>No defibrillation shock administered</td>
</tr>
</tbody>
</table>

Time must be recorded in military time format with the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Notes for Abstraction:

- Determine the earliest time that any inclusion terms for administration of a defibrillation shock are recorded. In most cases, this will be within fifteen minutes of the Cardiac Arrest Time.
- If there are multiple cardiac arrests in rapid succession in the same resuscitation effort, only select the first arrest and defibrillation times.
- If unable to determine the time of the first defibrillation shock, enter UTD
- If no defibrillation shock is administered, enter N.

Suggested Data Sources:

- Nursing notes
- Progress notes
- Procedure notes
- Resuscitation record
- Any Ed documentation
- ECG rhythm strip interpretation

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
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</tr>
<tr>
<td>-------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Defib.</td>
<td></td>
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<tr>
<td>Defibrillated</td>
<td></td>
</tr>
<tr>
<td>Shocked</td>
<td></td>
</tr>
<tr>
<td>Shock given</td>
<td></td>
</tr>
<tr>
<td>(Number) joules</td>
<td></td>
</tr>
<tr>
<td>First shock</td>
<td></td>
</tr>
<tr>
<td>Similar terminology</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Hispanic Ethnicity

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: Length: 1  
Type: Character  
Occurs: 1

Allowable Values:  
Y (Yes)  Patient is of Hispanic ethnicity or Latino.  
N (No)  Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, Race, is required in addition to this data element.

Suggested Data Sources:  
• Emergency department record  
• History and physical  
• Face sheet  
• Nursing admission assessment  
• Progress notes

Additional Notes:  

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
| A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.” Examples:  
• Black-Hispanic  
• Chicano  
• H  
• Hispanic  
• Latin American  
• Latino/Latina  
• Mexican-American  
• Spanish  
• White-Hispanic | • None |
<table>
<thead>
<tr>
<th>Data Element Name:</th>
<th>Implant Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected For:</td>
<td>SCA-01</td>
</tr>
<tr>
<td>Definition:</td>
<td>An implanted device is one inserted into the patient, either temporarily or permanently, that is designed to deliver a defibrillation shock at the time of a cardiac arrest.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>Did the patient have an implanted device in place prior to the date and time of cardiac arrest?</td>
</tr>
<tr>
<td>Format:</td>
<td>Length: 1, Type: Alphanumeric, Occurs: 1-5</td>
</tr>
<tr>
<td>Allowable Values:</td>
<td>Y (Yes) There is a documentation that the patient had an implanted device in place prior to the date and time of cardiac arrest</td>
</tr>
<tr>
<td></td>
<td>N (No) There is no documentation that the patient had an implanted device in place prior to the date and time of cardiac arrest</td>
</tr>
<tr>
<td>Notes for Abstraction:</td>
<td>• The implanted device must be in place prior to the date and time of cardiac arrest; scheduling a patient for the procedure, discussion with the patient or family, and considering placement are not to be abstracted as Y (Yes).</td>
</tr>
<tr>
<td></td>
<td>• External or wearable devices, such as LifeVest, are not included as implanted devices.</td>
</tr>
<tr>
<td>Suggested Data Sources:</td>
<td>• Any current medical record documentation</td>
</tr>
<tr>
<td>Additional Notes:</td>
<td>Guidelines for Abstraction:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion</td>
<td>Exclusion</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Initial Rhythm

Collected For: SCA-01, SCA-03

Definition: The initial rhythm is the first cardiac rhythm recorded during a cardiac arrest on a cardiac monitor or automated external defibrillator strip, or the first rhythm recorded on the resuscitation record (code sheet). Shockable rhythms are ventricular fibrillation or pulseless ventricular tachycardia.

Suggested Data Collection Question: What was the first cardiac rhythm recorded during a cardiac arrest on a cardiac monitor or automated external defibrillator strip, or recorded on the resuscitation record (code sheet)?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1-5

Allowable Values: Enter the first cardiac rhythm recorded via electronic interpretation during a cardiac arrest on a cardiac monitor or automated external defibrillator strip, or recorded on the resuscitation record.

1 The initial rhythm recorded during a cardiac arrest via electronic interpretation on a cardiac monitor or automated external defibrillator strip, or recorded on the code sheet, was ventricular fibrillation or pulseless ventricular tachycardia.

2 The initial rhythm recorded during a cardiac arrest via electronic interpretation on a cardiac monitor or automated external defibrillator strip, or recorded on the resuscitation record (code sheet) was asystole or some other rhythm.

3 Unable to determine (UTD) the initial rhythm.

Notes for Abstraction:
- Begin at the Cardiac Arrest Time and abstract the first rhythm recorded, using the same record as the Cardiac Arrest Time as the preferred source; if no rhythm interpretation is found, use the earliest rhythm recorded in any of the suggested sources.
- If there is no documentation of an initial rhythm in any suggested sources within 30 minutes of the Cardiac Arrest Time, choose value 3, UTD. Do not attempt to interpret any monitor or rhythm strips.
- If the initial rhythm is ventricular tachycardia but there is any recorded pulse rate at the same time, or there is no notation indicating no pulse, choose value 2, some other rhythm.
- If the initial rhythm is ventricular tachycardia without documentation of a pulse rate at the same time, choose value 1, pulseless ventricular tachycardia.
- If the initial rhythm on the resuscitation record is different than the initial rhythm on the monitor strip, and the patient was on a recording monitor at the time of cardiac arrest, use the monitor strip as the preferred source. If, however, the patient was not on a recording
monitor at the time of cardiac arrest, or there is no electronic rhythm strip for interpretation, use the initial rhythm listed on the resuscitation record.

**Suggested Data Sources:**
- Emergency department record
- Nursing notes
- Progress notes
- Physician’s notes
- Discharge summary
- Code records (resuscitation record)
- EMS records
- Discharge notes
- Transfer notes

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventricular fibrillation</td>
<td>None</td>
</tr>
<tr>
<td>• V. fib.</td>
<td></td>
</tr>
<tr>
<td>• Ventricular tachycardia, no pulse</td>
<td></td>
</tr>
<tr>
<td>(pulseless)</td>
<td></td>
</tr>
<tr>
<td>• V. Tach, no pulse (pulseless)</td>
<td></td>
</tr>
<tr>
<td>• Asystole</td>
<td></td>
</tr>
<tr>
<td>• Standstill</td>
<td></td>
</tr>
<tr>
<td>• Gallop rhythm</td>
<td></td>
</tr>
<tr>
<td>• Erratic heartbeat</td>
<td></td>
</tr>
<tr>
<td>• Paced rhythm</td>
<td></td>
</tr>
<tr>
<td>• Ectopic beats</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Left Ventricular Assist, Device Biventricular Assist Device

Collected For: SCA-01.

Definition: A left ventricular assist device (LVAD) is an implantable mechanical pump that helps pump blood from the left ventricle; a biventricular assist device; a biventricular assist device (BiVAD) is a mechanical pump implanted to assist both the right and left ventricles.

Suggested Data Collection Question: Did the patient have either a LVAD or BiVAD in place prior to the date and time of cardiac arrest?

Format: Length: 1
  Type: Alphanumeric
  Occurs: 1-5

Allowable Values:
  Y (Yes) There is a documentation that the patient had either an LVAD or BiVAD in place prior to the date and time of cardiac arrest
  N (No) There is no documentation that the patient had either an LVAD or BiVAD in place prior to the date and time of cardiac arrest

Notes for Abstraction:
• The LVAD or BiVAD must be in place prior to the date and time of cardiac arrest; scheduling a patient for the procedure, discussion with the patient or family, and considering placement are not to be abstracted as Y (Yes).

Suggested Data Sources:
• Any current medical record documentation

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Methods of Intubation Confirmation

SCA-02

The acceptable methods of confirmation of intubation are:

A. Capnometry – Measurement of the partial pressure of carbon dioxide in exhaled air, usually via a device attached to the endotracheal tube. Such measurements are abbreviated as PetCO₂, plus a number.

B. Electronic Waveform Capnography – Graphic tracing of carbon dioxide content in exhaled air, abbreviated as ETCO₂.

C. Esophageal Detection Devices – Mechanical devices used to check for tube placement that rely on the anatomy of the larynx and esophagus, more commonly used outside the hospital by EMS systems.

D. Exhaled CO₂ colorimetric monitor – measurement of exhaled carbon dioxide via infrared or other technology, abbreviated as ETCO2.

E. Revisualization with direct laryngoscopy – use of the laryngoscope to reviwealize the endotracheal tube insertion point.

F. Video-assisted laryngoscopy – Use of a video cable or camera in a rigid laryngoscope blade to visualize the glottis; images may be displayed on a LCD monitor. Common names for this equipment are Glidescope, Laryflex, McGrath, Airtraq, Macintosh, and others. This includes fiberoptic visualization.

What was the method used to confirm placement of the endotracheal tube?

Length: 1
Type: Alphanumeric
Occurs: 1-5

Allowable Values:

1 The method used to confirm endotracheal tube placement was either capnometry, electronic waveform capnography, esophageal detection device, exhaled CO2 colorimetric monitor, reviwsalization with direct laryngoscopy, fiberoptic visualization, or video-assisted laryngoscopy.

2 The method used to confirm endotracheal tube placement was not either capnometry, electronic waveform capnography, esophageal detection device, exhaled CO2 colorimetric monitor, reviwsalization with direct laryngoscopy, or video-assisted laryngoscopy.

3 There is no documentation that the endotracheal tube placement was confirmed, or UTD.
Notes for Abstraction:

- Begin at the time of endotracheal intubation and look for any inclusion term. If an inclusion term is noted within 30 minutes of intubation, select value 1.
- If there is no documentation of an inclusion or exclusion term within 30 minutes of intubation, select value 3.
- If there is documentation of an exclusion term within 30 minutes.
- If there is documentation of both an inclusion and exclusion term within 30 minutes of intubation, select value 1.

Suggested Data Sources:

- Anesthesia record
- Nursing notes
- Physician’s notes
- Code sheet (arrest record)
- Respiratory Therapy records

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>PetCO2 (plus any number)</td>
<td>Bilateral breath sounds</td>
</tr>
<tr>
<td>ETCO2 (plus any number)</td>
<td>Chest OK</td>
</tr>
<tr>
<td>Esophageal detection device</td>
<td>Tube placed OK</td>
</tr>
<tr>
<td>EDD</td>
<td>No gurgling</td>
</tr>
<tr>
<td>Capnometry</td>
<td>Chest X-Ray (CXR) for tube placement</td>
</tr>
<tr>
<td>Capnography</td>
<td>Chest PA and lateral</td>
</tr>
<tr>
<td>Color Waveform</td>
<td>Abdomen negative for air</td>
</tr>
<tr>
<td>Cords re-visualized</td>
<td></td>
</tr>
<tr>
<td>ETT re-visualized</td>
<td></td>
</tr>
<tr>
<td>Glottis seen</td>
<td></td>
</tr>
<tr>
<td>lidescope</td>
<td></td>
</tr>
<tr>
<td>Laryflex</td>
<td></td>
</tr>
<tr>
<td>McGrath</td>
<td></td>
</tr>
<tr>
<td>Airtraq</td>
<td></td>
</tr>
<tr>
<td>Macintosh</td>
<td></td>
</tr>
<tr>
<td>Storz</td>
<td></td>
</tr>
<tr>
<td>DCI</td>
<td></td>
</tr>
<tr>
<td>Pentax-Airway Scope</td>
<td></td>
</tr>
<tr>
<td>Bullard</td>
<td></td>
</tr>
<tr>
<td>Bonfile</td>
<td></td>
</tr>
<tr>
<td>Video laryngoscope</td>
<td></td>
</tr>
<tr>
<td>Any other brand name video laryngoscope</td>
<td></td>
</tr>
</tbody>
</table>
**Data Element Name:** Patient Location

**Collected For:** SCA-01,

**Definition:** Location of the patient at the time of cardiac arrest

**Suggested Data Collection Question:** Where was the patient on the date and time of cardiac arrest?

**Format:**
- **Length:** 2
- **Type:** Alphanumeric
- **Occurs:** 1-5

**Allowable Values:**

1 – In the electrophysiology department/lab, in the cardiac catheterization suite, on cardiac bypass during open heart surgery, or while on extracorporeal membrane oxygenation bypass.

2 - cardiac arrest occurred prior to arrival in the ED

3 – In a monitored patient bed in a patient care unit, including observation units

4 – in an unmonitored patient bed in a patient care unit, including observation units

5 – in the dialysis suite

6 – in the general operating room

7 – in a general hospital area, such as lobby, elevator, hallway, or during transport

8 – in a diagnostic testing or therapy area, such as diagnostic imaging, nuclear imaging, or physical therapy

9 - in the ED

10 – other

**Notes for Abstraction:**

- When determining location, if there is a procedure record, such as electrophysiology lab or ambulatory surgery, refer to the recorded times of arrival and departure from those areas that are recorded on the procedure note.
- Be as specific as possible
- When more than one choice is possible, choose the lowest applicable number. For example, if an outpatient comes for physical therapy and experiences a cardiac arrest in physical therapy and is subsequently transported to the ED for treatment, although Value 8 is applicable, Value 2 is also applicable and you would choose value 2, cardiac arrest occurred prior to arrival in the ED.
• Procedure codes for Value 1 are:
  ◦ Cardiac catheterization: 37.21 – 37.23 and 88.52 through 88.57
  ◦ Cardiac Electrophysiology testing: 37.26, 37.27
  ◦ Cardiac Bypass during open heart surgery: 39.61
  ◦ Extracorporeal membrane oxygenation: 39.65

• The patient must be actively in the cardiac cath lab, electrophysiology suite, or on open heart bypass or ECMO bypass to answer Value 1. ICD9-CM codes are given to assist abstraction, but their presence does not automatically require Value 1 to be chosen; the patient must be undergoing the bypass or in the specialty suites at the time of arrest.

Suggested Data Sources:
  • Any current medical record documentation

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Race

Collected For: All Records

Definition: Documentation of the patient’s race.

Suggested Data Collection Question: What is the patient’s race?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values: Select one:

1. White: Patient’s race is White or the patient has origins in Europe, the Middle East, or North Africa.
2. Black or African American: Patient’s race is Black or African American.
3. American Indian or Alaska Native: Patient’s race is American Indian/Alaska Native.
4. Asian: Patient’s race is Asian.
5. Native Hawaiian or Pacific Islander: Patient’s race is Native Hawaiian/Pacific Islander.
6. RETIRED VALUE (effective 07-01-05 discharges)
7. UTD: Unable to determine the patient’s race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:

• The data element Hispanic Ethnicity is required in addition to this data element.
• If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
• Although the terms “Hispanic” and “Latino” are actually descriptions of the patient’s ethnicity, it is not uncommon to find them referenced as race. If the patient’s race is documented only as Hispanic/Latino, select “White.” If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select “Black”). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.
**Suggested Data Sources:**
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Black or African American</strong>&lt;br&gt;A person having origins in any of the black racial groups of Africa. Terms such as&lt;br&gt;“Haitian” or “Negro” can be used in addition to&lt;br&gt;“Black or African American.”</td>
<td>• None</td>
</tr>
<tr>
<td><strong>American Indian or Alaska Native</strong>&lt;br&gt;A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American.)</td>
<td></td>
</tr>
<tr>
<td><strong>Asian</strong>&lt;br&gt;A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</td>
<td></td>
</tr>
<tr>
<td><strong>White</strong>&lt;br&gt;A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).</td>
<td></td>
</tr>
<tr>
<td><strong>Native Hawaiian or Pacific Islander</strong>&lt;br&gt;A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: 

Reason for Early Discontinuation of Therapeutic Hypothermia

Collected For: 

SCA-04

Definition: 

Documentation of a reason for discontinuation of therapeutic hypothermia before the achievement of twelve continuous hours of temperature between 32 degrees and 34 degrees Celsius.

Suggested Data Collection Question: 

Is there a reason documented for discontinuation of therapeutic hypothermia before the achievement of twelve continuous hours of temperature between 32 degrees and 34 degrees Celsius?

Format: 

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1- There is a system reason documented for discontinuation of therapeutic hypothermia before the achievement of twelve continuous hours of temperature between 32 degrees and 34 degrees Celsius

2- There is any other reason documented for discontinuation of therapeutic hypothermia before the achievement of twelve continuous hours of temperature between 32 degrees and 34 degrees Celsius, or unable to determine from medical record documentation.

3- There is no reason documented for discontinuation of therapeutic hypothermia before the achievement of twelve continuous hours of temperature between 32 degrees and 34 degrees Celsius, or unable to determine from medical record documentation.

Notes for Abstraction:

• **System reasons for discontinuation are:**
  ◦ Equipment-related (e.g., machine malfunction, ice machine broken, power outage)
  ◦ Staff-related (e.g., nursing staffed in numbers inadequate for hypothermia)

• If a system or staff-related reason is given for discontinuance, select value 1, there is a system reason. If there is a medical reason documented for discontinuance of hypothermia before the achievement of 12 continuous hours of temperature in the range of 32 to 34 degrees Celsius, select value 2, any other reason. (An example of this might be uncontrollable shivering.) If there is no documentation of a reason for discontinuing hypothermia before achievement of twelve continuous hours of temperature between 32 and 34 degrees Celsius, or if there is an order to re-warm the patient without additional documentation of a reason, select value 3, no reason.
Suggested Data Sources: PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION ONLY

- Consultation notes
- Emergency department record
- History and physical
- Physician orders
- Procedure notes
- Progress notes

Additional Notes: Excluded Data Sources:

- Any documentation dated/timed after discharge.

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Reason for Not Administering Therapeutic Hypothermia

Collected For: SCA-03.

Definition: Documentation of a reason for not administering therapeutic hypothermia.

Suggested Data Collection Question: Is there a reason documented for not administering therapeutic hypothermia?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
1 - There is a system reason documented for not administering therapeutic hypothermia.
2 – There is another reason documented for not administering therapeutic hypothermia
3 - There is no reason documented for not administering therapeutic hypothermia, or unable to determine from medical record documentation

Notes for Abstraction:
System reasons for not administering therapeutic hypothermia are:
- Equipment-related (e.g., machine malfunction, ice machine broken, power outage)
- Staff-related (e.g., nursing staffed in numbers inadequate for hypothermia)

Suggested Data Sources: PHYSICIAN/APN/PA or EMS DOCUMENTATION ONLY
- Consultation notes
- Emergency department record
- EMS records
- History and physical
- Physician orders
- Procedure notes
- Progress notes

Additional Notes: Excluded Data Sources:
- Any documentation dated/timed after discharge

Guidelines for Abstraction:
Data Element Name: Reason for Transfer

Collected For: SCA-03,

Definition: The reason for transfer is the reason documented for transferring a patient to another facility.

Suggested Data Collection Question: What was the reason the patient was transferred to another facility?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 – Transferred for therapeutic hypothermia
2 – Transferred for some other reason not related to therapeutic hypothermia
3 – Unable to determine reason for transfer, or no reason stated.

Notes for Abstraction:

• The specific reason for transfer must be stated; if there is no reason stated, select value 3, unable to determine the reason for transfer.
• If the reason stated is “Cardiac Care”, “Cardiac ICU”, or a similar term select value 2.
• If the reason for transfer is “consider hypothermia”, or “for hypothermia administration”, select value 1.
• If the transfer occurs more than 24 hours after the time of cardiac arrest, select N (No).

Suggested Data Sources:

• Any current medical record documentation

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transferred to (XXfacility) for hypothermia</td>
<td>• Transferred to ICU at (XXfacility)</td>
</tr>
<tr>
<td>• Transfer; consider hypothermia</td>
<td>• Transferred for advanced cardiac care</td>
</tr>
<tr>
<td></td>
<td>• Transfer</td>
</tr>
</tbody>
</table>
**Data Element Name:** Return of Spontaneous Circulation

**Collected For:** SCA-03

**Definition:** Patients with a return of spontaneous circulation are those patients who have a detectable pulse without human or mechanical assistance, such as chest compressions or ventricular assistance devices, after a period of pulselessness.

**Suggested Data Collection Question:** Was there documentation the patient had a return of spontaneous circulation following cardiac arrest?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) There was documentation that the patient had a return of spontaneous circulation.
- N (No) There was no documentation that the patient had a return of spontaneous circulation.

**Notes for Abstraction:**
- Begin abstraction at the Cardiac Arrest Time and end 2 hours after cardiac arrest, looking for a pulse rate recording by any method (apical, Doppler, etc.) at the same time that there are no chest compression or mechanical assistance devices being applied. If any
- If there is no pulse recorded, choose “No”.

**Suggested Data Sources:**
- Emergency department record
- Nursing notes
- Physician’s notes
- Code (resuscitation) record
- Observation notes
- Glasgow sheet

**Additional Notes:**

**Guidelines for Abstraction:**
<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Numerical recording of a pulse rate</td>
<td>• Pulseless</td>
</tr>
<tr>
<td>• Pulse by Doppler (XX number)</td>
<td>• pulse detected</td>
</tr>
<tr>
<td>• Apical rate (xx number)</td>
<td>• No heartbeat detected</td>
</tr>
<tr>
<td>• Pulse irregular</td>
<td>• Equivalent terminology</td>
</tr>
<tr>
<td>• Equivalent terminology</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Sex

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What is the patient's sex?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
- M = Male
- F = Female
- U = Unknown

Notes for Abstraction:
- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- UB-04 Field Location: 11
- Nursing admission notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• None</td>
<td>• None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Therapeutic Hypothermia Initiated

**Collected For:** SCA-03, SCA-04.

**Definition:** Documentation that therapeutic hypothermia was begun. Therapeutic hypothermia is a process of cooling a patient to a temperature range of 34 degrees to 32 degrees Centigrade following cardiac arrest. Cooling may be accomplished in a variety of ways that include administration of iced or refrigerated saline, application of cooling blankets, application of ice bags to various points of the body simultaneously, or by use of therapeutic hypothermia systems that use indwelling central venous cooling catheters and endovascular probes. In some cases, therapeutic hypothermia may be initiated prior to hospital arrival.

**Suggested Data Collection Question:** Is there documentation that therapeutic hypothermia was begun?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) There is documentation that therapeutic hypothermia was begun.
- N (No) There is no documentation that therapeutic hypothermia was begun

**Notes for Abstraction:**
- Therapeutic hypothermia is a relatively new procedure and may not be consistently coded. When coded, it is ICD-9-CM procedure code 99.81.
- Do not rely solely on coding; look in all suggested data sources to determine if therapeutic hypothermia was begun.

**Suggested Data Sources:**
- Emergency department record
- History and physical
- Nursing notes
- Progress notes
- Discharge summary
- Admission notes
- EMS record
- Hypothermia flow sheet

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cold saline infusing</td>
</tr>
<tr>
<td>---</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Therapeutic hypothermia started</td>
</tr>
<tr>
<td></td>
<td>Hypothermia begun</td>
</tr>
<tr>
<td></td>
<td>Cooling blankets applied</td>
</tr>
<tr>
<td></td>
<td>Cooling catheter inserted</td>
</tr>
<tr>
<td></td>
<td>Ice bags applied to groin, armpits, and neck</td>
</tr>
<tr>
<td></td>
<td>TH Machine on</td>
</tr>
<tr>
<td></td>
<td>Alsius on</td>
</tr>
</tbody>
</table>
Data Element Name: *Thermoregulation Maintained*

Collected For: SCA-04.

Definition: Maintenance of thermoregulation in therapeutic hypothermia occurs when there is at least one core temperature recording between 32 and 34 degrees Celsius every hour for a minimum of twelve continuous hours.

Suggested Data Collection Question: Was there a core temperature recording every hour that was between 32 and 34 degrees Celsius for a minimum of 12 continuous hours?

Format: Length: 1
Type: Numeric
Occurs: 1

Allowable Values:

1- Yes, there was at least one temperature recording every hour between 32 and 34 degrees Celsius for a minimum of twelve continuous hours.

2- No, there was not at least one temperature recording every hour between 32 and 34 degrees Celsius for a minimum of twelve continuous hours.

3- There are no temperature recordings, or unable to determine (UTD)

Notes for Abstraction: Therapeutic hypothermia has three stages. The first phase, induction, starts when hypothermia is begun and ends when the patient’s temperature has been reduced to any temperature within the range of 34 to 32 degrees Celsius. The second phase, maintenance, begins with the first temperature between 34 and 32 degrees Celsius and ends when re-warming begins. The third phase is re-warming, when the patient’s temperature is gradually raised to normal.

SCA-04 addresses the second phase, maintenance. Begin assessing temperature when the first temperature recorded is between 34 and 32 degrees Celsius. Since SCA-04 assesses the maintenance of appropriate temperature for a minimum of 12 continuous hours, there must be a temperature recording between 32 and 34 degrees Celsius as the first temperature recorded in each of the eleven hours after the first hour in which that temperature range is reached. If there is an hour within those next eleven hours in which there is no first temperature recording between 32 and 34 degrees Celsius, look at the next hour in which a temperature is recorded within 32 to 34 degree Celsius and count that as the first hour of another 12 hour period. If there is no **continuous** 12 hour period in which the first temperature recorded each hour was within the range of 32 to 34 degrees Celsius, select value 2, No.

For example, the first temperature recorded between 32 and 34 degrees Celsius is 33.6 degrees at 13:05. At 14:02 the temperature is 33.5, at 15:16 the temperature is 33.8, and at 16:12 the temperature is 34.2 (out of correct...
range). You would then look within the 17:00 hour to see if there is a
temperature in the range of 32 to 34 degrees, and if so then the 17:00 hour
temperature would be the first hour of a new 12 hour period. If a
temperature was recorded within the range of 32 to 34 degrees as the first
temperature recording in each of the next 11 hours, select value 1, Yes. If
no continuous 12 hour period of correct temperature range is recorded,
select value 2, No.

- If your facility uses Fahrenheit readings, convert the temperature to
  Celsius according to the following chart:

<table>
<thead>
<tr>
<th>Fahrenheit</th>
<th>Celsius</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>29.4</td>
</tr>
<tr>
<td>86</td>
<td>30</td>
</tr>
<tr>
<td>87</td>
<td>30.6</td>
</tr>
<tr>
<td>88</td>
<td>31.1</td>
</tr>
<tr>
<td>89</td>
<td>31.7</td>
</tr>
<tr>
<td>89.6</td>
<td>32</td>
</tr>
<tr>
<td>90</td>
<td>32.2</td>
</tr>
<tr>
<td>91</td>
<td>32.8</td>
</tr>
<tr>
<td>91.4</td>
<td>33</td>
</tr>
<tr>
<td>92</td>
<td>33.3</td>
</tr>
<tr>
<td>93</td>
<td>33.9</td>
</tr>
<tr>
<td>93.2</td>
<td>34</td>
</tr>
<tr>
<td>94</td>
<td>34.4</td>
</tr>
<tr>
<td>95</td>
<td>35</td>
</tr>
<tr>
<td>96</td>
<td>35.6</td>
</tr>
<tr>
<td>97</td>
<td>36.1</td>
</tr>
<tr>
<td>98</td>
<td>36.7</td>
</tr>
<tr>
<td>99</td>
<td>37.2</td>
</tr>
</tbody>
</table>

To convert Fahrenheit to Celsius, start with degrees Fahrenheit, subtract
32, multiply by 5, then divide by 9.

- If there is more than one temperature recorded at the same time from
different sources, use the temperature source in the following order:
  ◦ Any probe inserted in the cardiovascular system, such as
    pulmonary artery catheter or endovascular probe
  ◦ Any temperature probe inserted in the bladder or rectum
  ◦ Tympanic (ear) temperature
  ◦ Axillary
- Skin strip

**Suggested Data Sources:**

- Entire medical record

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Data Element Name:</td>
<td>Time Therapeutic Hypothermia Ended</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Definition:</td>
<td>Time of documentation that therapeutic hypothermia was ended.</td>
</tr>
<tr>
<td>Suggested Data Collection Question:</td>
<td>What time was there documentation that therapeutic hypothermia was ended?</td>
</tr>
</tbody>
</table>
| Format:            | **Length:** 5 - HH-MM (with or without colon) or UTD  
|                    | **Type:** Time  
|                    | **Occurs:** 1  |

**Allowable Values:**

- HH = Hour (00-23)  
- MM = Minutes (00-59)  
- UTD = Unable to Determine

Time must be recorded in military time format with the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required  
- If the time is in the p.m., add 12 to the clock time hour

**Notes for Abstraction:**

- If the time therapeutic hypothermia was ended is unable to be determined from medical record documentation, enter “UTD”.  
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”.  
  - Example:
    - Documentation indicates the time hypothermia ended was 26-42-20xx. No other documentation in the medical record provides a valid date. Since the Time Therapeutic Hypothermia Ended is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”.  
- If therapeutic hypothermia ends when re-warming begins. If the time re-warming begins is not documented, use the time in which “therapeutic hypothermia terminated/ended” is documented.  
- Use the latest time that therapeutic hypothermia is documented if there are multiple entries.  
- If the patient is transferred out prior to the time therapeutic hypothermia is ended, enter “UTD”.  

**Suggested Data Sources:**

- Nursing notes  
- Progress notes
- Hypothermia flow sheet

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Time Therapeutic Hypothermia Initiated


Definition: Time (military time) that therapeutic hypothermia was begun.

Suggested Data Collection Question: What time was therapeutic hypothermia was begun?

Format: Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format with the exception of midnight and Noon:

• If the time is in the a.m., conversion is not required
• If the time is in the p.m., add 12 to the clock time hour

Notes for Abstraction:

• If the time therapeutic hypothermia was begun is unable to be determined from medical record documentation, enter “UTD”.
• The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD”.
  ◦ Example:
    ■ Documentation indicates the time hypothermia started was 26-42-20xx. No other documentation in the medical record provides a valid date. Since the Time Therapeutic Hypothermia Initiated is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”. Note: Transmission of a case with an invalid time as described above will be rejected from the Joint Commission’s Data Warehouse. Use of “UTD” for Time Therapeutic Hypothermia Started allows the case to be accepted into the warehouse.
• Use the time that therapeutic hypothermia was begun
• Use the earliest time that therapeutic hypothermia is documented if there is conflicting documentation.

Suggested Data Sources:

• Emergency department record
• History and physical
Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Data Element Name:** Time Therapeutic Hypothermia Ordered

**Collected For:** SCA-03.

**Definition:** The time therapeutic hypothermia was ordered.

**Suggested Data Collection Question:** At what time was therapeutic hypothermia ordered?

**Format:**
- **Length:** 5 - HH:MM (with or without colon) or UTD
- **Type:** Time
- **Occurs:** 1

**Allowable Values:**
- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**
- Midnight - 00:00
- Noon - 12:00
- 5:31 am - 05:31
- 5:31 pm - 17:31
- 11:59 am - 11:59
- 11:59 pm - 23:59

**Note:**
00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the time should remain 11-24-20xx or if it should be converted to 11-25-20xx.

**Notes for Abstraction:**
- For times that include seconds, remove the seconds and record the time as is. Example: 15:00:35 would be recorded as 15:00
- If the Time Therapeutic Hypothermia Ordered cannot be determined from medical record documentation, enter "UTD". When the time documented is obviously invalid (not a valid format/range [26:33] and no other documentation is found that provides the correct information, the abstractor should select “UTD”.
- If the Time Therapeutic Hypothermia Ordered is obviously incorrect (in error) but it is a valid time and the correct time can be supported with other documentation in the medical record, the correct time may be entered. If supporting documentation of the correct time cannot be
found, the medical record must be abstracted as documented or at
“face value.”

- Example:
  - The *Time Therapeutic Hypothermia Ordered* is
documented as 12:00, but other documentation in the
medical record supports the correct time as 22:00. Enter
the correct time of 22:00 as the *Time Therapeutic
Hypothermia Ordered*.

**Suggested Data Sources:**
- Emergency department record
- Progress notes
- EMS record
- Nursing flow sheets
- **Priority Source:** Physician orders

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Therapeutic Hypothermia</td>
<td>• Ice bag to (one specific body part)</td>
</tr>
<tr>
<td>• Start Cooling Protocol</td>
<td></td>
</tr>
<tr>
<td>• Begin TH Protocol</td>
<td></td>
</tr>
<tr>
<td>• Iced saline at xx gtts. per min.</td>
<td></td>
</tr>
<tr>
<td>• Ice bags to groin, armpits, neck</td>
<td></td>
</tr>
<tr>
<td>• Apply cooling blankets</td>
<td></td>
</tr>
<tr>
<td>• Equivalent terminology</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Unique Blinded Case Identifier

Collected For: All Records , All Records (Used in transmission of anonymous patient-level data to the Joint Commission)

Definition: An identifier that is assigned to each patient by the hospital that uniquely identifies the patient for the episode of care. It is a fictitious identifier used to differentiate between individual patient records.

Suggested Data Collection Question: What number has been assigned to identify the patient?

Format: Length: 9
Type: Numeric
Occurs: 1

Allowable Values: Any valid positive number up to nine digits

- This identifier should not be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.
- Since a unique identifier is used for each medical record that is abstracted for the Joint Commission pilot, hospitals need to link this tracking identifier to the original patient record. This link will be important in the event that data quality issues arise and it is requested that the episode of care data be reviewed or if the patient is chosen to be included in the data reliability study.

Notes for Abstraction:

Suggested Data Sources: Does not apply, determined by the hospital.

Additional Notes: Does not apply, determined by the hospital.

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
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<td>None</td>
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</tbody>
</table>
Tables
Appendix A-1

<table>
<thead>
<tr>
<th>Appendix A-1</th>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.1</td>
<td>427.5</td>
<td>Cardiorespiratory arrest</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>668.10</td>
<td>Cardiac arrest or failure following anesthesia or other sedation in labor and delivery</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>668.11</td>
<td>Cardiac arrest or failure following anesthesia or other sedation in labor and delivery</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>668.12</td>
<td>Cardiac arrest or failure following anesthesia or other sedation in labor and delivery</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>668.13</td>
<td>Cardiac arrest or failure following anesthesia or other sedation in labor and delivery</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>668.14</td>
<td>Cardiac arrest or failure following anesthesia or other sedation in labor and delivery</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>997.1</td>
<td>Cardiac arrest during or resulting from a procedure, Cardiac insufficiency during or resulting from a procedure, Cardiorespiratory failure during or resulting from a procedure, Heart failure during or resulting from a procedure</td>
</tr>
<tr>
<td>Table 1.1</td>
<td>V12.53</td>
<td>Sudden cardiac death successfully resuscitated</td>
</tr>
</tbody>
</table>

Patient Identification

<table>
<thead>
<tr>
<th>Methods of Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM codes</td>
</tr>
<tr>
<td>Code Blue log</td>
</tr>
<tr>
<td>Hypothermia log</td>
</tr>
<tr>
<td>ED Record</td>
</tr>
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