National Cardiac Arrest Audit Report

St Elsewhere Hospital

01 April 2012 to 30 September 2012
(n = 122)

Date of report: 14/01/2013

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Supported by Resuscitation Council (UK) and Intensive Care National Audit & Research Centre (ICNARC)
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1. NCAA and your NCAA Report

About the National Cardiac Arrest Audit (NCAA)

The National Cardiac Arrest Audit (NCAA) is the national, clinical audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. NCAA is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre).

NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest.

Your hospital collects and enters data according to the NCAA data collection scope and comprehensive dataset specification. The NCAA dataset was developed to ensure that all hospitals collect the same standardised data, so that accurate comparisons can be made.

NCAA is listed as a national clinical audit in the Department of Health’s Quality Accounts.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report on in-hospital cardiac arrest procedures, ‘Time to Intervene?’ (2012), stated: "…Each Trust/hospital should collect structured information on patients who have a cardiac arrest. The National Cardiac Arrest Audit collects such data and hospitals are encouraged to participate...".

About your NCAA Report

The NCAA Report provides you with: an overview of the completeness of the data your hospital has reported; analyses of activity; stratified analyses of activity (drawing comparisons between your hospital and national data); and basic, anonymised comparative analyses (non-risk adjusted).

A multivariable statistical model allowing comparisons of outcomes between participating hospitals is being developed and tested. The timeline for this has been dependant on NCAA achieving a significant sample size.

Cumulative reports on validated data are produced and disseminated quarterly based on the financial year:

- Q1 (April – June)
- Q1+Q2 (April – September)
- Q1+Q2+Q3 (April – December)
- Q1+Q2+Q3+Q4 (April – March)
2. How to use your NCAA Report

The NCAA Report marks the beginning of your local performance management/quality improvement process. We encourage you to disseminate the information in this Report to relevant staff in your department, as well as to colleagues in your hospital, Trust, etc. in order to promote wider discussion.

**WHO to share your NCAA Report with:**

- Resuscitation Team and staff in your department
- Resuscitation Committee and Chair
- Non-Executive Director in your Trust responsible for Resuscitation Policy
- Trust/Board/Regional level
- Other staff involved with the NCAA data collection and validation process
- Patient groups at your hospital/Trust
- Regional Resuscitation Officer Representative
- Other clinical staff/teams that feed into the patient journey e.g. nursing, outreach, general ward, ICU/HDU/CCU, surgical staff, Allied Health Professionals, etc.
- Any other relevant departments/teams within your hospital/Trust e.g. audit, management, etc.
- Managers at your hospital/Trust responsible for service development and business planning

**HOW to share/disseminate your NCAA Report:**

- Raise at relevant meetings (monthly/quarterly/yearly), such as:
  - Resuscitation Team or Staff meetings;
  - Resuscitation Committee meetings;
  - Management meetings;
  - Service development and Business planning meetings; and
  - Regional Resuscitation Officer meetings.

- Why not add ‘NCAA Report-review and learn’ as a standing item on relevant meeting agendas?
- Provide a presentation/hold a seminar at relevant meetings (monthly/quarterly/yearly)
- Save NCAA Report electronically on your shared drive for colleagues to access
- Email NCAA Report to colleagues
- Include key points in any local newsletters or intranet
- Display key results on your staff notice board or performance boards in common areas

**WHAT to reflect upon in your NCAA Report:**

- Review the suggested questions at the end of each section, as a basis for your discussion.
- Identify and discuss areas of concern and areas for improvement.
- Identify any areas of interest (for further analysis)
- Agree targets for improvement for the next quarter and year (and put action plan in place)
- Discuss team visits to review in greater detail
- Discuss areas of success, and identify reason
- Collate any questions/feedback for the NCAA Team
Look out for the following boxes in each section, where we have provided some useful questions to prompt local discussion and/or further local investigation:

### Suggested questions for local use

- Have you shared and discussed results with relevant staff?
- Have you made this NCAA Report accessible to all relevant staff?
- Have you made the results of your NCAA Report a standing meeting agenda item?
- Have you highlighted areas for improvement for the next quarter and forthcoming year, and drawn up an action plan to achieve this?
- Have you shared local successes in the delivery of care?

**Please note:** When sharing or presenting NCAA results/data, you must acknowledge the scope of data collection, the period it relates to and how many team visit records it is based upon (sample size).
3. About the data in this Report

Scope of data collection

NCAA data are collected for all individuals (excluding neonates) receiving chest compressions and/or defibrillation and attended by the hospital-based Resuscitation Team (or equivalent) in response to a 2222 call – these are referred to, in this report, as team visits.

Data collection/validation method

Your data have been validated both at the point of entry on to the NCAA secure, web-based data entry system and centrally at ICNARC. Data are checked for completeness and illogicalities.

Numbers this Report is based on

Reported numbers of admissions to your hospital, 2222 calls, team visits and individuals covered by this Report are presented below.

<table>
<thead>
<tr>
<th>Period</th>
<th>Total number of admissions to your hospital*</th>
<th>Total number of 2222 calls†</th>
<th>Total number of 2222 calls solely for cardiac arrests</th>
<th>Number of team visits entered</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2012 - 30/09/2012</td>
<td>62,141</td>
<td>-</td>
<td>251</td>
<td>122</td>
<td>113</td>
</tr>
</tbody>
</table>

Please note:

* Total includes elective, non-elective (emergency) and day cases  
† Total includes arrests and fire

Where data are not plotted in relation to 2222 calls, note that hospitals are required to collect denominator data either for ‘Total number of 2222 calls’ OR ‘Total number of 2222 calls solely for cardiac arrest’.
The following graphs present the reported number of team visits against the reported denominator data (Total number of admissions to your hospital, Total number of 2222 calls OR Total number of 2222 calls solely for cardiac arrest), for your hospital, for the period that this Report covers.

Please note:

* Total includes elective, non-elective (emergency) and day cases
† Total includes arrests and fire
The following graph presents the reported number of team visits per 1,000 hospital admissions for adult, acute hospitals in NCAA (for the period that this Report covers).

Note that interpretation of these data is subject to:

- the inclusion of all adult, acute hospitals with at least five team visits (for the period that this Report covers) and at least three months data in the given financial year; and
- an assumption that all hospitals are capturing the numerator and denominator data accurately.

**Graphical presentation**

Data for your hospital are plotted in red, and data for other NCAA participating hospitals are plotted in blue.

These data are presented with 95% confidence intervals. The vertical line through each data point (see image to the left) represents the 95% confidence interval (CI) around the value plotted.

Values plotted for your hospital data and other NCAA data are estimates of the true underlying rates because they are based on a sample of data. The range of values most likely to contain the true rate is displayed as a 95% CI.

The CI gives an idea of how accurately the value has been estimated. A narrow CI indicates a more accurate value.
Suggested questions for local use

- Have you ensured that data are being captured on all team visits, and according to the current NCAA scope of data collection?
- Is the reported number and rate of team visits as you expected for your hospital?
- How might NCAA data collection /entry be improved locally?
- How might you share advice for capturing team visit data with other NCAA participating hospitals in your Trust/region that may be experiencing issues with data collection?
4. Data completeness

This section provides you with an overview of the completeness of NCAA data for reported team visits. The following graphs illustrate how complete your data are for each field in the NCAA dataset.

Completeness graphs are grouped and presented under the following categories:

- patient characteristics;
- hospital admission;
- 2222 calls;
- visit/arrest details;
- post-arrest location; and
- outcome.

On each graph, a red bar indicates where data are incomplete (less than 100%) for a given field and a blue bar indicates where data are complete (100%).

On each bar for each field, the number of complete team visits, relative to the number required to be complete, is presented. For example, 10/13 means 10 out of 13 team visits had complete data for this field.

- **Patient characteristics**

  
  
<table>
<thead>
<tr>
<th>Field</th>
<th>Completeness (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number*</td>
<td>119/122</td>
</tr>
<tr>
<td>Date of birth</td>
<td>122/122</td>
</tr>
<tr>
<td>Sex</td>
<td>122/122</td>
</tr>
<tr>
<td>Ethnicity^</td>
<td>122/122</td>
</tr>
</tbody>
</table>

  
  
  * n = 0 team visit records where individual was recorded as a "Non-UK patient" (these are considered as complete data)

  ^ n = 0 team visit records where individual had ethnicity recorded as "Not stated" (these are considered as incomplete data)
• Hospital admission

- Date of admission to/attendance at/visit to your hospital: 122/122
- Reason for admission to/attendance at/visit to your hospital: 122/122

Completeness (%)

© NCAA 2013

• 2222 calls

- Date of 2222 call: 122/122
- Time of 2222 call: 122/122

Completeness (%)

© NCAA 2013
• **Visit / arrest details**

<table>
<thead>
<tr>
<th>Category</th>
<th>Completeness (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of arrest</td>
<td>122/122</td>
</tr>
<tr>
<td>Status at team arrival</td>
<td>122/122</td>
</tr>
<tr>
<td>Presenting/first documented rhythm*</td>
<td>116/122</td>
</tr>
<tr>
<td>Reason resuscitation stopped at end of team visit</td>
<td>122/122</td>
</tr>
</tbody>
</table>

* n = 6 team visit records where individual had presenting/first documented rhythm recorded as "Unknown" (these are considered as incomplete data)

n = 0 team visit records where individual had presenting/first documented rhythm recorded as "Never determined" (these are considered as complete data)

• **Post-arrest location**

<table>
<thead>
<tr>
<th>Category</th>
<th>Completeness (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient post-arrest location</td>
<td>61/61</td>
</tr>
<tr>
<td>Post-arrest location</td>
<td>61/61</td>
</tr>
</tbody>
</table>
**Outcome**

<table>
<thead>
<tr>
<th>Field</th>
<th>Completeness (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status at discharge from your hospital*</td>
<td>54/54</td>
</tr>
<tr>
<td>Date of discharge from your hospital</td>
<td>29/29</td>
</tr>
<tr>
<td>CPC at discharge from your hospital^</td>
<td>28/28</td>
</tr>
<tr>
<td>Date of death</td>
<td>93/93</td>
</tr>
<tr>
<td>Time of death</td>
<td>93/93</td>
</tr>
</tbody>
</table>

* n = 0 team visit records where individual is recorded as “patient still in your hospital” (excluded from the denominator)

^ n = 1 team visit records where individual is recorded as sedated (excluded from the denominator)

**Suggested questions for local use**

- Is your hospital fully collecting every (appropriate) field in the NCAA dataset?
- How could your hospital:
  - improve the quality of data collection?
  - increase the speed of data collection/entry?
  - reduce the number of subsequent validation queries?
  - increase the speed of processing validation queries?

For definitions of any of the dataset fields in this section, refer to the current NCAA Data Collection Manual.
5. Activity

Pre-hospital and In-hospital

The graph below presents reported team visits where the location of arrest is ‘Pre-hospital’ and ‘In-hospital’, for your hospital.

A ‘Pre-hospital’ arrest is defined as prior to arrival at your hospital, and meets the current scope of NCAA data collection:
- individual is an adult or child over 28 days;
- individual received chest compressions and/or defibrillation;
- 2222 call made; and
- individual attended by hospital-based resuscitation team (or equivalent) in response to the 2222 call.

‘In-hospital’ is defined as any location within or around your hospital.
Activity (in-hospital)

This section provides you with an overview of NCAA data for reported team visits where the location of arrest is in-hospital (i.e. excludes team visits where the location of arrest is pre-hospital).

Activity graphs are grouped and presented under the following headings:

- patient characteristics;
- 2222 calls;
- location of arrest;
- status at team arrival;
- presenting/first documented rhythm; and
- outcome.

For each graph, team visits for each category are presented as a percentage on the y axis (vertical) and as a number on the top of each bar.

Patient characteristics

- **Sex**

![Sex Graph](image-url)
• Age

![Age chart]

• Age by sex

![Age by sex chart]

Please note: n = 0 estimated age
Reason for admission to/attendance at/visit to your hospital

Suggested questions for local use

- Are there any trends in these data on patient characteristics for your hospital?
- How might patient characteristics be affecting the care you deliver?
- How does seasonal variation affect patient characteristics?
- How could these data on patient characteristics be used for planning Resuscitation Team responses?
- How could these data on patient characteristics be used for wider service planning at your hospital?
2222 calls

- Day of week of 2222 call

- Hour of day of 2222 call
• Day of week/ hour of day of 2222 call

![Bar graph showing the percentage of team visits by day of week and hour of day for 2222 calls.](image1)

• Number of days from admission to 2222 call

![Bar graph showing the percentage of team visits by number of days from admission to 2222 call.](image2)
Location of arrest

- Location of arrest

![Bar chart showing the percentage of team visits by location of arrest. The chart indicates that the majority of visits are to the Emergency department (87%) with other locations such as Theatre & recovery, Imaging dept, and so on, receiving significantly fewer visits.]
Ward arrests by reason for admission to/attendance at/visit to your hospital

Please note: The above graph only includes team visits where location of arrest is ward.
Status at team arrival

- Status at team arrival

![Bar chart showing status at team arrival]

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Presenting/first documented rhythm

- Presenting/first documented rhythm

![Bar chart showing the percentages of different rhythms](image)

Suggested questions for local use

- What patterns are present in your activity data?
- How could activity data be used for planning Resuscitation Team responses?
- How could activity data be used for wider service planning at your hospital?
**Outcome**

- Staged outcome flow

![Outcome Diagram]

Number of individuals (in this report) 113

Reason resuscitation stopped

Dead 60 (53.1%)  Alive 53 (46.9%)  Missing 0 (0.0%)

Post-arrest location

Dead 6 (11.3%)  Alive 47 (88.7%)  Missing 0 (0.0%)

Status at discharge from your hospital

Dead 23 (48.9%)  Survival to hospital discharge 24 (51.1%)  Patient still in your hospital 0 (0.0%)  Missing 0 (0.0%)

Please note: The percentages shown at each stage in this flow represent individuals that survived the previous stage and Alive/Dead percentages are for each stage not an overall figure.
• Reason resuscitation stopped at end of team visit

![Bar chart showing reasons for resuscitation stop, with percentages for Alive - ROSC>20 min (61%), Dead - ROSC<20 min (10%), Dead - no ROSC (48%), Dead - DNAR (2%), Dead - futility (1%), and Missing (1%)% team visits.](chart.png)

© NCAA 2013
- Reason resuscitation stopped at end of team visit by presenting/first documented rhythm
• Reason resuscitation stopped at end of team visit: Shockable - VF

• Reason resuscitation stopped at end of team visit: Shockable - VT
- Reason resuscitation stopped at end of team visit: Non-shockable - asystole

- Reason resuscitation stopped at end of team visit: Non-shockable - PEA
- Reason resuscitation stopped at end of team visit: Non-shockable - bradycardia
• Reason resuscitation stopped at end of team visit by day of week/hour of day of 2222 call

![Bar chart showing the distribution of reasons for resuscitation stopped at end of team visit by day of week/hour of day of 2222 call.]

- Weekday 08:00-19:59
- Weekday 20:00-07:59
- Weekend 08:00-19:59
- Weekend 20:00-07:59
- Missing

Day of week/hour of day of 2222 call:

- Alive - ROSC>20 min
- Dead - ROSC<20 min
- Dead - no ROSC
- Dead - DNAR
- Dead - futility
- Missing

© NCAA 2013
• Post-arrest location

![Bar chart showing post-arrest location]

• Overall outcome flow

![Diagram flowchart showing overall outcome at discharge from your hospital]

Number of individuals (in this report) 113

Overall outcome at discharge from your hospital

Dead 89 (78.8%)
Alive 24 (21.2%)
Patient still in your hospital 0 (0.0%)
Missing 0 (0.0%)
• CPC at discharge from your hospital: Adults

Please note: CPC 5 (adult) is dead (brain death: apnea, areflexia or EEG silence)

n = 0 individuals sedated on discharge from your hospital (excluded)

• CPC at discharge from your hospital: Adult survivors

Please note: n = 0 individuals sedated on discharge from your hospital (excluded)
• CPC at discharge from your hospital: Paediatrics (aged less than 16)

Please note: CPC 6 (paediatric) is dead (brain death: apnea, areflexia or EEG silence)

n = 1 individuals sedated on discharge from your hospital (excluded)

• CPC at discharge from your hospital: Paediatric survivors (aged less than 16)

Please note: n = 1 individuals sedated on discharge from your hospital (excluded)
CPC at discharge from your hospital by presenting/first documented rhythm of first 2222 call: Adults

- **Shockable - VF**: 12 individuals
- **Shockable - VT**: 5 individuals
- **Non-shockable - asystole**: 30 individuals
- **Non-shockable - PEA**: 57 individuals
- **Non-shockable - bradycardia**: 8 individuals
- **Other or missing**: 0 individuals

Please note: CPC 5 (adult) is dead (brain death: apnea, areflexia or EEG silence) n = 0 individuals sedated on discharge from your hospital (excluded)

© NCAA 2013
• CPC at discharge from your hospital by day of week/hour of day of first 2222 call: Adults

Please note: CPC 5 (adult) is dead (brain death: apnea, areflexia or EEG silence)

n = 0 individuals sedated on discharge from your hospital (excluded)
Suggested questions for local use

- Are there any unexpected patterns in patient outcome?
- Are there any unexpected mortalities or unexpected survivors?
- Is there a need to identify and review any specific team visits?
- How could these data be used for planning Resuscitation Team responses?
- How could these data be used for wider service planning at your hospital?
6. Stratified analyses

This section provides you with a stratified overview of your NCAA data, for reported team visits (where the location of arrest is in-hospital i.e. excludes team visits where the location of arrest is pre-hospital), compared with all NCAA data (for the period that this Report covers).

Stratified analyses provide you with grouped comparisons on specific outcome variables. The outcomes included are:

- reason resuscitation stopped at end of team visit (Alive – ROSC>20 minutes) – reported as a percentage of team visits;
- survival to hospital discharge – reported as a percentage of individuals; and
- favourable neurological outcome (CPC 1 or 2 for adults, and CPC 1, 2 or 3 for paediatrics) at discharge from your hospital – reported as a percentage of individuals.

Stratified graphs are grouped and presented under the following headings:

- age;
- day of week/hour of day of 2222 call;
- location of arrest; and
- presenting/first documented rhythm.

Graphical presentation

Data for your hospital are plotted on each graph in red, and all NCAA data (for the period that this Report covers) are plotted in blue.

For each graph, the number of team visits/individuals in each category for your hospital, is presented above the x axis (horizontal), for the period that this Report covers. Where there are fewer than five team visits/individuals in a category for your hospital, data are not plotted.

The vertical line through each data point (see image to the left) represents a 95% confidence interval (CI) around the value plotted.

Values plotted for your hospital data and NCAA data are estimates of the true underlying rates because they are based on a sample of data.

The range of values most likely to contain the true rate is displayed as a 95% CI. The CI gives an idea of how accurately the value has been estimated. A narrow CI indicates a more accurate value.
• Alive – ROSC>20 minutes
• Survival to hospital discharge

- Survival to hospital discharge (%)

- Age (years)
  - 0-15
  - 16-64
  - 65-74
  - 75-84
  - 85+

- Your hospital
- NCAA

© NCAA 2013

• Favourable neurological outcome

- Favourable neurological outcome (%)

- Age (years)
  - 0-15
  - 16-64
  - 65-74
  - 75-84
  - 85+

- Your hospital
- NCAA

© NCAA 2013

Please note:

- n = 1 individuals sedated on discharge from your hospital (excluded)
- n = 0 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)
By day of week/hour of day of 2222 call

- Alive – ROSC>20 minutes

![Graph showing the percentage of alive ROSC>20 minutes by day of week and hour of day for 2222 calls. The graph includes data for Your hospital and NCAA.]
• Survival to hospital discharge

![Graph showing survival to hospital discharge by day of week and hour of day of 2222 call.]

• Favourable neurological outcome

![Graph showing favourable neurological outcome by day of week and hour of day of 2222 call.]

Please note:
- n = 1 individuals sedated on discharge from your hospital (excluded)
- n = 0 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)
By location of arrest

Definitions of the categories for the graphs in this section:

- **Presentation at hospital**: Emergency department, emergency admissions unit (or equivalent), clinic, non-clinical area
- **In-hospital location**: Ward, obstetrics area, other intermediate care area, other internal location
- **Treatment area**: Theatre & recovery, imaging department, cardiac catheter laboratory, specialist treatment area
- **Critical/coronary care unit**: ICU or ICU/HDU, HDU, PICU, PHDU, CCU

- **Alive – ROSC>20 minutes**

![Graph showing Alive ROSC>20 minutes by location of arrest]

Higher is better

© NCAA 2013
• Survival to hospital discharge

![Graph showing survival to hospital discharge (%).]

• Favourable neurological outcome

![Graph showing favourable neurological outcome (%).]

Please note:
- n = 1 individuals sedated on discharge from your hospital (excluded)
- n = 0 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)
By presenting/first documented rhythm

- Alive – ROSC>20 minutes

![Graph showing survival rates for different rhythms](image-url)
• Survival to hospital discharge

![Graph showing survival to hospital discharge for different rhythms]

• Favourable neurological outcome

![Graph showing favourable neurological outcome for different rhythms]

Please note:
- n = 0 individuals sedated on discharge from your hospital (excluded)
- n = 0 individuals alive, not sedated and missing CPC at discharge from your hospital (excluded)
Suggested questions for local use

- How does your hospital compare with all NCAA data in terms of age; day of week/hour of day of 2222 call; location of arrest; presenting/first documented rhythm, each outcome?
- How could these stratified data be used for planning Resuscitation Team responses?
- How could these stratified data be used for wider service planning at your hospital?
7. Comparative analyses

This section provides you with initial comparative analyses on resuscitation outcomes for your hospital. These are not risk adjusted. A multivariable risk model, required to make fair comparisons, is under development.

NCAA data for your hospital are compared with each participating hospital, for the period that this Report covers.

The outcomes included in this section are survival to hospital discharge (reported as a percentage of individuals), by:

- shockable presenting/first documented rhythm; and
- non-shockable presenting/first documented rhythm.

**Graphical presentation**

Data for your hospital are plotted on each graph in red, and data for other NCAA participating hospitals (for the period that this Report covers) are plotted in blue.

**Survival to hospital discharge (%) by rhythm by hospital**

These data are presented for all NCAA participating hospitals (your hospital in red) in a funnel plot with two standard deviation 2SD (dotted) and three standard deviation 3SD (solid) lines relative to the percentage of overall survival.

The 2SD and 3SD lines are wider at lower sample sizes given the greater imprecision with small numbers.

Data points for higher sample sizes indicate a more accurate value and therefore the 2SD and 3SD lines are narrower.
- Survival to hospital discharge by shockable presenting/first documented rhythm

![Graph showing survival to hospital discharge by shockable presenting/first documented rhythm](image)

- Survival to hospital discharge by non-shockable presenting/first documented rhythm

![Graph showing survival to hospital discharge by non-shockable presenting/first documented rhythm](image)

Please note: Outcomes on these graphs are not risk adjusted.
Note that interpretation of these data is subject to:

- the inclusion of all hospitals with data recorded for at least five individuals;
- an assumption that all hospitals are capturing data for presenting/first documented rhythm and outcome at hospital discharge accurately

Clearly, presenting rhythm is not the only determinant of survival and, were other risk factors (e.g. age, etc.) not similar across hospitals, survival rates could vary even within shockable/non-shockable rhythms. It is for this reason that a multivariable statistical risk model is being developed.

**Suggested questions for local use**

- How do your outcomes compare with the other NCAA participating hospitals?
- What other factors (e.g. age, etc.) might be causing the variation seen?
- How might your hospital improve survival rates following cardiac arrests that fall under the NCAA scope?
- Have quality improvement interventions at your hospital been successful?
- How could these comparative data be used for planning Resuscitation Team responses?
- How might you use these data to engage Clinicians, Managers, and Trust Board Members?
8. Comments on your NCAA Report

If you have any questions or comments about your NCAA Report, then please email the NCAA Team (ncaa@icnarc.org).