

## ARC Event

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<b>OPTIONAL:</b> Local Event ID:		
Date/Time need for emergency assisted ventilation first recognized:	___/___/___ :___ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
System Entry Date:	___/___/___ :___ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented

### ARC 2.1 PRE-EVENT Pre-Event Tab

Was patient discharged from ICU prior to this event?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, date admitted to non-ICU unit (after ICU discharge)	___/___/___	(MM/DD/YYYY)
OPTIONAL: Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hrs. prior to this ARC event?	<input type="radio"/> Yes	<input type="radio"/> No
OPTIONAL: Was patient in the Emergency Department (ED) within 24 hours prior to this ARC event?	<input type="radio"/> Yes	<input type="radio"/> No
OPTIONAL: Did patient receive conscious/procedural sedation or general anesthesia within 24 hrs. prior to this ARC event?	<input type="radio"/> Yes	<input type="radio"/> No
<b>REQUIRED:</b> Enter <b>last set</b> of vital signs within 4 hours of event	<input type="checkbox"/> Pre-Event VS Unknown/Not Documented	

Date/Time	Heart Rate	Systolic BP/ Diastolic BP	Respiratory Rate	SpO2	Temp	Units
___/___/___ :___	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND <input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ :___	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND <input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ :___	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND <input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F
___/___/___ :___	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND	_____ <input type="checkbox"/> ND <input type="radio"/> Room Air <input type="radio"/> Supplemental O2 <input type="radio"/> ND	_____ <input type="checkbox"/> ND	C   F

### ARC 2.2 PRE-EXISTING CONDITIONS Pre-Event Tab

Pre-existing Conditions at Time of Event (check all that apply)	
<ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Acute Stroke</li> <li><input type="checkbox"/> Acute CNS non-stroke event</li> <li><input type="checkbox"/> Baseline depression in CNS function</li> <li><input type="checkbox"/> Cardiac malformation/abnormality - cyanotic (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Cardiac malformation/abnormality - acyanotic (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Congenital malformation/abnormality (Non-Cardiac) (pediatric and newborn/neonate only)</li> <li><input type="checkbox"/> Congestive heart failure (prior to this admission)</li> <li><input type="checkbox"/> Congestive heart failure (this admission)</li> <li><input type="checkbox"/> Diabetes Mellitus</li> <li><input type="checkbox"/> Hepatic Insufficiency</li> <li><input type="checkbox"/> History of vaping or e-cigarette use in the past 12 months?</li> <li><input type="checkbox"/> Major Trauma</li> <li><input type="checkbox"/> Metabolic/Electrolyte Abnormality</li> <li><input type="checkbox"/> Myocardial ischemia/infarction (prior to this admit)</li> <li><input type="checkbox"/> Renal Insufficiency</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Metastatic or hematologic malignancy</li> <li><input type="checkbox"/> Myocardial ischemia/infarction (this admission)</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Respiratory insufficiency</li> <li><input type="checkbox"/> Sepsis</li> <li><input type="checkbox"/> <b>Active or suspected bacterial or viral infection at admission or during hospitalization:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Bacterial Infection</li> <li><input type="checkbox"/> Emerging Infectious Disease                             <ul style="list-style-type: none"> <li><input type="checkbox"/> SARS-COV-1</li> <li><input type="checkbox"/> SARS-COV-2 (COVID-19)</li> <li><input type="checkbox"/> MERS</li> <li><input type="checkbox"/> Other Emerging Infectious Disease</li> </ul> </li> <li><input type="checkbox"/> Influenza</li> <li><input type="checkbox"/> Seasonal cold</li> <li><input type="checkbox"/> Other Viral Infection</li> </ul> </li> </ul> <p><b>Additional Personal Protective Equipment (PPE) Donned by the responders?</b></p>

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<input type="checkbox"/> Hypotension/hypoperfusion	<input type="radio"/> Yes <input type="radio"/> No/ND
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**ARC 2.3 INTERVENTIONS ALREADY IN PLACE** **Pre-Event Tab**

**Interventions ALREADY IN PLACE when need for chest compressions and/or defibrillation was first recognized (check all that apply):**

<b>Part A:</b>	<input type="checkbox"/> <b>None</b>
<input type="checkbox"/> Non-invasive assisted ventilation <input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Mask and/or Nasal CPAP <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Mouth-to-Mouth <input type="checkbox"/> Laryngeal Mask Airway (LMA) <input type="checkbox"/> Other Non-Invasive Ventilation: (specify) _____	<input type="checkbox"/> Invasive assisted ventilation, via an: <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Tracheostomy Tube <input type="checkbox"/> Intra-arterial catheter <input type="checkbox"/> Conscious/procedural sedation <input type="checkbox"/> End Tidal CO <sub>2</sub> (ETCO <sub>2</sub> ) Monitoring <input type="checkbox"/> Supplemental oxygen (cannula, mask, hood, or tent)

Select Method(s) of confirmation used to ensure correct placement of Endotracheal Tube (ET) or Tracheostomy Tube placement in trachea (check all that apply):

<input type="checkbox"/> Waveform capnography (waveform ETCO <sub>2</sub> ) <input type="checkbox"/> Capnometry (numeric ETCO <sub>2</sub> ) <input type="checkbox"/> Exhaled CO <sub>2</sub> colorimetric monitor (ETCO <sub>2</sub> by color change)	<input type="checkbox"/> Esophageal Detection Devices <input type="checkbox"/> Revisualization with direct Laryngoscopy <input type="checkbox"/> None of the above <input type="checkbox"/> Not Documented
<b>Monitoring:</b>	<input type="checkbox"/> Apnea <input type="checkbox"/> Apnea/Bradycardia <input type="checkbox"/> ECG <input type="checkbox"/> Pulse Oximetry
Vascular Access:	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Any Vasoactive agent in place?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented

**OPTIONAL: Part B:**

<input type="checkbox"/> None <input type="checkbox"/> Chest tube(s) <input type="checkbox"/> Dialysis/extracorporeal filtration therapy (ongoing) <input type="checkbox"/> Extracorporeal Membrane Oxygenation (ECMO) <input type="checkbox"/> Implantable Cardiac Defibrillator (ICD)	<input type="checkbox"/> Inhaled nitric oxide therapy <input type="checkbox"/> IV/IO continuous infusion of antiarrhythmic(s) <input type="checkbox"/> Prostaglandins - continuous infusion (newborn/neonate) <input type="checkbox"/> Other prior interventions in place, specify: _____
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**ARC 3.1 EVENT** **Event Tab**

Date/Time of Birth:	____/____/____ : ____ (MM/DD/YYYY HH:MM)
Age at Event (in yrs., months, weeks, days, hrs., or minutes):	<input type="radio"/> Years <input type="radio"/> Months <input type="radio"/> Weeks <input type="radio"/> Days <input type="radio"/> Hours <input type="radio"/> Minutes <input type="checkbox"/> Estimated <input type="checkbox"/> Age Unknown / Not Documented
Subject Type	<input type="radio"/> Ambulatory/Outpatient <input type="radio"/> Emergency Department <input type="radio"/> Hospital Inpatient -(rehab, skilled nursing, mental health wards) <input type="radio"/> Rehab Facility Inpatient <input type="radio"/> Skilled Nursing Facility Inpatient <input type="radio"/> Mental Health Facility Inpatient <input type="radio"/> Visitor or Employee
Illness Category	<input type="radio"/> Medical-Cardiac <input type="radio"/> Surgical-Cardiac <input type="radio"/> Obstetric <input type="radio"/> Other (Visitor/Employee) <input type="radio"/> Medical-Noncardiac <input type="radio"/> Surgical-Noncardiac <input type="radio"/> Trauma
Event Location (Area)	<input type="radio"/> Ambulatory/Outpatient Area <input type="radio"/> Adult Coronary Care Unit (CCU) <input type="radio"/> Adult ICU <input type="radio"/> Cardiac Catheterization Lab <input type="radio"/> Delivery Suite <input type="radio"/> Diagnostic/Intervention Area (excludes Cath Lab) <input type="radio"/> Emergency Department (ED) <input type="radio"/> General Inpatient Area <input type="radio"/> Neonatal ICU (NICU) <input type="radio"/> Newborn Nursery <input type="radio"/> Operating Room (OR) <input type="radio"/> Pediatric ICU (PICU) <input type="radio"/> Pediatric Cardiac Intensive Care <input type="radio"/> Post-Anesthesia Recovery Room (PACU) <input type="radio"/> Rehab, Skilled Nursing, or Mental Health Unit/Facility <input type="radio"/> Same-Day Surgical Area <input type="radio"/> Telemetry Unit or Step-Down Unit <input type="radio"/> Other <input type="radio"/> Unknown/Not Documented
Event Location (Name) (ARC)	_____
Event Witnessed?	<input type="radio"/> Yes <input type="radio"/> No/Not Documented
Was patient conscious when the need for emergency assisted ventilation was first identified?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown/Not Documented

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Was patient breathing when the need for emergency assisted ventilation was first identified?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Agonal	<input type="radio"/> Assisted Ventilation <input type="radio"/> Unknown/Not Documented
Rhythm when the need for emergency assisted ventilation was first identified:	<input type="radio"/> Accelerated idioventricular rhythm (AIVR) <input type="radio"/> Bradycardia <input type="radio"/> Pacemaker <input type="radio"/> Sinus (including sinus tachycardia) <input type="radio"/> Supraventricular tachyarrhythmia (SVTarrhy) <input type="radio"/> Ventricular Tachycardia with a pulse <input type="radio"/> Unknown/Not Documented		
Was a hospital-wide resuscitation response activated?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
Was there an emergency airway team called?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Not Documented
Did patient become apneic or respirations agonal ANY time during ARC event?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented	
Date/time patient became apneic or respirations agonal	<input type="text"/> / <input type="text"/> / <input type="text"/> : <input type="text"/> : <input type="text"/> (MM/DD/YYYY HH:MM)		<input type="checkbox"/> Time Not Documented

### ARC 4.1 2 VENTILATION Ventilation Tab

<b>Types of Ventilation/Airways used</b>	<input type="checkbox"/> None	<input type="checkbox"/> Unknown/Not Documented
<b>Ventilation/Airways Used (select all that apply):</b>	<input type="checkbox"/> Bag-Valve-Mask ____/____/____:____	<input type="checkbox"/> Time Not Documented
	<input type="checkbox"/> Mask and/or Nasal CPAP/BiPAP	<input type="checkbox"/> Endotracheal Tube (ET)
	<input type="checkbox"/> Mouth-to-Barrier Device	<input type="checkbox"/> Tracheostomy Tube
	<input type="checkbox"/> Mouth-to-Barrier <input type="checkbox"/> Laryngeal Mask Airway (LMA)	<input type="checkbox"/> Other Non-Invasive Ventilation, Specify _____
Date/Time first emergency assisted ventilation during event:	____/____/____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
Was any Endotracheal Tube (ET) or Tracheostomy Tube inserted/re-inserted during event?	<input type="radio"/> Yes	<input type="radio"/> No
Date/Time Endotracheal Tube (ET) or Tracheostomy Tube inserted if not already in place and/or re-inserted during event:	____/____/____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented
Method(s) of confirmation used to ensure correct placement of Endotracheal Tube (ET) or Tracheostomy Tube (check all that apply):	<input type="checkbox"/> Waveform capnography (waveform ETCO2) <input type="checkbox"/> Capnometry (numeric ETCO2) <input type="checkbox"/> Exhaled CO2 colorimetric monitor (ETCO2 by color change)	<input type="checkbox"/> Esophageal detection devices <input type="checkbox"/> Revisualization with direct laryngoscopy <input type="checkbox"/> None of the above <input type="checkbox"/> Not Documented

### ARC 5.1 OTHER INTERVENTIONS Other Interventions Tab

Select each intervention that was employed during the ARC event

<b>Drug Interventions</b> (check all that apply)	<input type="checkbox"/> None (review options below carefully) <input type="checkbox"/> Bronchodilator: Inhaled <input type="checkbox"/> Bronchodilator: Sub Q or IV/IO <input type="checkbox"/> Calcium chloride/Calcium gluconate <input type="checkbox"/> Fluid bolus for volume expansion <input type="checkbox"/> Magnesium sulfate	<input type="checkbox"/> Neuromuscular blocker/muscle relaxant <input type="checkbox"/> Prostaglandin E1 (PGE) <input type="checkbox"/> Reversal agent <input type="checkbox"/> Other drug interventions: _____
	<input type="checkbox"/> None (review options below carefully) <input type="checkbox"/> Central venous catheter inserted/PICC <input type="checkbox"/> Chest tube(s) inserted <input type="checkbox"/> Needle thoracostomy <input type="checkbox"/> Nasogastric (NG) / Orogastric (OG) tube <input type="checkbox"/> Thoracentesis	<input type="checkbox"/> Tracheostomy / Cricothyrotomy (placed during event) <input type="checkbox"/> Tracheostomy change/replacement <input type="checkbox"/> Other non-drug interventions _____

### ARC 6.1 EVENT OUTCOME Event Outcome Tab

Was ANY return of <b>spontaneous</b> respiration documented during event (excluding agonal/gasping)?	<input type="radio"/> Yes	<input type="radio"/> No/Not Documented
Date/Time FIRST return of spontaneous ventilation (ROSV)	____/____/____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented

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Reason ARC event ended:	<input type="radio"/> Return of spontaneous ventilation (ROSV) (no further need for assisted ventilation) that was sustained for > 20 minutes. <input type="radio"/> Control of ventilation with assisted ventilation that is sustained for > 20 minutes either: <ul style="list-style-type: none"> <li>a. Non-invasively (includes mask/nasal CPAP/BiPAP, negative pressure ventilation, excludes manual bag-valve mask ventilation); <b>OR</b></li> <li>b. Via an invasive airway (includes assisted ventilation via endotracheal/tracheostomy tube, assist control, IMV, pressure support, high frequency mechanical ventilation)</li> </ul> <input type="radio"/> Transfer of newborn out of delivery room prior to 20 min of spontaneous/controlled vent. <input type="radio"/> Progressed to Cardiopulmonary Arrest; or ARC interventions terminated because advanced directive.	
If progressed to CPA, does CPA portion of event meet GWTG-R inclusion criteria?	<input type="radio"/> Yes	<input type="radio"/> No, not being entered (e.g., DNAR)
Enter Date/ Time of the <b>BEGINNING</b> of sustained ROSV or control of ventilation or need for chest compression and/or defibrillation (CPA) first identified.	<u>    </u> / <u>    </u> / <u>    </u> <u>    </u> : <u>    </u> (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented

**ARC 7.1 RESUSCITATION-RELATED EVENTS AND ISSUES** *Events and Issues Tab*

	<input type="checkbox"/> No/Not Documented	
<b>Universal Precautions</b>	<input type="checkbox"/> Not followed by all team members (specify in comments section)	
<b>Documentation</b>	<input type="checkbox"/> Signature of code team leader not on code sheet <input type="checkbox"/> Missing other signatures <input type="checkbox"/> Initial ECG rhythm not documented	<input type="checkbox"/> Medication route(s) not documented <input type="checkbox"/> Incomplete documentation <input type="checkbox"/> Other (Specify in comments)
<b>Airway</b>	<input type="checkbox"/> Aspiration related to provision of airway <input type="checkbox"/> Delay <input type="checkbox"/> Delayed recognition of airway misplacement/displacement <input type="checkbox"/> Intubation attempted, not achieved	<input type="checkbox"/> Multiple intubation attempts <ul style="list-style-type: none"> <li>▪ Number of attempts _____</li> <li><input type="checkbox"/> Unknown/Not Documented</li> </ul> <input type="checkbox"/> Other (specify in comments section)
<b>Vascular Access</b>	<input type="checkbox"/> Delay <input type="checkbox"/> Inadvertent arterial cannulation	<input type="checkbox"/> Infiltration/Disconnection <input type="checkbox"/> Other (specify in comments)
<b>Medications</b>	<input type="checkbox"/> Delay <input type="checkbox"/> Route	<input type="checkbox"/> Dose <input type="checkbox"/> Selection <input type="checkbox"/> Other (specify in comments section)
<b>Leadership</b>	<input type="checkbox"/> Delay in identifying leader <input type="checkbox"/> Knowledge of equipment <input type="checkbox"/> Knowledge of medications/protocols <input type="checkbox"/> Knowledge of roles	<input type="checkbox"/> Team oversight <input type="checkbox"/> Too many team members <input type="checkbox"/> Other (specify in comments section)
<b>Protocol Deviation</b>	<input type="checkbox"/> ACLS/PALS <input type="checkbox"/> NRP	<input type="checkbox"/> Other (specify in comments section)
<b>Equipment</b>	<input type="checkbox"/> Availability <input type="checkbox"/> Function	<input type="checkbox"/> Other (specify in comments section)
<b>Comments</b>		

NOTE: Please do not enter any patient identifiable information in these optional fields.

Field 1	Field 2
Field 3	Field 4
Field 5	Field 6
Field 7	Field 8
Field 9	Field 10
Field 11	Field 12
Field 13	Field 14

**END OF ARC FORM**