

ARC Event

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

Part A:	<input type="checkbox"/> None
<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 ₂ (ETCO ₂) 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 ₂) <input type="checkbox"/> Capnometry (numeric ETCO ₂) <input type="checkbox"/> Exhaled CO ₂ colorimetric monitor (ETCO ₂ 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
Monitoring:	<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"/> Weeks <input type="radio"/> Hours <input type="radio"/> Months <input type="radio"/> Days <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	____/____/____ ____:____ (MM/DD/YYYY HH:MM)	<input type="checkbox"/> Time Not Documented	

ARC 4.1 2 VENTILATION Ventilation Tab

Types of Ventilation/Airways used	<input type="checkbox"/> None <input type="checkbox"/> Bag-Valve-Mask ____/____/____ ____:____	<input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> Time Not Documented
Ventilation/Airways Used (select all that apply):	<input type="checkbox"/> Mask and/or Nasal CPAP/BiPAP <input type="checkbox"/> Mouth-to-Barrier Device <input type="checkbox"/> Mouth-to-Barrier <input type="checkbox"/> Laryngeal Mask Airway (LMA)	<input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> Tracheostomy Tube <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

Drug Interventions (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: _____
Non-Drug Interventions (check all that apply)	<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 spontaneous 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"> a. Non-invasively (includes mask/nasal CPAP/BiPAP, negative pressure ventilation, excludes manual bag-valve mask ventilation); OR b. Via an invasive airway (includes assisted ventilation via endotracheal/tracheostomy tube, assist control, IMV, pressure support, high frequency mechanical ventilation) <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 BEGINNING 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	
Universal Precautions	<input type="checkbox"/> Not followed by all team members (specify in comments section)	
Documentation	<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)
Airway	<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"> ▪ Number of attempts _____ <input type="checkbox"/> Unknown/Not Documented <input type="checkbox"/> Other (specify in comments section)
Vascular Access	<input type="checkbox"/> Delay <input type="checkbox"/> Inadvertent arterial cannulation	<input type="checkbox"/> Infiltration/Disconnection <input type="checkbox"/> Other (specify in comments)
Medications	<input type="checkbox"/> Delay <input type="checkbox"/> Route	<input type="checkbox"/> Dose <input type="checkbox"/> Selection <input type="checkbox"/> Other (specify in comments section)
Leadership	<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)
Protocol Deviation	<input type="checkbox"/> ACLS/PALS <input type="checkbox"/> NRP	<input type="checkbox"/> Other (specify in comments section)
Equipment	<input type="checkbox"/> Availability <input type="checkbox"/> Function	<input type="checkbox"/> Other (specify in comments section)
Comments		

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