

Cardiac Arrest in a High-Acuity Urgent Care Network: A Five-Year Retrospective Analysis of Adult Patients (2020–2025)

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57%

ROSC achieved at TEREM
36 of 63 adult cardiac arrests

71%

ROSC after collapse under
observation (30/42)

77%

ROSC in observed collapse
with shockable rhythm (23/30)

~33%

ROSC in European OHCA
registry (EuReCa TWO)

Objective

Cardiac arrest is traditionally managed by EMS and hospital emergency departments; little is known about arrests in high-acuity community urgent care centers. We aimed to characterize adult cardiac arrest and **resuscitation outcomes** in the TEREM network, comparing arrests occurring **under medical observation** with those occurring **before arrival**.

Methods

Retrospective review of adult (≥ 18 years) cardiac arrests across TEREM, ~30 urgent care centers in Israel serving nearly **one million visits annually**, 2020–2025. Cases were identified by incident/adverse-event review and by a search of all visits coded as resuscitation. Arrests were classified as **observed / in-clinic** (collapse after arrival) or **pre-arrival / outside** (arrived pulseless or collapsed outside). Outcomes: shockable rhythm (VF/pVT) at first assessment, ROSC and signs of awakening at the clinic.

Results

63 adult arrests were identified; **42 (67%)** occurred after arrival, 27 of them within 15 minutes. 21 were pre-arrival (16 arrived pulseless, 5 collapsed outside). Mean age 63 vs 68 years.

ROSC was achieved in 36/63 (57%) — well above the ~33% reported in European OHCA registries. After observed collapse, **ROSC 30/42 (71%)** vs 6/21 (29%) pre-arrival; with a shockable rhythm, **23/30 (77%)** vs 1/7 ($p=0.004$). Any sign of awakening: 20/42 vs 0/21.

Overall, **37/63 (59%)** presented in a shockable rhythm. Shockable rhythm was far more frequent after observed collapse: **30/42 (71.4%) vs 7/21 (33.3%)**; OR 5.0 (95% CI 1.6–15.4), $p=0.006$. Pre-arrival rhythms were mostly asystole or PEA.

Chest pain preceded 22/42 observed vs 1/21 pre-arrival arrests; excluding chest pain, shockable rhythm was 55% vs 30% ($p=0.20$).

Limitations

Small numbers; case mix differs between groups; time to first shock not recorded; follow-up ends at the clinic.

Conclusions

In a high-acuity urgent care network, **more than half of adult cardiac arrests achieved ROSC (57%), rising to 71% after observed collapse** — well above typical OHCA registry rates. Two-thirds of arrests occur under medical observation and are **more often shockable than not (71% vs 33%)**, a profile closer to EMS-witnessed arrest than to general OHCA. These findings support maintaining **immediate monitoring, defibrillation and trained staff** in urgent care centers; a prospective registry including post-transfer survival is the next step.

One pre-arrival case without documented rhythm was counted as non-shockable; missing outcomes counted as no event. ROSC measured at the clinic; follow-up ends at transfer, survival to discharge not assessed. Registry comparators: EuReCa TWO (EMS-treated OHCA: ~20% shockable, ~33% ROSC); EMS-witnessed arrest series. VF/pVT, ventricular fibrillation/pulseless VT; ROSC, return of spontaneous circulation; OR, odds ratio.