

**Alegent Health Immanuel Medical Center
Medical Emergency Team**

Activation Criteria for MET

<p>Staff Concerned Doesn't look right Failure to respond to treatment Unable to notify physician</p>
<p>Respiratory Status Changes in respiratory rate Decreasing O₂ sat despite O₂ SOB Change in breathing pattern Respiratory Distress Threatened airway</p>
<p>Heart Rate Changes in HR New irregular pulse Rhythm change</p>
<p>B/P Changes in B/P Undetectable</p>
<p>LOC Lethargic Confused Agitated Seizures (new, repeated, prolong)</p>
<p>Chest Pain New Recurring</p>
<p>Fluid Status I>O Rales UOP<50ml/4hrs</p>
<p>Critical Lab Value</p>

How to Initiate

Staff member or physician calls ICU charge nurse: Phone XXXX

- A. MET team needed in room _____
- B. Description of issue.

Charge nurse contacts the following:

- A. Charge respiratory therapy: Phone XXXX

In the event the pagers or phone is unanswered, the call should go to the house supervisor.

Alegent Health Immanuel Medical Center
Medical Emergency Team
MEDICAL EMERGENCY TEAM (MET) Pilot

Purpose

A Medical Emergency Team call is initiated when a patient's condition changes based on determined criteria, and additional critical care support is needed. The MET Nurse and MET Respiratory Therapist will function as consultants assisting with the assessment and management of the patient.

Rationale

Risk of death with cardiopulmonary arrest is stated in the literature as between 50-80% (in hospital cardiac arrests). Unexpected cardiac/respiratory arrests in the hospital are usually preceded by signs of clinical instability that are present for up to 6 to 8 hours (Franklin & Mathew, 1994).

Goals

- Reduce the incidence of cardiac/respiratory arrests
- Reduce incidence of "Failure to Rescue"
- Decrease mortality rates
- Promote appropriate level of care
- Improve critical thinking skills of staff

Expectations of Requesting Staff

Please note that the intention of the MET is to help those patients in the time window or clinical instability and not to take the place of immediate consultation with the physician if needed. This can be done simultaneously.

Three types of activation:

- 1) The patient's condition warrants the immediate attention of physician. The physician is called first, then MET.
- 2) The nurse is unsure if physician needs to be called. The MET can be activated first. The MET nurse will assist in calling the physician.
 - Initiate the activation of the MET team when the patient meets the criteria
 - SBAR is used to communicate with the MET and physician.
 - Stay with the patient. The MET RN will not assume care of the patient.
 - After consultation with the MET, a call is placed to the appropriate physician.
 - Institute any therapy needed and remain for any other evaluation or management
 - Remain available for transport to a higher level of care if applicable.
- 3) The Physician may recommend MET to evaluate the patient's status. After evaluating the situation, the MET will call the physician.

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Criteria for calling MET

- Respiratory distress, threatened airway, change in breathing pattern
- Acute change in B/P, HR
- Acute change in Level of Consciousness
- Decreased urine output without history of renal dysfunction
- New, repeated or prolonged seizures
- Failure to respond to treatment
- New onset of chest pain
- Staff nurse concerned about the patient

How to Initiate

Staff member calls charge nurse: Phone XXXX

- A. MET team needed in room _____
- B. Description of issue

ICU charge nurse contacts

- A. MET Nurse
- B. Charge Respiratory Therapy

In the event the pagers or phones are down, the staff nurse will call the House Supervisor.

Expectations of MET Team

- MET team should respond within 10 minutes and stay 20 minutes or less.
- Assess clinical situation focusing on stabilization of areas established in the call criteria:
 1. Airway
 2. Breathing
 3. Circulation
 4. Neurological
 5. Miscellaneous
- Assess if intervention is needed. In consultation with staff RN, make recommendations for appropriate interventions. The MET has the ability to notify the ICU team if transfer is anticipated.
- In consultation with the physician, appropriate level of care will be determined.
- If additional therapy needs (ie. vasoactive medications) to be initiated prior to higher level of care transfer, the MET may instruct the staff RN regarding monitoring needs and then assist in transport.
- Once assessment is made and stabilization plans are started, continued patient management and documentation in the patient's record is the responsibility of the staff RN.
- Full documentation of the MET intervention and outcome is documented in the patient's record.

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Protocols for MET RN/RT to follow:

Physician will be notified. In the event the physician cannot be reached, the MET has the ability to notify the ICU team if transfer is anticipated.

Respiratory Therapist:

1. Verify airway. Obtain pulse oximetry.
2. O₂ protocol may be initiated for patient experiencing signs of hypoxia or respiratory distress.
3. Advanced airway techniques will be initiated as needed.
4. Complete RT assessment completed.

Crisis Nurse:

1. Put patient on house-wide telemetry and treat according to house-wide telemetry orders.
2. Check for patient IV access. If not present, start with **Normal Saline** via infusion pump at 20 ml/hr.
3. If patient on opioids experiences respiratory rate less than or equal to 8/minute, may administer **Naloxone**. Mix 0.4mg (1 ampule) of Naloxone and 9 ml normal saline in a syringe; administer at rate of 1ml every minute.
4. If patient on Benzodiazepine experiences respiratory rate less than or equal to 8/minute, may administer **Romazicon**. 0.2mg (2 ml) at 1 minute intervals to a maximum of 1mg.
5. For suspected hypoglycemia, obtain capillary glucose and treat according to the hypoglycemic protocol.
6. For new and recurring chest pain, 12-Lead EKG. May administer SL **Nitroglycerin** 0.4mg every 5 minutes with maximum of 3 tablets if systolic BP 90 or above. Contact physician immediately.

If the patient's condition deteriorates to a cardiac or respiratory arrest, a Code Blue will be activated. ACLS algorithms will be followed by responding Code Blue team.

Data Collection

Ongoing data will be collected to include:

- Appropriateness for implementing MET
- Involvement of physician
- MET response time
- Time with patient
- Interventions required
- Outcome of patient
- Code Rates
- Data will be reported to the Critical Care Committee