

Medical Emergency Team (MET) Event

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OPTIONAL: Local Event ID:		
Date/Time MET was activated:	____/____/____ : ____ (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

MET 2.1 PRE-EVENT**Pre-Event Tab**

Was patient discharged from an Intensive Care Unit (ICU) at any point during this admission and prior to this MET call?	<input type="radio"/> Yes	<input type="radio"/> No
Was patient discharged from an ICU within 24 hrs. prior to this MET call?	<input type="radio"/> Yes	<input type="radio"/> No
Was patient discharged from a Post Anesthesia Care Unit (PACU) within 24 hrs. prior to this MET call?	<input type="radio"/> Yes	<input type="radio"/> No
Was patient in the ED within 24 hrs. prior to this MET call?	<input type="radio"/> Yes	<input type="radio"/> No
Did patient receive conscious/procedural sedation or general anesthesia within 24 hrs. prior to this MET call?	<input type="radio"/> Yes	<input type="radio"/> No
Enter all vital signs taken in the 4 hours prior to this MET event. For patients on continuous monitoring (e.g. ICU, Telemetry, PACU) where frequent pre-event Vital Signs have been documented, enter the last FOUR sets of vital signs prior to MET Activation.	<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

Neurological Assessment - AVPU Scale (most recent within last 4 hours prior to this MET event):

☐ A – Alert
☐ V – Voice
☐ P – Pain

☐ U – Unresponsive/Unconscious
☐ Not Documented

MET 2.2 MET PRE-EXISTING CONDITIONS**Pre-Event Tab**

Pre-existing Conditions at Time of Event (check all that apply):	Active or suspected bacterial or viral infection at admission or during hospitalization: <input type="checkbox"/> None <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Emerging Infectious Disease <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
	Additional Personal Protective Equipment (PPE) Donned by the responders? <input type="radio"/> Yes <input type="radio"/> No/Not Documented
	History of vaping or e-cigarette use in the past 12 months? <input type="radio"/> Yes <input type="radio"/> No/ND

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Event Tab

MET 3.2 MET ACTIVATION TRIGGERS – Check all that Apply

Event Tab

MET 4.1 DRUG INTERVENTIONS

Interventions Tab

<input type="checkbox"/> None <input type="checkbox"/> Albumin <input type="checkbox"/> Antibiotic (IV) <input type="checkbox"/> Antihistamine (IV) <input type="checkbox"/> Aspirin	<input type="checkbox"/> Atropine <input type="checkbox"/> Diuretic (IV) <input type="checkbox"/> Fluid Bolus (IV) <input type="checkbox"/> Glucose Bolus	<input type="checkbox"/> Epinephrine <u>Epinephrine Route:</u> <input type="radio"/> Inhaled Racemic <input type="radio"/> IM <input type="radio"/> SQ	<input type="checkbox"/> Nitroglycerin <u>Nitroglycerin Route:</u> <input type="radio"/> IV <input type="radio"/> SL <input type="checkbox"/> Reversal Agent	<input type="checkbox"/> Steroids <input type="checkbox"/> Vasoactive Agent Infusion (not bolus)
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<input type="checkbox"/> Antiarrhythmic Agent <input type="checkbox"/> Anti-epileptic	<input type="checkbox"/> Inhaled Bronchodilator <input type="checkbox"/> Insulin/Glucose	<input type="radio"/> IV	<input type="checkbox"/> Sedative	<input type="checkbox"/> Other drug intervention(s) _____
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MET 4.2 NON-DRUG INTERVENTIONS (Diagnostic and Therapeutic)

Interventions Tab

Respiratory Management:

<input type="checkbox"/> None <input type="checkbox"/> Non-Invasive Ventilation <ul style="list-style-type: none"> <input type="checkbox"/> Bag-Valve-Mask <input type="checkbox"/> Mask CPAP/BiPAP <input type="checkbox"/> Mask already in place and continued during MET event <input type="checkbox"/> Mask initiated during MET event <input type="checkbox"/> Nasal Airway <input type="checkbox"/> Oral Airway <input type="checkbox"/> Other Non-Invasive Ventilation _____ 	<input type="checkbox"/> Supplemental O2 <input type="checkbox"/> Suctioning <input type="checkbox"/> Invasive Ventilation <ul style="list-style-type: none"> <input type="checkbox"/> Endotracheal Tube (ET) <input type="checkbox"/> ET already in place and continued during MET event <input type="checkbox"/> ET inserted/re-inserted during MET event <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Tracheostomy already in place during MET event <input type="checkbox"/> Tracheostomy placed/re-placed during MET event <input type="checkbox"/> Other Invasive Ventilation _____
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If Endotracheal Tube (ET) or Tracheostomy tube placed during MET event, method(s) of confirmation used to ensure correct placement of 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		
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Monitoring:	<input type="checkbox"/> Apnea/Bradycardia	<input type="radio"/> Continued	<input type="radio"/> Initiated
	<input type="checkbox"/> Continuous ECG/Telemetry	<input type="radio"/> Continued	<input type="radio"/> Initiated
	<input type="checkbox"/> Continuous Pulse Oximetry	<input type="radio"/> Continued	<input type="radio"/> Initiated
	<input type="checkbox"/> Other Monitoring (Specify): _____		

Vascular Access:	<input type="checkbox"/> Central Vein	<input type="checkbox"/> Already in place	<input type="checkbox"/> Placed during MET event
	<input type="checkbox"/> Peripheral Vein	<input type="checkbox"/> Already in place	<input type="checkbox"/> Placed during MET event
	<input type="checkbox"/> Intraosseous (IO)	<input type="checkbox"/> Already in place	<input type="checkbox"/> Placed during MET event
	<input type="checkbox"/> Other Vascular Access: _____	<input type="checkbox"/> Already in place	<input type="checkbox"/> Placed during MET event

Stat consult:	<input type="checkbox"/> Critical Care	<input type="checkbox"/> Other Stat Consult: _____
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Other interventions initiated during the events:	<input type="checkbox"/> 12 Lead ECG <input type="checkbox"/> Cardioversion/Pacing <input type="checkbox"/> Electroencephalogram (EEG) <input type="checkbox"/> STAT Labs <input type="checkbox"/> Transfusion of blood products <input type="checkbox"/> Other Non-Drug Interventions, Specify: _____	<input type="checkbox"/> Imaging <ul style="list-style-type: none"> <input type="checkbox"/> Bedside Cardiac Ultrasound (Echo) <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Head CT (STAT) <input type="checkbox"/> Neonatal Head Ultrasound
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MET 5.1 MET OUTCOME

Outcome Tab

Did patient require emergency assisted ventilation for acute respiratory compromise (ARC) OR chest compressions and/or defibrillation for cardiopulmonary arrest (CPA) during the MET event?	<input type="checkbox"/> No	
	<input type="checkbox"/> Yes, Acute Respiratory Compromise (ARC) Event	Did ARC event meet GWTG-R ARC Inclusion Criteria? <input type="radio"/> Yes <input type="radio"/> No (e.g., DNAR) <input type="radio"/> N/A (not collecting ARC data in GWTG-R)
	<input type="checkbox"/> Yes, Cardiopulmonary Arrest (CPA) Event	Did CPA event meet GWTG-R CPA Inclusion Criteria? <input type="radio"/> Yes

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	<input type="radio"/> No (e.g., DNAR) <input type="radio"/> N/A (not collecting CPA data in GWTG-R)
Patient Transferred To:	<input type="radio"/> Not Transferred (remained on unit) <input type="radio"/> Intensive Care Unit Post-MET ICU length of stay for this ICU admission (days) _____ <input type="radio"/> Cardiac Catheterization Lab
	<input type="radio"/> Telemetry/Step-Down <input type="radio"/> Operating Room <input type="radio"/> Emergency Department <input type="radio"/> Other Hospital <input type="radio"/> Other (Specify) _____
Did patient die during MET event?	<input type="radio"/> Yes <input type="radio"/> No
Was MET response scope of care limited by patient/family end of life decisions or physician decision of medical futility?	<input type="radio"/> Yes <input type="radio"/> No
Was patient made DNAR during MET Event?	<input type="radio"/> Yes <input type="radio"/> No

MET 6.1 REVIEW OF MET RESPONSE

Review Tab

<input type="checkbox"/> No/Not Documented <input type="checkbox"/> MET trigger(s) present, but team not immediately activated <input type="checkbox"/> Incorrect Team Activated <input type="checkbox"/> Medication Delay <input type="checkbox"/> Equipment Issue Specify Equipment: _____ <input type="checkbox"/> Availability <input type="checkbox"/> Function	<input type="checkbox"/> MET Response Delay <input type="checkbox"/> MET criteria/process not known or misunderstood by those calling MET <input type="checkbox"/> MET communication system not working (e.g., phone, operator, pager) <input type="checkbox"/> Other, (Specify): _____ <input type="checkbox"/> Issues Between MET and Other Caregivers/Departments	<input type="checkbox"/> Essential Patient Data Not Available <input type="checkbox"/> Incomplete or inaccurate information communicated <input type="checkbox"/> Other, (Specify): _____ <input type="checkbox"/> Prolonged MET Event Duration
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MET 7.1 COMMENTS

Review Tab

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

Event Comments		
	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 MET FORM