

### MET Event Record 2

Date: \_\_\_\_\_ Time MET called: \_\_\_\_\_  
 1<sup>st</sup> Member Arrival Time: \_\_\_\_\_  
 Last Member Departure Time: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Race: \_\_\_\_\_  Hispanic Origin

### Patient Stamp

Patient Name \_\_\_\_\_  
 Medical Record # \_\_\_\_\_

**ICU Discharge prior to MET call?**  Yes  No  
 If Yes, date admitted to non-ICU unit (after ICU disch.): \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Discharged from PACU within 24 hrs of MET call?**  Yes  No  
**Sedation/anesthesia within 24 hrs of MET call?**  Yes  No  
**In ED 24 hours prior to MET call?**  Yes  No

**All vital sign signs taken in the 4 hrs prior to MET activation**  
*(if none, enter last documented vital signs prior to the MET activation):*  
**Date/Time** **HR** **BP** **Resp Rate** **SpO2** **Temp./Units**  
 \_\_\_\_\_ C | F  
 \_\_\_\_\_ C | F  
 \_\_\_\_\_ C | F

**At Time of Event:** Heart Rate: \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_ Respiratory Rate: \_\_\_\_\_ SpO2: \_\_\_\_\_ Temp/Units: \_\_\_\_\_ C | F

**Illness Category:**  Medical – Cardiac  Surgical – Cardiac  Newborn  Trauma  
 Medical – Non-Cardiac  Surgical – Non-Cardiac  Obstetric  Other (Visitor/Employee)

### MET Activation Triggers – Check all that apply

<p><input type="checkbox"/> <b>Trigger Unknown</b></p> <p><b>Cardiac:</b></p> <p><input type="checkbox"/> Bradycardia  <input type="checkbox"/> Tachycardia  <input type="checkbox"/> Hypotension  <input type="checkbox"/> Symptomatic  <input type="checkbox"/> Chest pain unresponsive to NTG</p>	<p><b>Respiratory:</b></p> <p><input type="checkbox"/> Respiratory Depression  <input type="checkbox"/> Tachypnea  <input type="checkbox"/> New onset of difficulty breathing  <input type="checkbox"/> Reversal agent without response  <input type="checkbox"/> Bleeding into airway  <input type="checkbox"/> Decreased oxygen saturation</p>	<p><b>Neurological:</b></p> <p><input type="checkbox"/> Mental status change  <input type="checkbox"/> Acute Loss of Consciousness (LOC)  <input type="checkbox"/> Seizure  <input type="checkbox"/> Suspected acute stroke  <input type="checkbox"/> Unexplained agitation or delirium</p>	<p><b>Medical:</b></p> <p><input type="checkbox"/> Acute decrease in urine output  <input type="checkbox"/> Rising lactate to &gt; 4 mEq/L  <input type="checkbox"/> Uncontrolled bleeding</p> <p><b>Other:</b></p> <p><input type="checkbox"/> Staff member concern  <input type="checkbox"/> &gt; 1 stat page  <input type="checkbox"/> Other: _____</p>
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### Drug Interventions – Check all given during MET event

<input type="checkbox"/> None	<input type="checkbox"/> Atropine	<input type="checkbox"/> Glucose Bolus	<input type="checkbox"/> Magnesium	<input type="checkbox"/> Reversal agent
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Calcium	<input type="checkbox"/> Heparin/(LMH)	<input type="checkbox"/> Mannitol	<input type="checkbox"/> Sodium bicarbonate
<input type="checkbox"/> Antiarrhythmic Agent	<input type="checkbox"/> Diuretic (IV)	<input type="checkbox"/> Inhaled Bronchodilator	<input type="checkbox"/> Nitroglycerin (IV)	<input type="checkbox"/> Thrombolytic
<input type="checkbox"/> Anti-epileptic	<input type="checkbox"/> Fluid Bolus (IV)	<input type="checkbox"/> Insulin/Glucose	<input type="checkbox"/> Nitroglycerin (SL)	<input type="checkbox"/> Vasoactive Agent Infusion (not bolus)
<input type="checkbox"/> <b>Other:</b> _____				

### Non-Drug Interventions (Diagnostic and Therapeutic) – Check all done or ordered during MET event

<p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Bedside Cardiac Ultrasound  <input type="checkbox"/> Bronchoscopy  <input type="checkbox"/> Cardioversion  <input type="checkbox"/> Chest Tube  <input type="checkbox"/> Chest X-ray  <input type="checkbox"/> Coma position  <input type="checkbox"/> <b>Consult (Stat):</b>  <input type="checkbox"/> Cardiology  <input type="checkbox"/> Critical Care  <input type="checkbox"/> Neurology  <input type="checkbox"/> Pulmonary  <input type="checkbox"/> Surgery  <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> CPR  <input type="checkbox"/> Cricothyrotomy  <input type="checkbox"/> Defibrillation</p>	<p><input type="checkbox"/> Electroencephalogram (EEG)  <input type="checkbox"/> Foley catheter  <input type="checkbox"/> Gastric lavage  <input type="checkbox"/> GI - Lower  <input type="checkbox"/> GI - Upper  <input type="checkbox"/> Head CT (stat)  <input type="checkbox"/> Hyperventilation  <input type="checkbox"/> <b>Monitoring:</b>  <input type="checkbox"/> Apnea/Brady.. (stand alone)  <input type="checkbox"/> ECG Monitor  <input type="checkbox"/> Non-Invasive BP (NIBP)  <input type="checkbox"/> Pulse Oximeter  <input type="checkbox"/> 12-lead ECG  <input type="checkbox"/> Nasogastric (NG) Tube  <input type="checkbox"/> Neonatal Head Ultrasound (echo)</p>	<p><input type="checkbox"/> Pacemaker  <input type="checkbox"/> Pericardiocentesis  <input type="checkbox"/> <b>Respiratory Management:</b>  <input type="checkbox"/> Elective intubation (airway protection)  <input type="checkbox"/> Mechanical Ventilation  <input type="checkbox"/> Supplemental O<sub>2</sub>  <input type="checkbox"/> Suctioning  <input type="checkbox"/> Tracheostomy Care/Replacement  <input type="checkbox"/> <b>Ventilation:</b>  <input type="checkbox"/> Bag-Valve-Mask  <input type="checkbox"/> Mask CPAP/BiPAP  <input type="checkbox"/> Nasal Airway  <input type="checkbox"/> Oral Airway  <input type="checkbox"/> Endotracheal Tube (ET)  <input type="checkbox"/> Laryngeal Mask Airway (LMA)  <input type="checkbox"/> Combitube  <input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Serum Lactate  <input type="checkbox"/> Thoracentesis  <input type="checkbox"/> <b>Transfusion:</b>  <input type="checkbox"/> Albumin  <input type="checkbox"/> Fresh frozen plasma  <input type="checkbox"/> Packed red blood cells  <input type="checkbox"/> Platelets  <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <b>Vascular Access:</b>  <input type="checkbox"/> Central Vein  <input type="checkbox"/> Peripheral Vein  <input type="checkbox"/> Intraosseous (IO)  <input type="checkbox"/> Umbilical Artery (UAC)  <input type="checkbox"/> Umbilical Vein (UVC)</p> <p><input type="checkbox"/> <b>Other Non-Drug Interventions</b>    _____    _____</p>
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### MET Outcome

Did event progress to Acute Respiratory Compromise (ARC) OR (CPA during the MET event?  No  ARC Event  CPA Event  
 Pt. Transferred To:  Morgue  Not Transf.  ICU  Cath Lab  OR  Telemetry/Step-Down  Other Hosp.  Other: \_\_\_\_\_  
 Was MET response scope of care limited by patient/family end of life decisions or physician decision of medical futility?  Yes  No

### Review of MET Response

<p><input type="checkbox"/> <b>MET trigger(s) present, but team not immediately activated</b></p> <p><input type="checkbox"/> <b>MET Response Delay:</b></p> <p><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"/> Incomplete or inaccurate information communicated  <input type="checkbox"/> Other Specify: _____</p> <p><input type="checkbox"/> <b>Essential Patient Data Not Available</b></p> <p><input type="checkbox"/> <b>Medication Delay</b></p>	<p><input type="checkbox"/> <b>Equipment Issue</b> → <input type="checkbox"/> Availability <input type="checkbox"/> Function    Specify Equipment: _____</p> <p><input type="checkbox"/> <b>Issues Between MET team and Other Caregivers/Departments</b></p> <p><input type="checkbox"/> <b>Prolonged MET Event Duration</b></p> <p><b>MET Member Signature:</b> _____</p> <p><b>MET Member ID #:</b> _____</p>
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