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Nurse-Led Medical Emergency Teams: A Recipe for Success in Community Hospitals

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When initiating the Medical Emergency Team (MET) concept and developing the team roles, often a critical care medicine physician is not an option. Community hospitals may not have physician coverage, either intensivists or hospitalists, in the facility around the clock. Instead, they must look within their current facility resources for rapid-response team personnel. When no physician is available, the development of the team requires not only delineation of specific team roles but also a treatment leader. This can be difficult because of the traditional professional roles in which health care workers have been constrained. In this chapter, I will describe characteristics and logistics of MET implementation in a community hospital, without an on-site physician readily available to be the team leader.

Identification of Hospital Resources

The development of team roles depends on several factors:

1. **Availability:** It is crucial that the staff of the hospital can call for a MET whenever needed: 24 hours per day, 365 days per year. Small community hospitals may have difficulty identifying available resources; they must look at several areas of the hospital that *could* provide resources to the Medical Emergency Team but currently do not. When the MET is called, the need is immediate, so the team members must be able to stop whatever they are doing and respond to the call. If the team members—especially the leader—have to prioritize tasks and make a snap decision, they may make incorrect choices. For example, they may choose to complete their current activity, and not make the priority the unseen patient who has begun to deteriorate, and thus the goal of intervening early in the patients' downhill spiral is doomed before the response even starts.
2. **Accessibility:** Calling the MET should be easy—1 number, 1 call. Staff members will not call for the “small things” if it is difficult. For example, if there are different numbers to call on the day shift or the weekend, it will

become more of a chore to call and more easy to make mistakes. Training becomes much more complex as the number of methods (phone numbers) to activate the crisis response increases. Simplicity and standardization are key. If the team is easy to reach, the staff is more likely to call at the first hint of trouble.

3. Ability/Skills: The team members must possess skills that match the tasks they are being asked to complete. It makes no sense to delegate the role of airway manager to someone who is untrained, inexperienced, and unskilled. To form a treatment plan, each team member must be able to assess the patient quickly and critically, perform their specified duties, and be confident in their decision-making skills. The team leader must not only be clinically competent in diagnosis and treatment of patients in crisis, but must also possess and be confident in the skills needed to lead a small group in crisis.

Nursing Leadership of Crisis Response Teams

With these factors in mind, an experienced nurse may best fill the leadership role in a small hospital. Critical care units, emergency departments, and post-anesthesia recovery rooms offer nurses great opportunities to develop vital skills, such as:

- The ability to accurately diagnose and collect key laboratory data;
- The ability to quickly assess a variety of complex patients;
- The opportunity to implement evidenced-based protocols and observe immediate patient outcomes;
- The ability to quickly respond and effectively perform in critical patient situations;
- Confidence in ability and motivation by the urgency of the patient populations;
- The ability to work with physicians in consultation rather than at the bedside.

Nurse-led Medical Emergency Teams have been successful in various hospital settings, from the small community hospital to the very large tertiary referral center. Jewish Hospital, a 442-bed facility in Louisville, KY, implemented a registered nurse (RN) Respiratory Therapist team in June 2003. Using 2 ICU-charge RNs and 1 respiratory therapist, the MET team responds to concerns about patient condition in the intermediate and medical surgical areas of the hospital within 10 minutes of a call. Several hospitals in Memphis, including Saint Francis Hospital and the Regional Medical Center, have also created nurse-led teams who have successfully treated numerous patients. METs are an important tool that can help to promote a culture of safety in the entire facility, and the absence of a physician on hand does not imply that METs cannot be implemented.