

MEDICAL EMERGENCY TEAM RESCUSITATION BAY (METRB)



Editor's Summary: In *Medical Emergency Team Resuscitation Bay (METRB)*, a team from Capital Health, Alberta Health Services Board describes an initiative designed to increase the capacity to move patients who are identified during a MET call and are in need of the Intensive Care Unit when there is no ICU bed available. To achieve this, each morning the ICU group identifies a current ICU patient who is ready to transfer to a regular ward. This involves ensuring that the necessary transfer orders and processes have been completed and that the patient is physically ready to transfer immediately upon identifying an urgent MET patient admission requirement. This creates capacity to treat and stabilize the patient in the most appropriate environment. If such a transfer is not possible, the team will continue emergency services in the ward until the transfer can be made, but the process is in motion and the care is ultimately safer. Evaluation data on this initiative is still in process.

Contact:

Dallas Schroeder

dallasschroeder@capitalhealth.ca

Authors:

- P. Lynkowski, Patient Care Director
- D. Schroeder, BSc. RRT, Acting Patient Care Manager
- N. Gibney, MD, FRCP(C), Regional Program Director of Critical Care Medicine
- M. Meier, MD, FRC(S)C, Medical Director, Critical Care
- C. Hartikainen, HBBScN, Unit Manger ICU, UAH
- C. Castle, RN, Unit Manger Burns, UAH
- S. Harper, BSN, Unit Manager ICU, UAH
- T. Pratt, RN, Unit Manager ICU, UAH
- H. Richardson, BScN, Patient Safety and Quality Lead, ICU, UAH
- E. Mondor, RN, BScN, MN, Clinical Nurse Educator ICU, UAH

Purpose:	The Medical Emergency Team (MET) Resuscitation Bay was designed to address the problem of delayed transfer of unstable MET call patients into the ICU where they could be cared for in a safe and appropriate environment. The problem was identified by physicians responding to MET calls where they were unable to transfer the patient immediately to a room within the ICU for stabilization and treatment. The delay in transfer was due to the lengthy and complicated process used to transfer a patient out of the ICU when they no longer needed ICU care and/or the difficulty in making provisions to admit a patient needing ICU care when there were no beds available.
Context:	The ICU has physical space for 30 beds but only 24 were open due to staffing restrictions. The prior practice to admitting a patient from the ward to ICU when there were no staffed beds available was to first try to find an ICU patient that was ready to go out. Once this patient was identified there was a nursing and a medical approach to transferring the patient. Medicine would try to find a service that would accept the patient, then to have a conversation with both the staff physician and the resident of the accepting service, then write orders. Nursing would have to wait until a service accepted the patient then request a bed placement from the bed coordinator who would check the available bed lists and que the patient behind any ER admissions. Once a bed was assigned, nursing would call to provide report to accepting ward, then transferring patient. This process had multiple steps where things could go wrong and further delay transfers. Meanwhile the unstable MET patient was waiting on the ward with the MET trying to stabilize the patient in a less than optimal environment.
Resources:	Operating \$: _0_ FTEs: _1.0_ This initiative does not require any additional funding or staffing over and above what was already in place. It simply reroutes what would have previously taken place with an established Medical Emergency Team.
Source of resource:	No funding requested
Population group:	This initiative is relevant to any acute care setting where MET is established and having delays in moving patients out of the ICU in order to admit new patients.
Patient flow entry and end points:	There are two patient flows within this initiative. The first starting point is the MET call patient on the ward with an end point of the ICU and the second starting point is for the ward ready patient in ICU with the end point being a bed on the ward.
Description/ approach:	The principle of getting the most appropriate care setting for the patient was the basis of the initiative. We held a meeting to identify a common purpose and vision of what we would like to achieve. We identified the blocks that contributed to transfer delays and identified individuals who would be essential to have in agreement and supportive of the initiative. From the initial meeting a plan was drawn up that identified roles and responsibilities of those involved in the MET Resuscitation Bay (MRB) (see attached). A set of guidelines for use were established and nursing and medical leadership took an active role in discussions with other impacted departments to find a workable solution.

Tools and tactics:	<p>The initiative developed a MET RB activation algorithm to guide the process (see attached). The algorithm identifies the step by step process to follow each day to ensure that the necessary planning has been made for a MRB utilization. This involves identifying each morning at team meeting which patient is to be designated ‘ward ready’ and have their orders written and be ready to go out as soon as the bed is needed. The MRB activation takes place when a MET patient needs to come into the ICU and there is no vacant bed. They can be transferred down to one of the blocked bed spaces where the MET nurse, physician and respiratory therapist will work to stabilize the patient. The algorithm makes use of the bed manager function in locating the most appropriate bed for the patient coming out of ICU and ‘ward ready’ ICU patient is transferred out. If there is no accepting service already identified then the ICU physicians will continue to retain medical responsibility for 24 hours until transfer of care can take place. Housekeeping services are essential in ensuring the necessary beds are cleaned and ready for the new patient within an hour. Once the ICU ward ready patient is transferred out the MRB patient is transferred to the care of the ICU bedside nurse and physician on service.</p> <p>The MET activation policy was developed and is in the process of being approved</p>
Measurement approach:	<p>The length of time the MET is out on a call continues to be monitored and the activation of the MET RB is followed. Nursing time spent in each role is tracked as is time to ward ready patient transfer out. Outcomes of patients admitted to ICU and of MET calls is collected. We also anticipate using a survey to query MET staff about their perceptions on the value of the MET RB .</p>
Impact/ evaluation:	<p>We believe that MET patients needing ICU care are transferred into ICU in a more timely manner allowing the care team full ICU back up environment for any procedures and resuscitation. Our data set does not reflect this however we believe the data is inconsistently recorded and not reflecting actual practice.</p>
Observation/ Discussion:	<p>It is important to keep optimal patient care as the focus of the change. Including as many of the impacted services in the development of the algorithm helped reduce resistance to the plan. Any localized initiative has multiple effects on the system and it is essential to success to identify these prior to implementation and to plan for how the change will impact the global system. There was initial resistance from the educator group who felt that this was going to be perceived by the staff at the bedside as a ploy to increasing the number of beds open without increasing the staffing for those beds. With frequent communication about the reason for the initiative and opportunities for staff to be included in unit discussions, these fears were alleviated.</p>
Critical success factors/ lessons:	<p>Nursing and Medical leadership support and willingness to have difficult conversations about why the ICU cannot just open another bed to take the patient in need.</p> <p>Leaders passionate about effecting change that improves patient care. The ability to envision a different way of doing what has always been done. A willingness to keep trying to find a way to make it work despite being told, “It won’t happen”.</p> <p>Clear and transparent communication and a willingness to collaboration</p>
Limiting factors:	<p>Back log of patients on the wards awaiting transfer to long term care or alternative levels of care.</p> <p>Culture of working in silos within an institution.</p>

	<p>Shortage of nursing staff positions</p>
--	--

Inconsistent data from time of MET call to admission to ICU. Education would be needed for nursing staff to understand the fine points of what admitted means and why accurate times are important.