

# Medical Emergency Team: A Game Changer in the Wards

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Most of the literature related to the medical emergency team (MET) has concentrated on their efforts in reducing cardiac arrests and serious adverse events.<sup>1,2</sup> Up to 80% of adverse events are preceded by physiological and biochemical derangements.<sup>3,4</sup> Early identification and rapid intervention are the keys to preventing these adverse events. Many modified early warning scores are used to identify these vulnerable patients.<sup>5</sup> Medical emergency team has long been mobilizing patients to the Intensive care unit (ICU) in case of these adverse events.

Our hospital is predominantly a gastro-liver hospital with other specialties supporting it. MET functions along with the primary physician in the wards. Modified early warning scores are used in identifying sick cases.

We did a clinical audit and found that we received 657 MET calls over a period of 12 months out of which 225 patients were shifted to ICU (34.25%) and 390 patients were managed bedside (59.36%). A total of 10% of patients required respiratory support such as a non-invasive ventilator (NIV) and 10% of patients were hypotensive requiring vasopressor support and supportive care for underlying diseases such as dobutamine infusions for cardiac failure. About 7.3% of patients required monitoring as their modified early warning score (MEWS) was high due to underlying disease conditions such as chronic pancreatitis with necrosis, with multiple interventions. About 6.69% of patients had altered sensorium with other organ dysfunction secondary to chronic liver disease. All these patients were monitored until discharge or death.

Multispecialty hospitals are now facing a surge in patients requiring long-term care in hospitals, especially post-COVID-19. Most of them with either single or multiorgan injuries need hemodynamic monitoring and support. These patients also have turbulent flow in the hospital with frequent ICU admission and ward care.

When critical care physicians along with primary consultants care for these patients in the wards, the number of severe adverse events and cardiac arrests can be reduced and the outcome is appreciable. Infusions can be started in the wards, and procedures like central line can be done at the bedside. Bedside ultrasound and other point-of-care tests such as arterial blood gas (ABG) can be done and interpreted without wasting time. Shifting these patients to diagnostic areas can be supervised reducing risks such as desaturation during shifting.

Thus, we recommend hospitals have a rapid response team as a critical care team at the bedside along with doctors and nurses

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providing all care similar to ICU, and shifting cases to a higher level of care only when cannot be managed at the bedside such as intubations and ventilator care, thereby reserving ICU beds for real critically ill patients.

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