Telemetry Utilization in Med/Surg at SJMC

June 21, 2013

Med/Surg Telemetry History (excludes 3N, 4N, 4SW, ED, & MBU's):

- Pre-2010:
  - Little effort to reduce utilization: Physician's order remained until discontinued. Tele was interrupted (removed) during transport.
- 2010:
  - Tele reduction efforts began:
    - Cardiology QRC approved use of the ACC Telemetry guidelines for SJMC
    - Implemented initial order good x 48 hrs, then daily renewal required in Med/Surg/Tele units
    - Telemetry Order built w/ timeframe & indication
    - Coordinators/staff to audit daily & request d/c or renewal order from the MD
  - Decision made to maintain monitoring even while pt off floor; monitor cert staff required to travel w/ pt & Transporter
  - Cross trained pool of staff as Transport Techs to minimize pulling staff RN to transport patients
  - Installed additional antennae. Began "remote" monitoring throughout the facility allowing 3N monitor bank to "monitor" patients after leaving the patient care areas even while in all Imaging departments.
- 2011:
  - Cross trained MRI techs to perform basic dysrhythmia to reduce Transport Tech & RN hours to "monitor" tele pts there.
  - Installed special telemetry equip in the MRI area. So the MRI techs can interpret the rhythms freeing up the RN (staffed till 5pm).
- 2012-13:
  - Eliminated the Transport Tech positions (remote tele everywhere needed)
  - Refocus on daily management of tele orders & decreasing utilization

        - Eliminated the 2 Main Monitor Tech position d/t reduced tele volumes
        - During peak tele volumes a 3rd monitor tech is used & placed on 3N
- Literature review completed June 21, 2013

New FY14 Proposal:

- Continue Level 3 criteria patients in CCU:
    - CCU New: ***Prior to transfer to lower level of care Tele Criteria is reviewed, entered into Teletracking, & appropriate bed (tele vs non) is requested.***
- Continue Level 2 criteria patients in SDU/3N:
    - SDU/3N New: ***Prior to transfer to lower level of care Tele Criteria is reviewed & appropriate bed (tele vs non) is requested.***
- **Bed Control/ARN New**: Telemetry bed request requires criteria based justification.
- **Med/Tele units (2M, 2W, 4W, 5N) Nursing & MD's New**:
    - Hardwire use of Level 1 Criteria:
        - Seek approval from Cardiology Dept Chief, Hospitalist leads, Emergency Medicine Chief, Surgery Chief to:
            - New: ***Move from soft-stop reminder calls to "Hard Stop/Discontinue" protocol @ 48hrs for Level 1 patients w/o ectopy***
            - New: ***Move to 24hr hard stop/discontinue protocol for patients on telemetry who do not meet the ACC Telemetry Criteria AND have not had a new irregular or symptomatic rhythm within past 24 hours***
    - Propose a change in the order sets to match above (? CIS moratorium)
    - Educate:
        - MD's: Website, blast fax, chairs/leads with their peers
        - Nursing: Module in Healthstream
    - New: Q PM: Unit level daily management audits

- New: Tele volume audits per pay period & annual

<u>FY14 Telemetry bed in Med/Surg LOC Proposal</u>:

Literature Review:

1. AHA Guidelines have not changed from 2004.
2. ACC has adopted the AHA Guidelines indicating 3 levels of Telemetry Care/Criteria (see attached).
3. Emergency Medicine:
   a. AHA guidelines are comprehensive; yet do not address several non-cardiac conditions that clinicians might often monitor on telemetry.
   b. When physicians do not systematically apply rigourous criteria for inpatient telemetry admissions, monitored beds quickly become unavailable and ED's get overcrowded.
   c. Practical question for ED MD's: Can this patient safely walk around the shopping mall without being monitored? If a patient's admission diagnosis and treatment plan do not increase his/her dysrhythmia risk above the general population then he/she should not require telemetry monitoring simply because he/she is now in the hospital.
4. ACP Hospitalist:
   a.