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

**FY14 Telemetry bed in Med/Surg LOC Proposal:**

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:
   - AHA guidelines are comprehensive; yet do not address several non-cardiac conditions that clinicians might often monitor on telemetry.
   - When physicians do not systematically apply rigorous criteria for inpatient telemetry admissions, monitored beds quickly become unavailable and ED’s get overcrowded.
   - 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:
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