I. PURPOSE:
To assure patient safety by providing consistent care of the patient on centralized telemetry monitoring throughout the hospital.

II. POLICY:
It is the policy of Northwestern Memorial Hospital that all centralized telemetry monitored patients admitted to the cardiology, heart failure, cardiac surgical units, general medical, surgical, and oncology telemetry beds are:

1. Placed on units appropriate for their clinical diagnosis and treatment.
2. Admitted and cared for utilizing the American Heart Association (AHA) Practice Standards for Electrocardiographic Monitoring in Hospital Settings and the Northwestern Memorial Hospital (NMH) established Admitting Cardiac Monitoring Guidelines for proper placement.

III. PERSONS AFFECTED:
This policy applies to all employees, physicians and others involved in providing care, treatment or services to patients requiring centralized telemetry monitoring. Primary areas affected include cardiology, heart failure, cardiac surgical units, general medical/surgical and oncology telemetry beds.

IV. DEFINITIONS:
Centralized Telemetry Monitoring: Telemetry cardiac monitoring widely distributed across multiple inpatient units (refer to Appendix 7 for listing of telemetry capable inpatient units) with 24 hour visualization from a Centralized Telemetry Monitoring Center staffed by Telemetry Monitoring Technicians.

V. RESPONSIBILITIES:
Physician Role: Physicians are responsible for ordering cardiac monitoring, interpreting rhythm strips, managing the treatment of patients receiving care, and discontinuing cardiac monitoring.

Nursing Role: Nurses are to ensure the initiation of cardiac monitoring upon a patient’s admission, communicate with the telemetry monitoring technicians, perform ongoing patient assessment and monitoring, and document care as outlined in the Appendices.

Telemetry Monitoring Technician Role: Telemetry monitoring technicians confirm the initiation of cardiac monitoring with the nurse upon a patient’s admission, perform ongoing monitoring of the patients on telemetry, and communicate to the nurse upon significant changes of patient cardiac parameters.

Bed Assignment Role: Bed Assignment, upon admission of a patient to a telemetry bed, routes a PRIMES output sheet for the telemetry patient to the admitting nursing unit and the Centralized Telemetry Monitoring Center.

Patient Escort Role: Patient Escort communicates with the nurse prior to the transportation of all telemetry patients and confirms whether the patient is to be transported with or without a nurse. Transport follows the procedures for transport as outlined in PC 5.110 Patient Transportation and Clinical Support Guidelines.
Role of Ambulatory / Diagnostic Testing Area Staff Receiving Telemetry Patient: Staff notifies Centralized Telemetry Monitoring Center when patients are taken off and put back on Dash® wireless monitor, and also notifies Center when patients transfer to additional testing.

VII. PROCEDURE:

A. Refer to Appendices for specific procedures.
   1. TELEMETRY INITIATION GUIDELINES AND BOX PLACEMENT/CONFIRMATION
   2. ALARM / ARRHYTHMIA NOTIFICATION
   3. PATIENT TRANSPORT
   4. TELEMETRY WIRELESS DOWNTIME PROCEDURE DURING TRANSPORT
   5. DOCUMENTATION GUIDELINES
   6. DISCONTINUATION OF TELEMETRY
   7. LIST OF TELEMETRY CAPABLE NURSING UNITS
   8. NURSING COVERAGE FOR PROCEDURAL AREAS
   9. DOWNTIME PROCEDURES (EFFECTIVE JUNE 2, 2008)

B. The procedures as contained in the appendices are utilized for training and operationalizing consistent care of the patient on centralized telemetry monitoring throughout the hospital and may be updated at any time by the Telemetry Steering Committee with approval by the Directors of Nursing and Medical Director of Telemetry, but without requiring approval by the assigned committees and individuals responsible for overall policy approval.

VIII. RELEVANT REGULATORY AND/OR PROFESSIONAL PRACTICE REFERENCE:


Bekken, RN, MS, CCRN, N., Canary, RN, PhD, CS, PN, C., Diehl-Oplinger, RN, MSN, CCRN, APRN, BC, L., Hanes, RN, MSN, NP-C, CNS, D., Kruithof, RN, MN, CCRN, J., Lu, PharmD, MS, BCPS, Y., McAvoy, RN, MSN, CCRN, J., Palmer, RN, MSN, ANPC, ACNPC, T., Pence, RN, MSN, CCRN, C., Stahl, RN, MSN, APRN, BC, CCRN, M., Zalman, RN, BSN, CCRN, D. ECG Interpretation Made Incredibly Easy: 3rd Edition. 2005, Lippincott, Williams & Wilkens, Philadelphia.

IX. POLICY UPDATE SCHEDULE:

Every three years or more often as appropriate.

X. KEY WORDS AND CROSS REFERENCING:

PC 5.18 Levels of Care: Intensive, Surveillance & Specialty Care
PC 5.110 Patient Transportation and Clinical Support Guidelines
RESPONSIBLE PARTIES:  Corinne Haviley
Director, Medicine Nursing

Carol Payson
Director, Surgical Nursing

REVIEWERS:  Telemetry Steering Committee
Directors of Nursing
Medical Director, Telemetry
Nursing Practice Committee

COMMITTEES:  Patient Care Committee
Medical Executive Committee

APPROVAL PARTIES:  Michelle Janney, RN
Senior Vice President, Operations and Chief Nurse Executive
Electronically Approved: December 11, 2007

Chuck M. Watts, MD
Senior Vice President, Medical Affairs
Electronically Approved: December 11, 2007

Dennis Murphy
COO
Northwestern Memorial Hospital
Electronically Approved: December 12, 2007
APPENDIX 1 – TELEMETRY INITIATION GUIDELINES AND BOX PLACEMENT / CONFIRMATION

A. Telemetry Initiation Guidelines:

Per physician order, patients may be placed on cardiac monitoring for the following reasons:

1. Anti-arrhythmic drug therapy
2. Atrial fibrillation/atrial flutter/supraventricular tachycardia (SVT)
3. Acute decompensated heart failure
4. Drug overdose
5. Drug toxicity
6. Elective cardioversion
7. Significant hyperkalemia
8. Chest pain (no history of coronary artery disease)
9. Chest pain (history of coronary artery disease)
10. Ventricular tachycardia
11. Palpitations
12. Post-pacemaker and/or implantable cardiac defibrillator (ICD)
13. Symptomatic bradycardia
14. Syncope
15. Chronic intravenous inotropic therapy
16. Cardiac transplant/ventricular assist device (LVAD)
17. Other*

* If “other” is selected, the telemetry order will still be enacted but will be routed to the Power Chart inbox of the acting Medical Director of Telemetry for telemetry approval.

B. Telemetry Box Placement / Confirmation:

1. The admitting physician requests a telemetry bed from Bed Assignment.
2. Bed Assignment staff assigns the patient to a telemetry bed on the appropriate unit.
3. Bed Assignment personnel routes a PRIMES output sheet for the telemetry patient to the admitting nursing unit and the Centralized Telemetry Monitoring Center.
4. Upon receipt of the PRIMES output sheet, the telemetry monitor technician sends a telemetry box, cardiac leads (indicating the patient’s name, room number, and telemetry box number) to the nursing unit via the pneumatic tube system.
5. The nurse places electrodes on the patient and connects the patient to the telemetry box upon patient arrival to the nursing unit.
6. The nurse calls the telemetry monitor technician to confirm placement of telemetry on the correct patient, identifies the cardiac rhythm and documents such in the medical record.
7. The phone number of the nurse caring for the telemetry patient is confirmed upon initial placement and updated every shift directly on the Central Information Center (CIC) monitor. The Telemetry Phone Assignment Sheet is tubed to the Centralized Telemetry Monitoring Center.
a. Phone numbers for each telemetry patient’s nurse are updated by the telemetry monitor technician at staffing/shift changes.

b. The telemetry monitor technician verifies the nurse phone number at the beginning of each shift.

8. Upon the receipt of the physician orders, the nurse calls the telemetry monitor technician to confirm the cardiac notification parameters.
Appendix 2 – Alarm / Arrhythmia Notification

A. Alarm / Arrhythmia Notification

1. The telemetry monitoring technician calls the patient’s nurse for the following cardiac rhythm abnormalities:
   a. Ventricular heart rate less than 50 or greater than 100 or as determined by the physician-ordered parameters for vital signs.
   b. Greater than 6 premature ventricular contractions (PVC’s) per minute or as determined by the physician-ordered parameters for vital signs.
   c. Runs of ventricular tachycardia (defined as 3 or more PVCs in a row), ventricular fibrillation or asystole.
   d. Supraventricular tachycardia – new onset or change from previous rhythm (e.g., atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, junctional tachycardia).
   e. Any other new cardiac rhythm – new onset or change from previous rhythm (e.g., sinus pause/arrest, AV heart block, pacemaker malfunction, widened QRS, conversion from abnormal rhythm back to normal sinus rhythm/baseline rhythm.
   f. Mechanical or persistent artifact.

2. The following outlines the procedure that occurs when the telemetry monitoring technician identifies a cardiac arrhythmia for a patient on a nursing unit:
   a. The telemetry monitoring technician calls the nurse taking care of the patient via a wireless phone and identifies the arrhythmia to the nurse.
      i. If the nurse does not answer the phone the call will be forwarded to the clinical coordinator or charge nurse.
      ii. If there is no response, the Rapid Response Team is contacted.
   b. The telemetry monitoring technician documents the phone conversation on the waveform/ECG mounting form and tubes to appropriate nursing unit.
   c. The nurse assesses the patient and determines whether the alarm is a true arrhythmia or mechanical in nature (mechanical issues include low battery, failed leads, or failed telemetry boxes).
      i. If the alarm is due to a mechanical problem with the telemetry box, the nurse obtains a replacement telemetry transmitter.
      ii. If the alarm is due to battery or leads, the nurse or patient care technician changes the battery or replaces the leads.
      iii. If the alarm is due to an arrhythmia, the nurse assesses the patient and notifies the primary physician service / the Rapid Response Team / or the Code Team based on rhythm and assessment.
   d. The nurse documents the intervention within Power Chart.

3. The following outlines the procedure that occurs when the telemetry monitoring technician identifies a cardiac arrhythmia for a patient who is off the nursing unit and is undergoing a test or procedure or in transit to a procedure area:
   a. The telemetry monitoring technician calls the phone assigned to the Dash® monitor and confirms the patient’s location with the receiver of the call.
b. The telemetry monitoring technician calls the primary nurse when an arrhythmia arises on a patient in transit; the nurse makes the determination if the Rapid Response Team should be notified.
APPENDIX 3 – PATIENT TRANSPORT

A. Patient Transport

1. In accordance with AHA Practice Standards, all Class I telemetry patients as outlined below must be accompanied off unit by a nurse. AHA Practice Standards Class I telemetry patients include:
   a. Patients who have been resuscitated from cardiac arrest.
   b. Patients in the early phase of acute coronary syndromes
      i. ST elevation or non-ST elevation myocardial infarction (MI)
      ii. Unstable angina/Rule-out MI
   c. Patients with unstable coronary syndromes and newly diagnosed high-risk coronary lesions.
   d. Patients who have undergone cardiac surgery within 24-72 hours (post surgery).
   e. Patients who have undergone non-urgent percutaneous coronary intervention (PCI) with complications.
   f. Patients who have undergone implantation of an automatic defibrillator lead or a pacemaker lead and are considered pacemaker dependent.
   g. Patients with a temporary pacemaker or transcutaneous pacing pads.
   h. Patients with AV block (with more than 1st degree AV block).
   i. Patients with arrhythmias complicating Wolff-Parkinson-White syndrome with rapid anterograde conduction over an accessory pathway.
   j. Patients with Long-QT Syndrome and associated ventricular arrhythmias.
   k. Patients on the intra-aortic balloon counterpulsation.
   l. Patients with severe heart failure symptoms.
   m. Patients with indications for intensive care.
   n. Patients who have undergone diagnostic/therapeutic procedures requiring moderate sedation or anesthesia.
   o. Patients with any other hemodynamically unstable arrhythmia. Patients with a low cardiac output state, defined as low blood pressure with signs of organ hypo perfusion are also considered.

2. The following outlines the procedure for transporting the telemetry patient:
   a. Home Unit
      i. Upon arrival of the patient escort to pick the patient up for test/procedure, the patient escort confirms transport with the nurse.
      ii. The nurse refers to the AHA Guidelines for Class I Monitoring to determine whether a nurse is required to accompany the patient to the test/procedure area.
      iii. Upon return from the testing area, the unit nurse discontinues the wireless Dash® and reconnects the patient to the telemetry box.
   b. Receiving Ambulatory / Diagnostic Testing Area
      i. Upon patient arrival at the destination, the patient escort enters the patient’s arrival into Teletracking.
ii. If the patient handoff is to a procedure room nurse (see Appendix 8 for those testing/procedure locations that have a nurse handoff), and if the patient is to be transferred to a procedure department monitor then:

   iia. The procedure nurse calls the telemetry monitoring technician to inform him/her that the patient is being taken off of the Dash® monitor.

   iib. The telemetry monitoring technician notates the time of the above activity in the transport log.

   iic. The procedure room staff assumes responsibility for cardiac monitoring.

iii. If the patient handoff is not to a nurse, the patient remains on the wireless Dash® and continues central monitoring (see Appendix 8 for departments with nursing support).

iv. If a patient is scheduled for additional testing in another department, the patient is placed on the wireless Dash®. The original testing area updates Teletracking with patient’s destination.

v. If a patient is not going for additional testing, the patient is placed back on the wireless Dash® (if off),

vi. Patient escort returns the patient to their nursing unit.
<table>
<thead>
<tr>
<th>Cardiac Problem</th>
<th>General Medicine Unit with Telemetry/Surgical Telemetry (Need reevaluated q.12 hrs)</th>
<th>Observation Unit Bed (OU)</th>
<th>Heart Failure and Cardiac Telemetry Bed (medicine patient)</th>
<th>CCU Bed (medicine patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td>If patient has significant CAD risk factor (prior MI, CAD, DM), ideally admit patient to cardiac unit</td>
<td>• OU criteria plus accompanying condition(s) requiring inpatient workup and/or therapy (e.g., heart failure, dialysis pt. with electrolyte imbalance/fluid overload, HTN urgency, accompanying syncope)</td>
<td>• EDOU criteria plus accompanying condition(s) requiring inpatient workup and/or therapy (e.g., heart failure, dialysis pt. with electrolyte imbalance/fluid overload, HTN urgency, accompanying syncope)</td>
<td>• History consistent with ACS (STEMI, NSTEMI or Unstable Angina)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Possible MI w/true DNR status &amp; no aggressive medical management (exception)</td>
<td>• Possible MI w/true DNR status &amp; no aggressive medical management (exception)</td>
<td>• ECG: ST segment elevation in 2 or more contiguous leads or new BBB OR new ischemic changes (ST segment depression &amp;/or T wave inversion)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chest pain with risk factors and non-specific EKG abnormalities</td>
<td>• Chest pain with risk factors and non-specific EKG abnormalities</td>
<td>• Requiring IV anti-thrombotic/anti-ischemic therapy (exception: heparin/enoxaparin)</td>
</tr>
<tr>
<td>Syncope - neurologic to NICU, Neuro Step-Down</td>
<td>• Not attributable to life-threatening cardiac disease</td>
<td>• Non-cardiac syncope, i.e. orthostatic hypotension, hypoglycemia</td>
<td>• Not attributable to life-threatening cardiac disease</td>
<td>• Hemodynamically unstable arrhythmia (VT or high-degree AV block)</td>
</tr>
<tr>
<td>Pulitations</td>
<td>• Class II</td>
<td>• Class II</td>
<td>• Class II</td>
<td>• Class I</td>
</tr>
<tr>
<td>Atrial Fibrillation (AF)/Flutter (AFl)</td>
<td>• Chronic or controlled ventricular response AF</td>
<td>• Hemodynamically stable AF/AFl requiring rate control, drug loading to convert, or new onset AF/AFl</td>
<td>• Hemodynamically unstable SVT: unable to control ventricular response, hypotensive</td>
<td>• Class I</td>
</tr>
<tr>
<td></td>
<td>• AF NOT requiring IV drips or drug loading</td>
<td>• SVT controlled by initial therapy or not requiring continuous IV therapy</td>
<td>• SVT not controlled by initial therapy &amp;/or requiring continuous IV therapy</td>
<td>• Immediate post-op</td>
</tr>
<tr>
<td></td>
<td>• SVT controlled by initial therapy or not requiring continuous IV therapy</td>
<td>• Class II</td>
<td>• Class II</td>
<td>• Homodynamically unstable merchandised and/or electronically unstable</td>
</tr>
<tr>
<td></td>
<td>• Hemodynamically stable AF/AFl requiring rate control, drug loading to convert, or new onset AF/AFl</td>
<td>• Class II</td>
<td>• Class I</td>
<td>• Class I</td>
</tr>
<tr>
<td>Follow-up Post Transplant</td>
<td>• Class II</td>
<td>• Class II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable Post-VAD</td>
<td>• Class II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventricular Tachycardia (VT)</td>
<td>• Transfer to cardiac unit</td>
<td>• Hemodynamically stable/non-sustained VT (no acute ischemia requiring workup &amp;/or treatment)</td>
<td>• Class I</td>
<td>• Sustained VT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Class I</td>
</tr>
<tr>
<td>Cardiac Problem</td>
<td>General Medicine Unit with Telemetry/Surgical Telemetry (Need reevaluated q.12 hrs)</td>
<td>Observation Unit Bed (OU)</td>
<td>Heart Failure and Cardiac Telemetry Bed (medicine patient)</td>
<td>CCU Bed (medicine patient) SICU/CTICU Bed (surgical patient)</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
</tbody>
</table>
| Symptomatic Bradycardia – workup & treatment | • Non-life threatening rate without significant pauses and NOT requiring external/temporary transvenous pacing  
• Class II |   | • Non-life threatening rate without significant pauses and NOT requiring external/temporary transvenous pacing  
• CVT 11 West accepts pacing wires  
• Class II | • Life-threatening AV block or sinus arrest with hypotension &/or requiring external or temporary transvenous pacing  
• Class I |
| Antiarrhythmic Drug Therapy – loading/ changing dose | • No IV infusions or drug loading  
• Transfer to Cardiac Telemetry or CVT 11W (if surgical patient)  
• Class I | • Transfer to cardiac unit  
• Class I | • Drugs requiring hospitalization for initiation (e.g. QT monitoring during drug loading)  
• IV infusions: diltiazem; ibutilide with MD present at bedside; amiodarone for AF ONLY  
• Class I | • IV infusions: esmolol; ibutilide; amiodarone for VT  
• Class I |
| Elective Cardioversion | • No elective cardioversion  
• Transfer to Cardiac Telemetry or CVT 11W (if surgical patient)  
• Class I | • Transfer to cardiac unit  
• Class I | • Elective inpatient cardioversion  
• Elective outpatient cardioversion (ICR-CSU preferred)  
• Class I | • Unstable patient (hypotensive or significant decrease in Hgb)  
• Class I |
| Post-Pacemaker &/or ICD Implant | • Transfer to Cardiac Telemetry  
• Post surgical patients with new device transfer to 11W  
• Class I | • Transfer to cardiac unit  
• Class I | • Hemodynamically stable post-procedure  
• Class I | • Hemodynamically unstable &/or requiring PA line  
• In pulmonary edema/ requiring greater than 50% FiO₂  
• Class I |
| Acute Decompensated Heart Failure | • Hemodynamically stable patient requiring IV diuretic therapy  
• NO IV nesiritide or inotropes  
• Class II |   | • Hemodynamically stable pt. w/ heart failure:  
• Requiring IV therapy (nesiritide or dobutamine)  
• Newly diagnosed (arrhythmia risk)  
• LV dysfunction requiring aggressive IV diuretic therapy  
• Class II | • Hemodynamically unstable &/or requiring PA line  
• In pulmonary edema/ requiring greater than 50% FiO₂  
• Class I |
| Significant Hyperkalemia | • Potassium levels greater than 6.0 mEq/L without life threatening EKG changes  
• Class I until electrolytes correct |   | • Potassium levels greater than 6.0 mEq/L without life threatening EKG changes  
• Class I | • Potassium levels greater than 6.0 mEq/L with EKG changes  
• Class I |
| Drug Toxicity Drug Overdose | • Low probability for life-threatening arrhythmia  
• Without respiratory depression (not requiring continuous pulse oximetry)  
• Consider telemetry for 24 hours and reevaluate* |   | • Low probability for life-threatening arrhythmia  
• Without respiratory depression (not requiring continuous pulse oximetry)* | • High probability for life-threatening arrhythmia or respiratory depression (CCU or MICU)  
• Class I |

APPENDIX 4 - TELEMETRY WIRELESS DOWNTIME PROCEDURE

If the telemetry wireless capability should become unavailable, including during transport, the following takes place:

a. Those patients identified by the AHA Guidelines as Class I cardiac patients are placed on Dash® monitors.

b. Those patients identified by the AHA Guidelines as Class II or Class III cardiac patients are placed on Dash® monitors, if available. If the Dash® monitor is unavailable, patients have close observation and nursing care.

c. Those patients in transport return to their nursing unit.
APPENDIX 5 – DOCUMENTATION GUIDELINES

A. Documentation Guidelines

1. Telemetry Monitoring Technician:
   a. The telemetry monitoring technician prints out and interprets cardiac strips on the following occasions:
      i. Patient admission
      ii. Every 8-hour shift
      iii. Any change in cardiac rhythm (e.g. atrial-fibrillation, ventricular tachycardia, supraventricular tachycardia, atrioventricular blocks, etc.).
   b. The telemetry monitoring technician places the strips on the Waveform/ECG Mounting Form and tubes the forms to the respective units (frequency indicated above), alerting the Unit Secretary prior to tubing to the unit.
   c. The telemetry monitoring technicians interpret the patient cardiac strips on the Med/Surg and Oncology telemetry units and document results on the Waveform/ECG Mounting forms prior to tubing strips to the unit.

2. Cardiac Nurses (15 East, 15 West, 11 West):
   a. Nurses evaluate the patient cardiac strips upon their receipt from the Centralized Telemetry Monitoring Center.
   b. Nurses complete a Power Chart Cardiac Monitoring Evaluation Tool twice per day (0600 and 1600).

3. Med/Surg Telemetry Nurses
   a. Nurses complete a Power Chart Cardiac Monitoring Evaluation Tool every 12 hours (0600 and 1600)

4. Physicians:
   a. Physicians are required to sign off on cardiac strips once every 24 hours.
APPENDIX 6 – DISCONTINUATION OF TELEMETRY/TELEMETRY BOX REMOVAL

A. Discontinuation of Telemetry

Those patients who have been arrhythmia-free for 12 hours and no longer meet monitoring criteria are considered for telemetry discontinuation.

1. The staff nurse completes the Power Chart Cardiac Monitoring Evaluation Tool twice per day (0600 and 1600).
2. The telemetry monitoring technician provides twice daily (0600 and 1600) a list of those patients who have been arrhythmia-free for the previous 12 hours to clinical coordinator for follow up.
3. The patient’s nurse contacts the ordering physician regarding the cardiac status (need for further telemetry monitoring OR arrhythmia status, etc.) and requests an order for telemetry discontinuation.
4. The nurse contacts the Medical Director of Telemetry or designee in order to review all patients who no longer meet cardiac monitoring criteria after 12 hours but are maintained on telemetry. The Medical Director of Telemetry will review the 12-hour disclosure and most recent Cardiac Monitoring Evaluation Tool and discuss with the Attending Physician.

B. Telemetry Box Removal

1. Once an order is received to discontinue telemetry, the nurse or PCT disconnects the telemetry box from the patient and removes the electrodes.
2. The nurse or PCT places the telemetry box and cardiac leads in a biohazard bag and tubes them to the Centralized Telemetry Monitoring Center with the requisition located in patient chart.
3. The telemetry monitoring technician documents the return of the telemetry box and cardiac leads.
4. The telemetry monitoring technician cleans the telemetry box and cardiac leads with recommended bactericidal solution for future use.
### APPENDIX 7 - LIST OF TELEMETRY CAPABLE NURSING UNITS

<table>
<thead>
<tr>
<th>Unit</th>
<th>Patient Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16S Prentice</td>
<td>Hematology/Oncology</td>
</tr>
<tr>
<td>16W</td>
<td>Medicine Short Stay</td>
</tr>
<tr>
<td>16E</td>
<td>Medicine/VIP</td>
</tr>
<tr>
<td>15W</td>
<td>Heart Failure/Pulmonary</td>
</tr>
<tr>
<td>15E</td>
<td>Cardiology</td>
</tr>
<tr>
<td>14E</td>
<td>Medicine: Teaching and Hospitalist</td>
</tr>
<tr>
<td>13W</td>
<td>General Medicine</td>
</tr>
<tr>
<td>13E</td>
<td>Medicine: Teaching</td>
</tr>
<tr>
<td>12E</td>
<td>Surgery: GI and Surg Onc, General</td>
</tr>
<tr>
<td>11W</td>
<td>CVT/Vascular Surgery</td>
</tr>
<tr>
<td>10W</td>
<td>Neurosciences, Stroke</td>
</tr>
<tr>
<td>10E</td>
<td>Neurosciences, Spine</td>
</tr>
</tbody>
</table>
# APPENDIX 8 – NURSING COVERAGE FOR PROCEDURAL AREAS

<table>
<thead>
<tr>
<th>Modality</th>
<th>Portable</th>
<th>Hours of Operation Mon-Fri</th>
<th>Telemetry Nursing Coverage</th>
<th>Places Patient on Unit-based Telemetry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastroenterology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI Lab</td>
<td>Yes</td>
<td>7:00A – 7:00P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Neurological Testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological Testing Center</td>
<td>Yes</td>
<td>7:30A – 4:00P</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Nuclear Medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>No</td>
<td>7:00A – 6:00P</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Pulmonary / Cardiac</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Echo Lab</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TTE when patient cannot travel</td>
<td></td>
<td>7:30A – 6:00P</td>
<td>Yes, for TEE and Dobutamine Stress</td>
<td>Yes</td>
</tr>
<tr>
<td>TEE if nurses have moderate sedation training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular Lab</td>
<td>Yes</td>
<td>7:30A – 6:00P</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Cardiac Cath Lab</td>
<td>No</td>
<td>7:00A – 5:30P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Electrophysiology</td>
<td>No</td>
<td>7:00A – 5:30P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Invasive Cardiac Recovery</td>
<td>No</td>
<td>6:00A – 8:30P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Stress Testing</td>
<td>No</td>
<td>7:30A – 4:30P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pulmonary Function</td>
<td>No</td>
<td>7:00A – 6:00P</td>
<td>Yes, for bronchoscopy patients</td>
<td>No</td>
</tr>
<tr>
<td><strong>Radiology</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td>No</td>
<td>7:00A – 7:00P</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MRI</td>
<td>No</td>
<td>24/7</td>
<td>7:00A – 11:00P Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CT</td>
<td>No</td>
<td>24/7</td>
<td>7:00A – 7:00A Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Yes</td>
<td>24/7</td>
<td>7:00A – 7:00A Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>General Radiology</td>
<td>Chest</td>
<td>24/7</td>
<td></td>
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<tr>
<td>Radiology Holding Room (Prep and Recovery)</td>
<td>N/A</td>
<td>24/7</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Radiation Oncology</strong></td>
<td></td>
<td></td>
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<tr>
<td>Radiation Oncology – Feinberg &amp; Prentice</td>
<td>No</td>
<td>7:00A – 5:50P</td>
<td>Yes</td>
<td>No</td>
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<td>Gamma Knife</td>
<td>No</td>
<td>7:00A – 5:50P</td>
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APPENDIX 9 - DOWN TIME PROCEDURES

General

When a Telemetry outage is identified, any employee may activate the Service Disruption/Emergency Operations Plan by dialing the hospital emergency number: 5-5555 and reporting the outage location.

Immediate Response

1. The individual in charge (clinical coordinator or charge nurse) of the department or clinical area affected by the Telemetry disruption will assess and triage the monitoring needs of the patients from that area.
   A. Those patients identified by the AHA Guidelines as Class I cardiac patients are placed on Dash monitors or portable monitor/defibrillators.
   B. Those patients identified by the AHA Guidelines as Class II or Class III cardiac patients are placed on Dash monitors, if available. If portable monitoring is not available, patients have close observation and nursing care.
   C. The transfer of Class I, II or III patients that require a higher level of care will be expedited by bed assignment/HOA.
   D. Monitored patients in transport return to their nursing unit.

2. In consultation with the managing Medicine/Surgery service and/or the Hospitalists/ Critical Care Service, determine the patients who have a continuing need for cardiac monitoring.

3. Once conversation has been established, back-up monitors not in use by other units are deployed to areas in need via Bio-med department.