**JERSEY SHORE UNIVERSITY MEDICAL CENTER**
**NEPTUNE, NJ 07754**

**Department of Nursing-Critical Care**

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| **SUBJECT:** **Criteria for Initiating and Maintaining Telemetry Monitoring** | **EFFECTIVE DATE:** **June 1992** | **Policy #: 2-6** |
| | **REVISION DATE:** **July 2017** | **PAGE: 1 of 3** |

**SCOPE**
All cardiac monitored patient care units.

**POLICY**
All patients requiring telemetry will require an ordering for continuous telemetry monitoring. To ensure the availability of essential medical equipment for high-risk patients, the following guidelines will be used to determine those patients who require continuous telemetry monitoring**:**

**Class I**

**Cardiac monitoring is indicated in most if not all such patients in this group. This category includes all patients who are at significant risk of an immediate, life-threatening arrhythmia.**

1. Early hospital phase of ACS or suspected cardiac event need to be monitored for at least 2 days after the complication has been corrected or stabilized (see Class II).
2. Patients at risk for a potentially life threatening arrhythmia
3. During the acute phase of management for patients poisoned with drugs or chemicals at doses known or suspected to have cardiac arrhythmic toxicity (e.g., tricyclic antidepressants, phenothiazides, digitalis, and antiarrhythmic drugs).
4. During initiation and titration of antiarrhythmic drugs.
5. Immediately after cardiac intervention. Monitoring should continue until the patient's condition has been deemed stable
6. Patients with high-risk coronary artery lesions (e.g., high grade left main coronary artery disease or its equivalent) who are candidates for, and who will undergo urgent revascularization.
7. Patients who are being evaluated for CVA, unexplained syncope, or other transient neurologic signs or symptoms.
8. Patients with decompensated heart failure

**Class II Cardiac monitoring may be of benefit in some patients but is not essential for all.**

1. Patients with complicated AMI after 48 hours, especially those suspected to be at risk for ventricular fibrillation such as those with anterior wall infarction, conduction defects or the complications of infarction indicated in I-1. Patients with no complications, non-Q wave events or non-anterior wall infarction are at lower risk.
2. Patients with uncontrolled atrial fibrillation whom are otherwise hemodynamically stable.
3. Patients, who because of their underlying disease state, are deemed by the physician to be a significant risk for cardiac arrest, respiratory arrest or the development of hypotension
4. Patients with suspected or proved hemodynamically significant paroxysmal tachyarrhythmias or bradyarrhythmias.
5. During the acute phase of pericarditis.

**Class III Cardiac monitoring is not indicated because the patient's risk of a serious arrhythmia or the likelihood of therapeutic benefit is low.**

1. Post-operative patients who are at low risk, such as young patients after relatively simple uncomplicated operations that don't involve cardiopulmonary bypass.
2. Obstetric patients, except for those with significant medical (especially cardiovascular) conditions or those who develop the cardiovascular difficulties defined in Class I or II.
3. Patients who have a terminal illness and who are not candidates for the treatment of arrhythmias that may be detected. Many, but not necessarily all patients with a "do not resuscitate" order may fit into this category.
4. Patients who have undergone routine, uncomplicated coronary angiography.
5. Patients with stable asymptomatic premature ventricular contractions or nonsustained ventricular tachycardia that are hospitalized for reasons other than cardiac or hemodynamic compromise.
6. Patients with chronic, stable atrial fibrillation.
7. A patient who's underlying cardiac disease has been stabilized and has had no arrhythmia for 48 hours of monitoring.
8. Patients who do not meet Class I or Class II criteria and have had no arrhythmias in 24 hours.
9. Medical and surgical patients without known significant cardiac risk.

## PROCEDURE

The Emergency Department physician shall request a telemetry bed based on these criteria.The Bed Manager/ ED case manager will verify compliance with these criteria prior to transfer. If the criteria are not satisfied the Bed Manager/ ED case managerwill contact the admitting physician to confirm or deny admission to a telemetry-monitored bed. If a concensus is not reached the patient will be admitted to telemetry but the case will be subject to review by the department chair or his/her designee.

Reference:

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