Using Telemetry Transport Phones for Low Risk Patients
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Problem: Difficulty locating telemetry patients off the unit for tests/procedures when their monitor indicated a critical alarm.

Evidence: Inability to locate two patients off the unit when their telemetry indicated a critical alarm. Critical alarms must be responded to by an RN within 1 minute per policy. The Pennsylvania Patient Safety Authority's (2008) root cause analysis on telemetry alarm failure found 66.9 % of failures related in some way to failure to monitor.


Practice Change: Transport team obtains a phone from the telemetry technician when transporting low risk telemetry monitored patients, leave it with the staff in the destination location and return it to the unit with the patient. All alarms triggered when the patient is off the unit are called to the transport phone. Action taken is based on type/cause of alarm. (Jackson, et al. 2011)

Evaluation: Frequency of phone use for alarms, potential time RN's retained on unit not transporting patients and number of critical alarms resulting in Codes or Rapid Response Team calls.

Results: 26 critical alarm calls over a 6 month period, estimated nursing time retained 10 to 14 hours, no Codes or Rapid Response Team calls resulted.

Recommendations: Implement the process for all non-critical care units within the hospital. Disseminate findings to other hospitals through presentations and publishing.

Lessons Learned: Phones got lost, batteries died and transport staff was not informing the telemetry technician what phone they had when the location of phones was in an area separate from the central telemetry station. Telemetry technicians now check batteries and keep a daily log. The transport staff picks up and returns phones to them. Transport staff needed support to realize they were not given additional patient care responsibilities or asked to practice outside their scope.

Bibliography


