

## Guideline for use of continuous cardiac monitoring in UHP inpatients

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### INDICATION

- All patients requiring monitoring should have this documented in their medical notes
- Document any specific objectives for monitoring or criteria that need to be met for removal

### REMOVAL

- Telemetry is a falls risk and should be removed once no longer clinically indicated
- Patients on telemetry should have their ongoing need for this reassessed every 24 hours
- This guideline can be used to ensure the most appropriate patients take priority in the event of telemetry shortage. Those at lowest risk will need assessing, with the reason for removal documented in their notes
- If the Nurse in Charge is unsure who to take off telemetry, please contact the on-call Cardiology SpR

## Ward staff responsibility in response to alarms

### **Lethal arrhythmia alarms**

- Immediately review the patient and check for signs of life
- If not artefactual then contact their medical team, on-call doctor, or MET team as appropriate for urgent clinical review
- Perform a 12-lead ECG

### **High-priority arrhythmia alarms**

- Immediately review the patient and check for signs of life
- If not artefactual then contact their medical team, on-call doctor, or MET team as appropriate for clinical review
- Perform a 12-lead ECG

### **Medium-priority arrhythmia alarms**

- Record and print a snapshot of the arrhythmia. Add to telemetry folder in patient's notes
- Contact the clinical team if needed

### **Troubleshooting technical alarms**

- Review the patient and telemetry unit to identify the issue
- Replacing ECG dot stickers and shaving the contact area may improve the reliability of the trace
- Consider using 5 lead monitoring rather than 3 to help with rhythm recognition in challenging cases (e.g. differentiating between VT and other broad complex tachycardias)

<b>Common indications for telemetry</b> <i>Does not replace clinical judgement.</i>	<b>Duration/Criteria for removal</b>
<b>Ischaemic Heart Disease</b>	
<b>STEMI</b>	12-24 hours post reperfusion <sup>1</sup> (up to 48 hours if ongoing rhythm/haemodynamic instability) <sup>1</sup>
<b>NSTEMI</b>	Until stable & pain free for 48 hours <sup>1</sup>
<b>ACS (All)</b>	Continue monitoring if any ongoing haemodynamic instability <sup>1</sup>
<b>Patients awaiting CABG</b>	Until revascularisation if high risk disease (e.g. 3VD or Left main stem disease) <sup>2</sup>
<b>Cardiac arrest or unstable VT due to ischaemia</b>	48 hours after stable <sup>1</sup>
<b>Following elective coronary procedures</b>	4 hours post diagnostic LHC 6 hours post PCI
<b>Structural Heart Disease</b>	
<b>Severe Aortic Stenosis</b>	If syncope or arrhythmia present, then monitor until treated <sup>1</sup>
<b>Cardiac arrest or unstable VT (non-ischaemic)</b>	Until ICD implanted or cause treated <sup>1</sup>
<b>Type A Aortic dissection</b>	Until treated <sup>1</sup>
<b>Mitral valve prolapse</b>	In the event of syncope, monitor until diagnosis & plan in place <sup>1</sup>
<b>Following TAVI</b>	If periprocedural conduction abnormality, monitor until stable or pacemaker implanted <sup>1</sup>
<b>Following Cardiac Surgery</b>	48 hours after the patient is deemed stable <sup>1</sup>
<b>Cardiomyopathy</b>	
<b>Admissions with acute decompensated heart failure</b>	Until precipitating event is successfully treated <sup>2</sup>
<b>Myopericarditis</b>	Until no longer deemed at elevated risk of cardiac dysrhythmia <sup>3</sup>
<b>Takotsubo/Stress Cardiomyopathy</b>	Until symptoms resolved <sup>2</sup>
<b>Arrhythmias</b>	
<b>Broad complex tachycardia (&gt;7 beats)</b>	Until specialist advice available <sup>1</sup>
<b>Recurrent ICD shocks/therapies</b>	Until rhythm stable <sup>1</sup>
<b>Narrow complex tachycardia</b>	Until HR consistently <130bpm <sup>1</sup> (AF/Atrial flutter <110bpm <sup>2</sup> )
<b>Symptomatic bradyarrhythmia</b>	Until symptoms and rhythm stable or pacemaker implanted <sup>1</sup>
<b>Suspected cardiac syncope</b>	Until no longer deemed high risk <sup>3</sup>
<b>Post structural VT ablation</b>	Until ICD implanted <sup>1</sup>
<b>Miscellaneous</b>	
<b>Severe electrolyte disturbance predisposing to arrhythmia</b>	Until normalisation of electrolytes <sup>2</sup>
<b>Inherited arrhythmia syndrome with syncope (LQTS, Brugada, CPVT, ARVC)</b>	Until stable <sup>1</sup>
<b>Poisoning with risk of arrhythmia</b>	Up to 48 hours <sup>1</sup> or as directed by Toxbase
<b>Congenital or drug induced QT prolongation</b>	Until stable <sup>1</sup>

#### REFERENCES

1. British heart rhythm society standards for continuous cardiac monitoring in-hospital published 29/09/2020. <https://bhrc.com/wp-content/uploads/2020/09/BHRS-cardiac-monitoring.pdf> accessed on 09/11/2022
2. Sandau KE, Funk M, Auerbach A, Barsness GW, Blum K, Cvach M, et al. Update to Practice standards for Electrocardiographic Monitoring in Hospital Settings: A Scientific Statement From the American Heart Association. *Circulation* 2017; 136:e273-344.
3. Caforio ALP, Pankuweit S, Arbustini E, Basso C, Gimeno-Blanes J, Felix SB, et al. Current state of knowledge on aetiology, diagnosis, management, and therapy of myocarditis: A position statement of the European Society of Cardiology Working Group on Myocardial and Pericardial Diseases. *Eur Heart J* 2013;34:2636–48.
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