EKG TECH BASICS · ONE-PAGER

Telemetry Monitoring and Reporting

Central-station workflow, alarm types and priorities, false alarms, what to report and to whom, SBAR and read-back, strips, handoff and patients off the monitor

24 sources + more detail
ekgtechbasics.com/sheets/ekg-telemetry-reporting.html
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1 Who gets which call

CALL	WHEN
Bedside nurse	Abnormal or lethal rhythm, a worsening trend, loss of signal you cannot explain
Runner (rover) or support staff	Low battery, leads off, noisy leads to adjust
Charge nurse, then supervisor	The nurse does not answer, or a problem stays unresolved
Emergency line, rapid response or code team	A possibly lethal rhythm and no one is reaching the patient; per policy

The technician records and reports; the nurse assesses the patient and calls the provider. Who answers what, and how fast, is set by local policy.

2 Alarm types and priorities

TYPE	EXAMPLES	FIRST MOVE
Arrhythmia	Asystole, VF, VT, pause, brady, AF	Look at every lead and the pulse oximetry waveform
Parameter	Heart rate above or below its limit	Compare with the patient's baseline
Technical	Leads off, low battery, no signal	Send help; an unexplained no-signal goes to the nurse

Monitors rank alarms high, medium or low priority, often shown red, yellow and blue; colours and sounds vary by maker. Your policy says which alarms may ever be turned off; one example policy never allows it for lethal, ventricular or PVC alarms.

3 Is it real? Check in seconds

1. Look at every lead, not only the one on screen: one clean lead showing the old rhythm means artifact.
2. Check the SpO_2 pleth: a pulse waveform at the old rate argues against asystole or VF.
3. Compare with the patient's own baseline: a bundle branch block or paced rhythm can set off VT alarms.
4. Ask the nurse to look at the patient. You see the tracing; only someone at the bedside sees the patient.

⚠ **SAFETY** If you cannot rule out a lethal rhythm at once, call first and keep checking. If you are at the bedside and the patient is unresponsive, shout for help, call the code team, and start CPR or use an AED if trained.

4 Report now (your policy sets the list)

FINDING	HOW
VF, sustained VT, asystole, extreme bradycardia	At once: the nurse by the emergency phone, or the route your policy names
Loss of signal with no known reason	Nurse now: it may be a fall, not a battery
New Mobitz II or complete heart block	Nurse now, even if the patient feels well
Long or new pauses	Nurse now; threshold set by policy
New AF or flutter, runs of VT, a new fast rhythm	Nurse now, with onset time and rate
New ST elevation or depression	Nurse now; a 12-lead per unit protocol
A rhythm that resolves (run stops, rate settles)	Tell the nurse; it closes the loop

5 The call: SBAR and check-back

- S: who you are, the patient (two identifiers) and the finding.
- B: the baseline rhythm and when it changed.
- A: what you measured (rate, intervals, duration), without diagnosing the patient.
- R: what you need: 'Please see the patient now.'
- Check-back: the nurse repeats it; you confirm. Then log the finding, the time and the name of the person told.

⚠ **SAFETY** No answer? Move up the chain (charge nurse, then supervisor, then rapid response) on your policy's clock. A voicemail, a text or a message through the clerk is not a report.

6 Strips, handoff and patients off the monitor

- Strips: at the start of monitoring, on the schedule your policy sets, and with any rhythm change. Label the name, a second identifier, date, event time and lead; record rate, PR, QRS (QTc if abnormal) and the rhythm. Mount them in time order.
- The event time is when the rhythm happened, not when it was printed or mounted.
- Document any alarm you adjusted or turned off, and every call you made.
- Handoff: patients to watch, unreturned calls, open equipment problems, changed alarms; the receiver repeats it back.
- Off the monitor (shower, test, transfer): the nurse tells the station when the patient leaves and returns; you confirm the waveform on return. No warning and no waveform: call the nurse.
- Discharge the patient from the transmitter's channel before it is reused; admit the next patient with two identifiers.

💡 **EXAM TIP** Exams reward: the nurse before the strip, calling before measuring a lethal-looking rhythm, the chain of command when the nurse does not answer, asking the nurse rather than widening limits or lowering the volume, read-back plus a time-and-name record, and the event time on the strip.

MORE The central station and the people around it

Hospital telemetry sends the ECG by radio from a transmitter the patient wears, so the patient can walk; hardwired monitors are used for patients in bed, mostly in intensive care. Most hospital systems monitor three, five or six leads, less often 12. The ISHNE-HRS consensus describes two halves of the job: the afferent half (good skin preparation, correct placement, watching the alarms and telling true events from noise) and the efferent half (the team that responds). It also notes that who recognizes rhythms and who notifies varies between hospitals, from nurses to monitor technicians.

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