**The Problem:**
When the new telemetry monitoring system was introduced at BIDMC in 2013, the first unit received education based on an historic industry model: vendor conducted in-service sessions for super users and staff nurses covering all that the technology could do. As the system was applied to patients it became clear we had a problem.

- Current work flow did not match new system requirements.
- Variable messaging to staff during training and go-live regarding functionality and process.
- Identified actual and potential patient safety issues when certain sequences were not followed.
- Potential for increased unit noise, worsening alarm fatigue and gaps in patient safety.

**Aim/Goal:**
To design a telemetry system education model that optimizes cardiac monitoring data collection, improves alarm management, remains consistent through multiple unit roll outs and reduces potential harm to the patient.

- Standardize the technical information describing the hardware and software capabilities of the system in electronic and paper form.
- Scripting the processes and workflow for the transmitters and central stations – develop simulation training and go-live support utilizing scripts.
- Develop staff education materials with consistent messaging and terminology.

**The Team:**

- Pamela Browall RN MS
- Donna Williams RN MS CCRN
- Tricia Bourie RN MS
- Paul Anderson BSET, BSBA
- Phillips Healthcare - Vendor

- Sheri Paquette RN BSN
- Kathy Baker RN MSN
- John Whitlock RN MS
- Telemetry Task Force

**The Interventions:**

**The Interventions:** (Cont.)

- NM CNS UBE leadership team examined current work flow and scripted processes to validate fit, focusing on new practice changes: Admission, Discharge, Standby, SpO2, Alarm management.
- Model of support for go-live - Prior unit and staff pay it forward helping new unit with education and live roll out.

**The Results/Progress to Date:**
Five medical surgical units have completed the educational process with the new education system.

**Lessons Learned:**

- Industry approaches for introducing new technology may not be the correct approach for many clinical environments.
- Unit work flows vary, but the safety scripted processes can be applied.
- Retesting of the steps and sequencing is important for each unit.
- Selective content review with hands on simulation prior to the application going live with patients insures consistent safety messaging.

**Next Steps/What Should Happen:**

- Review current practice since Go Live to evaluate the admission, standby, discharge, alarm management, and battery management processes.
- Reeducate as.
- Evaluate the education module effectiveness with new RN hires to the live units.