ALARM FATIGUE = PATIENT SAFETY CONCERN

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It has become standard practice within most clinical areas of the hospital setting to rely on audible monitor alarms to alert the nurse or other care providers when limits are exceeded, certain dysrhythmias occur or even if a confused patient is arising from bed. Given the large volume of potential alarms on equipment within the clinical environment, there is a high risk of caregivers becoming desensitized to the sound of patient alarms. Additionally, alarms may be disabled, silenced, or ignored. These practices put patients at risk and create a serious safety concern.

PATIENT INJURY AND DEATHS HAVE BEEN ATTRIBUTED TO ALARM FATIGUE

Many professional organizations have recognized the dangers associated with alarm fatigue and are working together to combat it. As part of this effort The Joint Commission has added “improving the safety of clinical alarm systems” to the 2014 National Patient Safety Goals which are applicable to hospitals and critical access hospitals. (See page 2)

“Physiologic monitors are only as reliable as the clinicians who use them.” (1)

Quality improvement projects have demonstrated that strategies such as daily electrocardiogram electrode changes, proper skin preparation, education, and customization of alarm parameters have been able to decrease the number of false alarms. (2)

Alarm overload causes clinicians to be desensitized
Joint Commission Perspectives®, July 2013, Volume 33, Issue 7 published the following: National Patient Safety Goal (NPSG) NPSG.06.01.01: Improve the safety of clinical alarm systems.

Rationale for NPSG.06.01.01
Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices.

The implementation for NPSG.06.01.01 will occur in two phases:

- In Phase I (beginning January 2014), hospitals will be required to establish alarms as an organization priority and identify the most important alarm to manage based on their own internal situations.

- In Phase II (beginning January 2016), hospitals will be expected to develop and implement specific components of policies and procedures. Education of those.

Alarm fatigue has come into play in cases where:

1. Patient falls from bed or chair
2. Dysrhythmia goes unnoticed or does not receive timely intervention
3. Patient on a PCA (pain pump) goes into respiratory arrest
4. Patient on a ventilator develops a mucous plug and is oxygen deprived
5. Patient IV is occluded


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