Clinical Alarm Safety: Combating Alarm Fatigue, Improving Alarm Management, and Reducing Patient Harm

A Three-Part Audio Conference Series

9:00 a.m. – 10:30 a.m. (CDT)

July 23, 2013 – Alarm Management Challenges and Opportunities
August 6, 2013 – Alarm Management Strategies
August 27, 2013 – Technology Solutions for Improving Alarm Management

Overview:

The ubiquitous sounds of beeps coming from patient monitors, infusion pumps, and other alarm-equipped devices can desensitize clinicians and lead to serious adverse events—even deaths. Recent studies indicate that between 150-400 alarms per patient per day can be typical in a critical care unit. This phenomenon—known as alarm fatigue—is a highly visible and extremely complex patient safety concern, and while there has been a great deal of attention placed on the importance of alarm management over the past 35 years, many of the core problems in the provider setting have not improved.

The Joint Commission's sentinel event database, a voluntary reporting system, contains 98 reports of alarm-related events between January 2009 and June 2012, 80 of which resulted in death, and 13 of which resulted in serious injury. The U.S. Food and Drug Administration's Manufacturer and User Facility Device Experience (MAUDE) database includes more than 560 alarm-related patient deaths occurring between January 2005 and June 2010. ECRI Institute, a Pennsylvania-based safety group, has consistently featured device alarms on its annual list of “top ten” health technology hazards, most recently ranking them No. 1 for 2013.

On April 8, 2013, The Joint Commission released a sentinel event alert calling for hospitals to work harder to address medical device alarm safety and alarm fatigue, which The Joint Commission said “can have serious, often fatal, consequences.” The Joint Commission has also included alarm management as a proposed National Patient Safety Goal for 2014. If finalized, it would make adherence to alarm-related standards part of the hospital accreditation process. In its newly issued sentinel alert, The Joint Commission included a list of recommendations, such as drafting guidelines for tailoring alarm settings and conducting regular equipment inspections. That kind of alarm-management strategy—although critically important—is difficult, especially as technology grows ever more complex.

In order to help hospitals address this complex issue, this three-part audio conference series will examine the impact of clinical alarms on patient safety and evaluate opportunities for improvement that are within a hospital’s control. Participants will hear from nationally-respected...
experts in the field of alarm safety as they share innovative and successful approaches to reducing alarm fatigue and improving patient safety. Leave with a better understanding of the issue and actionable next steps for improving alarm management and reducing patient harm in your facility.

- **Part I: July 23, 2013: Alarm Management Challenges and Opportunities**
  - This audio conference will provide a statement of the problem and examine the underlying causes of alarm fatigue. Faculty will discuss challenges that many hospitals experience, and opportunities for improvement that are within a hospital's control. A general approach for improving alarm management will also be explained.

- **Part II: August 6, 2013: Alarm Management Strategies**
  - This audio conference will discuss specific, actionable, and practical strategies for addressing alarm safety issues, such as alarm fatigue.

- **Part III: August 27, 2013: Technology Solutions for Improving Alarm Management**
  - This audio conference will discuss various technology solutions, such as alarm integration systems for improving alarm management. It will also outline the potential benefits, challenges, and successful implementation of these technologies.

All parts to be held from 9:00 a.m. – 10:30 a.m. (CDT)

**Target Audience:**

This audio conference series will be of particular interest to anyone working in patient safety activities and health care quality within their organization; hospital executives; physician and nurse leaders and managers responsible for patient care, safety, and performance improvement; patient safety officers; quality improvement professionals; risk managers; hospital counsels; physicians; and chief medical officers.

**Faculty:**

**Maria Cvach, MSN, RN, CCRN,** Assistant Director of Nursing, Clinical Standards, Central Nursing Administration, The Johns Hopkins Hospital. A nationally recognized expert in the area of alarm safety and management, Maria Cvach is currently co-chair of The Johns Hopkins Hospital's Alarm Management Committee and the chair of a national Alarm System Steering Committee with the Association for the Advancement of Medical Instrumentation (AAMI). She is working with national experts to inform hospitals and industry leaders, through research initiatives, on best practices for alarm systems and reducing alarm fatigue. In addition, Maria is currently leading an eIRB-approved research study on alarm escalation algorithms and cardiac monitor alarm notification. Maria is the recipient of several national awards for her work in the area of alarm safety, including the 2011 Johns Hopkins Hospital (JHH) Nursing Publication Award (Monitor Alarm Fatigue: Standardizing Use of Physiological Monitors and Decreasing Nuisance Alarms); 2012 ECRI Health Devices Achievement Award; 2013 JHH Nursing Publication Award (Daily Electrode Change and Effect on Cardiac Monitor Alarms: An evidence-based approach); and 2013 JHH Shirley Sohmer Research Award (Effect of Enhanced Alarm
Rikin Shah, Senior Associate, Applied Solutions Group and Vladimir Cadet, MPH, Clinical Writer/Analyst, ECRI Institute, Plymouth Meeting, PA. ECRI Institute, a nonprofit organization, dedicates itself to bringing the discipline of applied scientific research to health care to discover which medical procedures, devices, drugs, and processes are best to enable improved patient care. As pioneers in this science for 43 years, ECRI Institute marries experience and independence with the objectivity of evidence-based research. ECRI Institute is designated as a World Health Organization Collaborating Center for Patient Safety, Risk Management, and Healthcare Technology, and an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality (AHRQ). ECRI Institute PSO, listed as a federally certified Patient Safety Organization by the U.S. Department of Health and Human Services, strives to achieve the highest levels of safety and quality in health care by collecting and analyzing patient safety information and sharing lessons learned and best practices.

Registration:

There is a site fee of $175.00 for NDHA Member Hospitals and $300.00 for Non-members for this course. Member Hospital is referred to as an individual freestanding facility, not a hospital system. The registration fee provides you with one phone number, Web connection and a downloadable handout. Numerous people at one physical site are encouraged to participate in the Web Conference through one registration (utilizing the same telephone/Web connection). If any additional locations or facilities are added into your connection, additional registration fees will be charged. If participants at your site require more than one telephone/Web connection, additional registration fees will be charged.

Prior to the program you will receive an e-mail containing instructions on how to connect to the conference. This e-mail will also contain codes to access the conference call. Advance registration by June 28, 2013 is required to ensure delivery of instructional materials. A late fee of $25.00 will be charged for any registrations after this date. This fee is necessary, as we are being charged a late fee for any last minute registrations that require an overflow line on the bridge. If you do not receive an e-mail from Linda Simmons prior to the program with your handouts and dial-in information, please contact her at 701 224-9732.

Please contact Linda Simmons at 701 224-9732 or lsimmons@ndha.org for further information. You may register by fax (701) 224-9529, online at http://www.ndha.org under Education or by mail PO Box 7340, Bismarck ND 58507.

Registration fees are non-refundable unless notice of an individual’s cancellation is received at NDHA five working days prior to the event, in which case a cancellation fee of $50.00 will be deducted from your registration fee. If notice of cancellation is received after this date, there is no refund. You will be billed whether or not you attend the program.
Part I: July 23, 2013  Alarm Management Challenges and Opportunities ______

Part II: August 6, 2013  Alarm Management Strategies ______

Part III: August 27, 2013  Technology Solutions for Improving Alarm Management ______

Facility ________________________________________________________________

Contact Name/Title________________________________________________________

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Phone Number ___________________________________________________________