Alarm Fatigue

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Abstract

Usage of medical equipment and technology to monitor patient conditions in acute care units has expanded in recent years. Although intended to be beneficial, the various simultaneous alarms have now posed a risk to patient safety. The prevalence of the alarm sounds has caused desensitization in nurses whereas the alerts are being ignored, silenced, or disabled. Commonly known as alarm fatigue, this phenomenon has created a barrier to patient care because nurses fail to act urgently, resulting in the risk of adverse patient outcomes. Research conducted by Casey et. al. (2018) has shown the average response rate to patients to be 66%. According to Lewis and Oster (2019), 98 alarm-related events were reported to The Joint Commission between January 2009 and June 2012. Of such incidents, 80 led to fatalities, 13 to permanent function loss, and 5 to unanticipated increase in hospital stays. To reduce the occurrence of alarm fatigue, acute care nurses will be oriented on their organization's alarm management procedure and the duty for prompt response. They will also receive training on how to customize alarms to individual patients and restore them to default upon discharge. To evaluate the effectiveness of the educational intervention and also promote organization-wide growth, monthly in-services will be held to share recent alarm-related incidents, lessons learned from them, and strategies that can be implemented to prevent reoccurrence. While sensory overload from alarm sounds seems to be a minute issue when compared to others within the acute care environment, it can lead to serious consequences for both patients and nurses. As such, alarm management education should be implemented on acute care units to reduce alarm fatigue and ensure exemplary care for patients.