Creating an Action Plan
Reducing clinical alarm hazards through better alarm management is a complex and lengthy process. To navigate this critical patient safety issue—and thus to comply with the Joint Commission’s National Patient Safety Goal on alarm management—ECRI Institute recommends the plan outlined in this chapter.

This plan, in conjunction with the resources provided throughout this publication, is intended to serve as a model from which hospitals can create their own alarm management programs. Because the “most important alarm signals to manage,” to use the Joint Commission’s phrase, will vary from one hospital to the next—and thus the efforts required to effectively manage those signals will vary—this plan (or any other) will need to be adapted to address local factors.

The approach we recommend, while not the only valid path, is based on

- Completed projects in which we’ve helped healthcare facilities improve their management of clinical alarms. (See page 51 for more information.)
- Our research into the initiatives implemented at other healthcare facilities.
- Our more than 40-year history evaluating the performance and safety of alarm-equipped medical technologies.

Following is our step-by-step guide for improving clinical alarm management and reducing alarm hazards. A collection of tools to help you complete specific steps is provided in Chapters 4 and 5 and in the accompanying Workbook.
1. Set the Tone

Leadership demonstrates a readiness to tackle the problem

Because of the time involved and the complexity of the issue, an alarm management program must be supported from the top of the organization. In fact, the first Element of Performance specified in the Joint Commission’s National Patient Safety Goal on alarm safety is that leaders must establish alarm system safety as an organizational priority.

To set the proper tone, leaders must recognize that the technology and processes used at the frontlines of patient care are not the only considerations. ECRI Institute has found that the culture of the organization can be just as important to the success of an alarm management program.

When assessing the culture at your organization, consider questions like the following:

▷ Are staff comfortable talking about safety problems, or are they reluctant to report adverse incidents or near misses? Fear of reprisals, for example, may dissuade staff from reporting safety problems.

▷ Are staff across multiple departments willing and able to work together, or do real or perceived barriers prevent multidisciplinary cooperation? Stakeholders from throughout the organization must be willing and able to work together to effect meaningful change.

▷ Are individuals at all levels of the organization open to new ways of managing alarms? Alarm improvement efforts can require philosophical shifts in terms of how technologies are implemented, which patients are monitored, what alarm settings are used, which conditions will activate an audible alarm, and how alarms are communicated to staff.

Many healthcare facilities find it helpful to contract with an independent organization to assess the culture and to bring together stakeholders from various departments to develop a coordinated, institution-wide strategy for improving the management of clinical alarms. Consulting organizations with experience in this area can direct you toward strategies that have been proven effective at other facilities.*

* ECRI Institute is one of several organizations that offers this kind of customized, on-site assistance. Our Applied Solutions Group has worked with world-renowned healthcare facilities and health systems to identify and address clinical alarm hazards. See page 51 for contact information.
Sample Announcement from Leadership (Workbook, part A). This sample letter can serve as a guide to assist hospital leadership in announcing the alarm management effort and in communicating its importance to staff.

Leadership sets the tone:
- Establishes alarm safety as an organizational priority
- Creates a culture in which staff are comfortable talking about safety problems
- Fosters collaboration among departments (bridges silos)
- Advocates for new approaches that reflect best practices.

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