Management of Alarm Fatigue in ICU
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**Background**
- Excessive alarms in intensive care settings, particularly those that are not significant, results in alarm fatigue for healthcare providers and poses a risk to patient safety
- In 2013, The Joint Commission reported 80 deaths from alarm related events with alarm fatigue being the most common contributing factor
- Considering the risk for patient harm and critical delays in patient care, reducing alarm fatigue intensive care units can directly improve patient care and outcomes

**Methods**
- Pre alarm fatigue survey was distributed to ICU RNs
- Alarm fatigue was discussed during daily shift huddles and RNs were encouraged to modify alarms appropriately for each patient at the beginning of each shift
- Education and assistance was provided to staff as needed in order to improve alarm management
- Post alarm fatigue survey was distributed to ICU RNs

**Measures and Results**

**Survey Results**

**Educational Pamphlet**
- Educational Pamphlet
  - Most survey participants agree that alarm fatigue is a problem in our ICU and this needs to be addressed
  - There is an opportunity surrounding alarms and educating staff how to maximize their efficacy in their nursing practice in order to decrease fatigue and improve patient satisfaction

**Summary/Discussion**

**Next Steps:**
- Create and implement a training pamphlet
- Develop a plan to include this education into new hire orientation
- Continue to provide education to RNs and CNAs working in the clinical setting

**Barriers of this Study:**
- Lack of time or interest to complete a pre and post survey
- Inability to directly implement changes
- Measurement of success is subjective
- Low number of responses compared to the number of surveys to distributed to staff
- The results of this project only reflect the pre-education

**References**