Common professional certifications include Certified Professional in Healthcare Quality (CPHQ, 23%), always the most frequently noted professional certification, followed by Certified Specialist in Healthcare Accreditation (CSHA, 17%). There was also a jump from 4% to 7% among respondents holding the Certified Professional in Medical Staff Services (CPMSM) credential, proving that there is still a clear connection between medical staff and accreditation professionals.

**Geography and hospital type**
Lastly, to help paint a picture of our respondents, we asked a few basic questions about hospital and location. Every year the AHAP salary survey sees a bit of fluctuation between rural, urban, and suburban hospital responses, and this year the survey attracted more urban hospital responses (49%) than suburban (29%) or rural (25%).

This year also saw a slant toward larger hospitals (over 300 beds) among respondents, at 49%. Mid-sized hospitals (150 to 300 beds) and smaller hospitals (under 150 beds) were roughly on par at 27% and 25%, respectively.

Finally, respondents were asked in which part of the country they worked. Though there were smaller showings from the mid-Atlantic states than other regions this year, overall, the responses were well-distributed across the country:

- Southeast (AL, FL, GA, KY, MS, NC, SC, TN, VA, WV): 20%
- North Central (IA, IL, IN, MI, MN, ND, NE, OH, SD, WI): 20%
- Pacific (AK, CA, HI, OR, WA): 17%
- Northeast (CT, MA, ME, NH, NY, RI, VT): 18%
- Mid-Atlantic (DC, DE, MD, NJ, PA) 6%
- West (AZ, CO, ID, MT, NM, NV, UT, WY): 9%

What do you think of this year’s results? Take the conversation to the listserv by emailing ahap_talk@hcpro.com. We are also accepting suggestions for our next AHAP benchmarking survey, and would love to hear any feedback or suggestions. Please contact AHAP Director Matt Phillion at mphillion@hcpro.com.

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**Joint Commission announces clinical alarms NPSG**

The Joint Commission announced in June a new National Patient Safety Goal (NPSG) aimed at improving the safety of clinical alarm systems. The goal is currently planned for implementation on January 1, 2014, and has been designated as NPSG.06.01.01.

According to The Joint Commission’s website (www.jointcommission.org), the purpose of the NPSG is to address improper management of alarms. Although alarms are necessary and serve an important role in the healthcare setting, mismanagement of those alarms can reduce or eliminate the benefits they provide.

The Joint Commission has identified a series of issues, distinct but interconnected, that contribute to the overall problem with clinical alarms:

- **Unreliable detection**: Some clinical alarms are difficult to detect in the healthcare setting amidst other noises and distractions.
- **Staff desensitization**: Faced with a barrage of alarms from various sources, staff become immune to the noises of alarms, presenting a danger when an alarm that requires immediate response falls on desensitized ears.
- **Improper disabling of alarms**: Closely tied to the previous example, staff find workarounds to remove what they consider “unnecessary” alarms. But in the process, staff may disable alarms that need to remain active.
- **Alarm overload**: In an environment rich with alarms of all kinds, identifying and prioritizing alarms becomes nearly impossible.
- **Inability to personalize alarm settings**: Some of the above challenges could be circumvented if organizations had the ability to change the tones and volumes of various alarms to ensure each signal remains distinct.

The Joint Commission has recommended two additional resources for alarm safety in preparation for the January 2014 implementation date for NPSG.06.01.01:
• The Association for Advancement of Medical Instrumentation has provided additional information on alarms at www.aami.org/htsi/alarms.
• ECRI (formerly the Emergency Care Research Institute) lists its top hazards, including alarms, at www.ecri.org/forms/pages/alarm_safety_resource.aspx.

Stages of implementation
While NPSG.06.01.01 becomes effective January 1, 2014, the overall implementation of requirements will be staggered as follows:

Hospital leaders have until July 1, 2014, to make alarm system safety “a priority,” according to The Joint Commission.

Throughout 2014, hospitals should begin prioritizing alarms, garnering feedback from staff, care providers, units and clinical departments, and other sources. They should begin to address the results of a missed or ignored alarm and whether the alarm is in fact critical—is it necessary, or does it just add to the overall level of sound pollution and prevent staff from hearing truly important alarms?

Hospitals and critical access hospitals should look for best practices to prevent risks caused by alarm overuse and overexposure.

Alarm fatigue: The Joint Commission’s stance on prevention

Editor’s note: The following report was authored by AHAP advisor Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, a healthcare consultant in Trabuco Canyon, Calif., and former Joint Commission surveyor.

Spend a few moments in any hospital and it is likely you’ll encounter them—the endless beeps, sirens, alarms, and call tones that staff face every shift. We as a healthcare community have come to recognize that alarm fatigue is a real danger—everyone knows a story, either in passing or from firsthand experience, of the wrong alarm being silenced or simply missed among the many alerts assaulting our ears.

In April, The Joint Commission stepped up its focus on alarm fatigue by issuing Sentinel Event Alert #50, which specifically addresses medical device alarm safety in hospitals.

(The Sentinel Event Alert can be found on The Joint Commission’s website by visiting the following link: www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF.)

Think about the average number of alerts and alarms a healthcare provider might encounter in the course of a day. They come from sources such as the following:
• Electrocardiogram machines
• Pulse oximetry devices