

CLINICAL ALARMS RESPONSE EVALUATION

Date: _____

Time: _____

Department: _____

Cubicle: _____ Cubicle Type: _____

Equipment or Device Tested: _____

Was the Alarm initiated with simulator? Y / N

If no, how was the Alarm initiated? _____

What Type of Alarm was initiated? _____

Is the Alarm considered Critical to the Patient care? Y / N

Did the Alarm activate as expected? Y / N

Was the Alarm heard? Y / N

If the Alarm was heard, where was the individual when he/she heard it? _____

If the Alarm was not heard, indicate the reason: _____

How long did it take someone to respond to the alarm? _____

How many people responded to the alarm? _____

What other noises were in the environment, competing with the alarm? _____

What changes, if any, are needed to improve the effectiveness of critical clinical alarms? _____

Name & Signature of Department Representative: _____

Name & Signature of Evaluator: _____