NR 361 Week 6 Discussion: Distractors in our Environment

Distractions are everywhere. They may include cellphones, multiple alarms sounding, overhead paging, monitors beeping, and various interruptions that disrupt your clinical practice. Give an example of an ethical or legal issue that may arise if a patient has a poor outcome or sentinel event because of a distraction such as alarm fatigue. What does evidence reveal about alarm fatigue and distractions in healthcare when it comes to patient safety?

Answer:

Distractions are everywhere. They may include cellphones, multiple alarms sounding, overhead paging, monitors beeping, and various interruptions that disrupt our clinical practice. I know when I am on the unit, I can tune out certain sounds due to constantly working in that environment it becomes white noise. I can recall working on a vent floor early in my career and at first every beep I tended to. It caused me to be exhausted every night the up and down along with the back and forth. Frequent false alarms as the biggest problem, and nearly 20% of respondents reported they knew of a false alarm–related adverse events despite institutional initiatives designed to address the problem (Winter et al, 2018).

There are several ethical and or legal issue that can arise from these distractions. Research has demonstrated that 72% to 99% of clinical alarms are false. The high number of false alarms has led to alarm fatigue (Sendelbach & Funk, 2013). It has been determined that the result is desensitization to alarms and or missed alarms. Over medicating of patient's post, a procedure has been any issue. Clinician will over medicate to decrease the amount of call bells for pain management. This can result in respiratory depression or false sense the patient is recovering well due to lack of check-in on them. Even more server, patient deaths have been attributed to alarm fatigue. there has been a push in quality improvements projects for patient safety. The