GradeMiners

Alarm Fatigue Case Study

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University Affiliation

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Assignment Due Date

Alarm Fatigue Case Study

Complete the fishbone diagram (To be done in PPT).

What happened?

Mrs. Katz, 72 years old, is transferred from the Cardiac Care Unit (CCU) to the Progressive Cardiac Care Unit (PCCU), where she has been for two days. She presented with an inferior Myocardial Infarction (MI). She has no complications, and under PCCU, Mrs. Katz's was monitored. She had a saline lock, but she was no longer in bed. Sara, the monitoring technician, tells Rob, the nurse in charge, that she turned off Mrs. Katz's Electrocardiogram (ECG) alarm because of frequent alarming and disturbing everyone while the monitor shows many artifacts. Robs will check Mrs. Katz, so Sara asks him to check her cardiac leads and change the electrodes if necessary. Rob arrives at Mrs. Katz's room at 0740 for an initial assessment. She is pain-free, VS is stable, and lung sounds are clear. One electrode is out of place, and others are loose, so Rob cleans and dries her skin and attaches new electrodes for improved ECG reading. Rob leaves Mrs. Katz's room and hears someone calling for help down the hall. He ran to the room and noticed the patient had gotten up, pulled his IV, fallen, lacerated his head, and was unconscious.

After helping the patient regain consciousness, he notices that he must help the patient get sutures for the laceration. Rob asks his other staff to cover for him, informing them he has assessed Mrs. Katz, but none of the other patients except the fallen one. At 0915, Rob attends to the patient who has fallen and settles him back. Rob embarks on taking back his other patient, but forgets to tell the monitor tech to turn Mrs. Katz's alarm back on. The monitoring tech, Sara, also fails to take the initiative to turn the alarm back on once she realizes Mrs. Katz's ECG is working. At 0930, Sara sends a nursing tech to check Mrs. Katz's electrodes as the monitor displays a flat line, and she immediately knows the alarm is not on. Mrs. Katz is in cardiac arrest when the nursing tech arrives. A code blue is initiated, but the time of her arrest cannot be determined. After resuscitation, Mrs. Katz is transferred to the CCU, intubated and ventilated, but unresponsive. Two days later, Mrs. Katz has no brain activity, her life support is removed, and she dies. Her death is seen as a sentinel event.

Why did it happen?

The unfortunate events leading to the death of Mrs. Katz occurred due to poor communication, an

ineffective team, and improper coordination of care. There are instances of poor communication, such as when the monitoring technician turns off Mrs. Katz's alarm because she thinks it is disturbing others. Also, poor communication is observed when Rob forgets to inform the monitoring tech to turn Mrs. Katz's alarm back on after conducting his observation. Lack of teamwork plays a huge role in the death of Mrs. Katz. Even though there is an element of desire to work as a team, most patient care decisions are undertaken independently and without consulting or informing other staff. As a result, disrupted or discontinued care has consequences, as observed when an individual's decision turns Mrs. Katz's alarm off. The consequences of a lack of coordinated care are irreparable, especially when it becomes an individual's responsibility instead of teamwork.

Discuss the factors, such as environmental, organizational, staff/team, individual staff, task, and/or patient factors (further defined in your textbook), identified in your fishbone diagram.

The actors that contribute to these sentinel events include, but are not limited to the following:

- Environmental factors: The environmental factors that might contribute to the sentinel event include the single patient room and the alarm switched off. Single-patient rooms may lead to a lack of patient safety, especially if there is no close monitoring of critically ill patients. When the patient alarm is switched off, there is a lack of communication between the staff and caregivers, especially during an emergency.

- Organizational factors: Organizational policy, poor communication practices, and inadequate IT resources. If the hospital policy does not support a culture that promotes patient safety, sentinel events are bound to happen. Poor communication between staff leads to discontinued and disrupted care, thus jeopardizing the patient's life. Inadequate IT systems, such as digital alarm systems, could hinder effective communication. Alarm systems that send mixed signals can be misinterpreted, leading to patient safety issues.

- Staff/team factors: Incomplete training, limited staff, staff fatigue, lack of teamwork, and lack of coordinated care (Rosen et al., 2018). Poor staff training, huge workload, and uncoordinated care often contribute to the worst patient safety outcomes.

- Individual staff factors: Inadequate skills, conflict, and poor relationships with other staff. Individual

Question 4

- characteristics can drag down healthcare activities, leading to poor outcomes such as interference with care procedures.
- Patient factors: Patient position, patient movement, and patient education. Patient characteristics like position in bed and movement could send misleading signals that they are getting well. Patients with self-care knowledge can protect themselves from harm compared to those without such knowledge.

What recommendations are needed to prevent this from happening again?

It is prudent to implement general awareness measures and disseminate learning about patient safety events, the root cause factors, and the remedial measures (Binkheder et al., 20233). It is also important to make patient safety a priority issue and integrate it into key organizational culture, and it should be reflected in the hospital's mission and vision statements.

References

Binkheder, S., Alaska, Y. A., Albaharnah, A., AlSultan, R. K., Alqahtani, N. M., Amr, A. A., Aljerian, N., & Alkutbe, R. (2023). The relationships between patient safety culture and sentinel events among hospitals in Saudi Arabia: a national descriptive study. BMC Health Services Research, 23(1), 270. https://doi.org/10.1186/s12913-023-09205-0

Rosen, M. A., Diaz-Granados, D., Dietz, A. S., Benishek, L. E., Thompson, D., Pronovost, P. J., & Weaver, S. J. (2018). Teamwork in healthcare: Key discoveries enabling safer, high-quality care. The American Psychologist, 73(4), 433–450. https://doi.org/10.1037/amp0000298