


# Saying ‘Sorry’ Saves Money, Too

Apologizing for patient errors up front and offering compensation, when appropriate, reduces the number of medical malpractice claims as well as associated legal costs and processing time.

Prompt, direct conversations with patients after mistakes ensures safety, mitigates legal issues.

That’s the word from risk managers at the University of Michigan Health System (UMHS), Ann Arbor, who describe their philosophy as “apologize and learn when we’re wrong. Explain and vigorously defend when we’re right. View court as a last resort.”

Key components of UMHS’s innovative medical malpractice and patient safety program — which saved the university \$2 million during 2001, its first year — include communication, full disclosure and learning from experiences. New claims at UMHS fell from 91 in 2004 to 61 in 2006. Total open claims dropped from 155 in 2004 to 83 in 2007.

UMHS risk managers say prompt, direct conversations with patients after mistakes occur ensures patient safety and mitigates legal issues. Risk management nurses conduct a thorough investigation to determine if medical malpractice has occurred and identify areas for clinical improvement. Designated risk management staff will talk with a patient’s legal counsel even without the threat of a lawsuit. To learn more visit (<http://www.med.umich.edu/news/newsroom/Boothman%20et%20al.pdf>) and (<http://www.med.umich.edu/news/newsroom/mm.htm>) 



## Clinical Cue

**Physicians now ask nurses to adjust care routines so patients can sleep, especially at night. Since most patients already receive pain medication and sedation, what’s changed?**

### What we know

- Patients perceive sleep disruption as distressing.
- Circadian rhythm disruption starting in the ICU continues after discharge from the unit.
- The following contributes to sleep disruption: noise, abrupt changes in light intensity, medications (including benzodiazepines and opioids), mechanical ventilation and patient activity.
- Decreased periods of rapid-eye movement and slow-wave sleep affect respiration, neurocognition, hormonal homeostasis and proper functioning of the immune system.
- Patients who experience delirium in the ICU suffer higher morbidity and mortality rates.
- A correlation between sleep deprivation and delirium has not been validated.

### What this means for patient care

- Sedation and pain control alone don’t produce restorative sleep. Sleep patterns and medication administration require individualized patient assessment.
- Evaluate the effect of routine medications on sleep. Pay

particular attention to medications halted abruptly or discontinued from the patient’s routine.

- Alter lighting throughout the day to maintain circadian rhythms.
- Timing is everything. Coordinate care activities -- vital sign assessment, bathing and drawing blood -- so patients can sleep, especially at night.
- Turning frequency should be patient-driven. Evidence does not validate a standard time frame for turning.
- Decrease nighttime noise. Patients may perceive a certain level of background sounds as white noise; however, talking, equipment alarms, moving furniture and similar activities may disrupt sleep.
- Consult with the respiratory therapist about nighttime ventilator adjustments to approximate normal changes to respiratory patterns of sleep.

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