Better communication between caregivers reduces medical errors, study finds

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A study tested the effects of a standardized method for medical residents to hand off information about their patients at shift changes. Credit: Wavebreakmedia/Shutterstock

A method of handing off information about pediatric patients when residents change shifts reduced preventable adverse events by 30 percent, a new study has found.

Miscommunication among caregivers is one of the largest causes of

medical errors, but a new study suggests that the problem is at least partly preventable.

The study at nine children's hospitals, led by Boston Children's Hospital and including Lucile Packard Children's Hospital Stanford, tested the effects of a standardized method for medical residents to hand off information about their patients at shift changes. Shorter shifts for residents have increased the number of such handoffs, prompting increased scrutiny of what happens during them.

"This focus is not unique to medicine," said Lauren Destino, MD, clinical assistant professor of pediatrics at Stanford. The link between handoff communication and safety has been demonstrated in industries such as nuclear power, emergency medical services and the airline industry, she said.

Destino is a co-author of the study, which was published Nov. 6 in The *New England Journal of Medicine*.

At each participating hospital in the study, medical residents were trained to use an acronym that reminded them what information to share about each patient, and in what order. The handoff process included both oral and written communication, and ended with the person who was receiving the information repeating back a summary of what was shared with the person who gave it. The program also included other supports to ensure that the handoff procedure was embedded in the hospital's culture and did not have a negative effect on the doctors' overall workflow.

"We decreased preventable adverse events by 30 percent, but there was no change in nonpreventable events," said Destino, who is also a pediatrician at Lucile Packard Children's Hospital Stanford. "That suggests that it was the improved handoffs themselves that led to the reduction in errors." If both preventable and nonpreventable errors had

dropped, that might have suggested the hospitals were seeing healthier or lower-risk patients at the end of the study, she explained.

"It's tremendously exciting to finally have a comprehensive and rigorously tested training program that has been proven to be associated with safer care and that meets this need for our patients," Amy Starmer, MD, lead author of the study, said in a news release from Boston Children's Hospital.

The program tested in the new research is available for free at www.ipasshandoffstudy.com.

More information: For more information, see: www.ipasshandoffstudy.com/

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