Does a Patient- and Family-Centered Hospital Communications Program Reduce Medical Errors?

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**What was the research about?**
Even with ongoing efforts to improve care, medical errors still happen in hospitals. Medical errors are mistakes that may or may not cause harm to patients. An example of a medical error is when a doctor prescribes the wrong medicine to a patient. When medical care causes harm, it is known as an adverse event, for example when a patient has an allergic reaction to a prescribed medicine.

In this study, the research team wanted to see if improving communication would help reduce hospital medical errors and adverse events. The team created a program to help doctors and nurses communicate with families during rounds. Rounds are meetings every day when hospital staff, usually doctors and nurses, review patients’ progress. Then staff come up with a plan for the day. Staff often make these plans without direct input from the patient or their family.

The program took place in hospital pediatric units, where children receive care. The program included:

- A way to make sure that doctors and nurses included families on daily rounds
- A way to make sure medical staff talked about everything important on daily rounds
- Write-ups of rounds for patients and their families
- Training to help staff learn how to include families in the rounds

**What were the results?**
Compared with before hospitals used the program, after hospitals used the program,

- There was no difference in overall medical errors, but patients had 38% fewer harmful medical errors.
- Patients had 46% fewer adverse events.
- Parents rated their child’s care experiences higher on 6 of 25 measures. None of the measures received a worse rating.
- Nurses and parents were more involved in rounds. For example, parents spoke up more and asked more questions.

**Who was in the study?**
The study included 3,106 children receiving care in pediatric units at seven hospitals in the United States and Canada. Of these, 51 percent were girls, and 8 percent had two or more long-term health problems. The average child’s age was seven years. The study also included 1,837 parents of children in the study. In addition, 925 doctors and nurses treating the children took part in the study.

**What did the research team do?**
The research team taught staff how to use the program for nine months. For three months before the training started and three months after the training ended, the team observed doctors, nurses,
and parents to rate their communication. The team also looked for changes in medical errors and adverse events using hospital data, surveys of doctors and nurses, and reports from parents.

Family advisors, nurses, doctors, researchers, teachers, and people trained in health literacy helped plan and carry out the study.

**What were the limits of the study?**
Because of the design of this study, it isn't possible to know for sure if the changes in medical errors and adverse events happened because of the program or because of something else that occurred at the same time. This study focused on children and their parents. The program might not have the same results with hospitals that care for adults.

Future research could test the program with hospitals that care for adults as well as children.

**How can people use the results?**
Doctors and hospitals can use this program to improve how well doctors, nurses, and families communicate and to improve patient safety.

*To learn more about this project, visit www.pcori.org/Landrigan139.*