

## **Closing the loop: follow-up and feedback in a patient safety program.**

January 5, 2017

Gandhi TK, Graydon-Baker E, Huber CN, et al. Closing the loop: follow-up and feedback in a patient safety program. *Jt Comm J Qual Patient Saf.* 2005;31(11):614-21.

<https://psnet.ahrq.gov/issue/closing-loop-follow-and-feedback-patient-safety-program>

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This commentary describes the experiences of a single institution's [integrated patient safety team](#) in managing the information obtained from different reporting systems, such as [Patient Safety Leadership Walk Rounds™](#). The discussion emphasizes the need for an action-oriented approach in utilizing such information to institute change. The authors provide a number of case examples to illustrate how a systematic method of providing a reporter with feedback to "close the loop" may be more important in fostering continued reporting and system improvements than the reporting systems themselves. They also share the role and development of an information tracking database that supports their safety initiatives, improves communication, and cultivates their safety culture.