

Closed-Loop Communication

HOW THE DEATH OF SILENCE MIGHT PREVENT A SILENT DEATH

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INTRODUCTION AND BACKGROUND

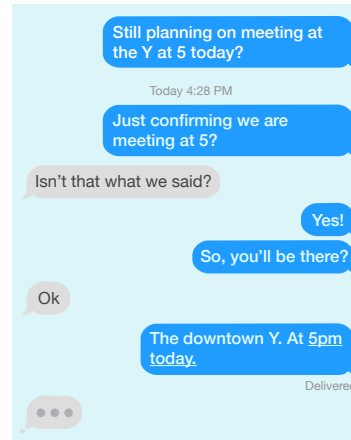
Failure to use closed-loop communication in pre-hospital air medical transport affects patient safety and healthcare quality.

Accrediting organizations such as the Commission on Accreditation of Air Medical Transport Systems recognize loop closure in an air transport program's Quality Management because it ensures timely reporting and resolution of incidents which leads to overall system improvement.

Challenges:

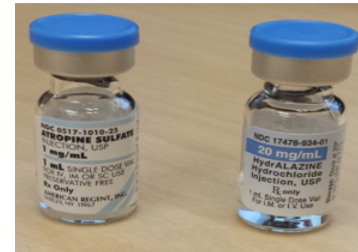
- Patient care is shared between two providers
- Flight environment includes: confined space, excess noise, night operations.
- Dispatch to crew communication via radio transmissions potentially garbled and scratchy.
- Crews hesitate to report incidents when they feel "no one is listening."

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The perils of the text message

organization, Life Flight developed a new element to its Quality Management reporting procedure with a goal of notifying report authors of issue resolution within 30 days.



Atropine Sulfate and Hydralazine Hydrochloride

response to QM reports.



"Life Flight 26, flight request: St. Joseph's to Harborview"

"Copy. Life Flight 26, going St. Joe's to Harborview"

1 DISCUSSION

The aviation industry is inherently high-risk; many communication strategies translate to other fields, particularly healthcare. Loop closure in quality reporting is the key to providing education, improving systems, and avoiding repetition of dangerous errors.

Effective communication involves:

- Timeliness
- Certainty
- Specificity

In order to avoid risks:

- Unnecessary delays in definitive treatment
- Medication errors
- Under-reporting of incidents

2 IMPLEMENTATION

Life Flight has employed a number of strategies aimed at improving closed-loop communication as a means of improving program safety and quality.

- Clinicians are expected to use a system of "check-and-double-check" with their partners prior to initiating interventions.
- Pilots and medical crews follow a policy of repeating back all radio transmissions from dispatch, emphasizing the ABCs of communication (Accurate, Bold and Concise).
- Finally, after receiving feedback from a site visit by an accrediting

3 EVALUATION AND OUTCOMES

Improvement of closed-loop communication is always a work in progress, and is a key performance indicator for the organization. With that in mind, an audit of dispatch tapes at Life Flight Network is underway in order to evaluate this indicator. After completion of the data collection phase, if any deficits are found, Life Flight's QM department hopes to develop an Action Plan, likely involving education and/or policy revision. Following this, the audit would be repeated to evaluate whether the intervention has been successful. With regard to QM reporting, the impact of loop closure has already been made clear by both the increase in the rate of reporting and the rate of system improvements in

4 IMPACT AND LESSONS

Health care as an industry can learn from the aviation industry by implementing closed-loop communication in all aspects of patient care, response to emergency transport requests, and incident reporting. Pre-hospital air medical transport is the ideal platform for trialing improved communication methods and strategies, as it integrates the two industries, with one leading the other in this aspect. Ultimately, more lives—both patients and clinicians—will be saved with simple behavioral changes that incorporate loop closure in all communication.



Dilbert, by Scott Adams





LIFE FLIGHT NETWORK

PROFESSIONAL PRESENTATIONS

I *Multi-Agency QI Collaborative to Improve Neonatal and Pediatric Safety During Transport*

Presented at:

National Association for Healthcare Quality (NAHQ) (2018)
Institute for Healthcare Improvement/National Patient Safety Foundation Patient Safety Congress (2018)
AirBorne Neonatal and Pediatric Transport Conference (2018)

II *Closed Loop Communication: How a Death of Silence Might Prevent a Silent Death*

Presented at:

Association of American Medical Colleges' Integrating Quality Conference (2019)
Air Medical Transport Conference (AMTC) (2019)

III *Root Cause Analysis: Lessons Learned from Highly Reliable Organizations*

Presented at:

Northwest Patient Safety Conference (2015)
Office of Quality and Patient Safety – The Joint Commission (2015)

IV *Quality Management: Turn “Best QM Practice” into “Best QM Program”*

Presented at:

Air Medical Transport Conference (AMTC) (2018)

V *Essential Qualities of Highly Reliable Organizations: A Transition From Blaming to Learning*

Presented at:

National Association for Healthcare Quality (NAHQ) (2019)

VI *Utilizing TeamSTEPPS Methodology To Become a High-Reliability Organization*

Presented at:

Agency for Healthcare Research and Quality (AHRQ) (2014)

VII *Safety Ignited Industry in Action*

Presented at:

Heli-Expo (2017)

VIII *Flight Data Monitoring: Creating, Managing and Learning*

Presented at:

Air Medical Transport Conference (AMTC) (2017)

IX *The Cost of a Poor Investigation*

Presented at:

HAI Heli-Expo (2018)

X *Not Seeing is Believing*

Presented at:

Air Medical Transport Conference (AMTC) (2018)

XI *Trust, Transparency, and the EDP: Learning from a Near Fatal Event*

Presented at:

Air Medical Transport Conference (AMTC) (2018)