Using After Action Review to Support Safety

NPSO Conference 2018
Adopting AAR for use in the context of the HSE's Incident Management Framework

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Listening to service users/families and staff

• Need for support in the aftermath of an incident
• Responsiveness and timeliness of the review process
• Complexity of reports – not written in a style that they can relate to.
• Want to see changes made as a result of review
• Service users and families want to ensure that reviews address any questions that they have.
Seeking alternative approaches to review – ‘one size does not fit all’
The origins of AAR as a methodology for review

- Originated in the US Army nearly 40 years ago
- Used there to debrief soldiers after missions in the field
- Senge described it as ‘arguably one of the most successful organisational learning method yet devised’\(^1\).
- Adapted for use in healthcare by the Education Service University College Hospital London.

What is After Action Review?

- This is a **structured facilitated discussion** of an event, the outcome of which enables the individuals involved in the event to understand why the outcome differed from that which was expected and what learning can be identified to assist improvement.
Circumstances where you can use AAR

Positive Outcome
- Review/debrief on situations with a positive outcome
- Better understand factors that led to the outcome

Briefing Tool
- When planning for event or at start of teams day
- Common understanding of plan, critical steps and actions.

Review of less serious incidents
- Incidents which do not reach the threshold of serious

Debriefing after serious incidents
- To enable staff to debrief, understand what happened and identify early learning opportunities. A more formal review may also be required.
What is it about AAR that makes it so suitable for use in healthcare?

• It provides teams with a structured mechanism for talking about incidents
• It involves listening to multiple perspectives on the event in a way that promotes learning
• It is focused on learning and not blame
• It is simple, universal and scalable
• It can be lead by anyone with good facilitation skills
• It can be used by MDTs to identify learning close to the event
• It promotes the development of a safety culture amongst staff
Adopting and adapting AAR for use by the HSE

• Discussions with University College Hospital London (UCLH)
• Access to training provided by UCLH
• Establishment of a co-design group to include a rep from UCLH
• Appointment of RCSI Institute for Leadership to assist in the design of and to deliver the course
• Development of support materials
Materials Developed to Support the Use of AAR
The Story

• Professor Aidan Halligan (MA, MD, FRCOG, FFPHM, FRCC)
  17th September 1957 - 27th February 2014

• Brought AAR to UCLH in 2008

• Led the embedding of AAR in UCLH
RCSI Facilities
After Action Review Training & Facilitation Programme Outline

Expert and Peer debriefing supported by Video

Pre-program activity

Workshop 1:
Full Day
AAR basics
Simulation

Inter-modular Work

Workshop 2:
Half Day
Personal Experience
Peer coaching

RCSI Simulated Learning Suite
After Action Review  Training & Facilitation  Programme Outline

<table>
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<tr>
<th>Pre- programme</th>
<th>Workshop 1: Full Day AAR Foundation</th>
<th>Inter-modular Work</th>
<th>Workshop 2: Full Day Personal Experience</th>
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**Organisational engagement:**
- Meet QPS staff
- Identify staff for AAR
- Meet key stakeholders
- Co design organisational approach to AAR

**Topics:**
- Learning outcomes
- What is AAR?
- Culture & Leadership
- Communication Impact
- Exploring AAR and principles & video clip
- Practice AARs
- Exercises and Feedback
- Group discussion AAR in your organisation

**Topics:**
- Stakeholder engagement
- Presenting AAR concept to key stakeholders
- Taking Feedback
- Conducting AAR

**Topics:**
- Understanding your context
- Hearing your experience of AAR practice
- Presenting AAR report
- Presenting AAR feedback
- Resilience strategies
- Where to next?
Creating the learning materials: Scenarios

Bed Management

Deteriorating Patient
Creating the learning materials: Scenarios

A&E Cleaning

Mental Health
Programme Outcomes

My AAR facilitation skills have improved
Reviewing the video of my AAR simulation was beneficial to my learning
Staff in my organisation know about AARs
My confidence in handling challenging AAR scenarios has improved
Applying AARs following positive event(s) has increased staff buy-in to the approach
I am confident that I am following the AAR approach as designed

Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree

Total number of participants: 16
Total number of responses: 13
Response Rate 81.25%
Programme Outcomes

- I have learned from my peers strategies for handling challenging situations in an AAR: 7 Strongly Agree, 4 Agree, 6 Neutral, 3 Disagree, 6 Strongly Disagree
- I have increased the peer support available to me through connection with AAR facilitators in other organisations: 5 Strongly Agree, 8 Agree, 4 Neutral, 3 Disagree, 6 Strongly Disagree
- Challenges to progressing AARs in my organisation are not dissimilar to other organisations: 7 Strongly Agree, 6 Agree, 4 Neutral, 3 Disagree, 6 Strongly Disagree
- I have gained ideas about how to progress the application of AARs in my organisation: 9 Strongly Agree, 4 Agree, 6 Neutral, 3 Disagree, 6 Strongly Disagree
- I would recommend the programme to colleagues: 6 Strongly Agree, 4 Agree, 8 Neutral, 3 Disagree, 6 Strongly Disagree

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Pilot Group January 2018 : Actions for increasing the application of AARs in your organisation

Using AAR in day-to-day practice - start with small events, i.e. after handover meetings, meeting colleagues, families (patients)

Education / awareness needs to be ongoing. Keep it on the agenda of all meetings until the "appropriateness of use" is embedded.
Pilot Group January 2018: Actions for increasing the application of AARs in your organisation?

- Spread knowledge of the process and use it regularly to gain confidence.
- Roll out - use the 'positive' outcome scenarios and after meetings.
Deploying AAR in an acute hospital setting

Ms Una Healy, Clinical Safety Lead, Quality and Safety Improvement Directorate, St James’s Hospital Dublin.
Where we started

• Selecting the team
  • Have a plan
  • Strategic placement – ED / ICU / AHP / Medical / L&D / Safety
  • Why the team matters

• Securing support
  • Frontline
  • Corporate – Exec Mgmt and Hospital Safety Governance Group
  • External partners – RCSI & HSE
Branding

• Product placement.....
Socialisation

- effective meetings
- coaching
- planning
- training evaluation

Improvement

- shift change/handover
- project evaluation
- reviewing positive events
- patient satisfaction

Events / Incidents

- briefing
- debriefing
- Hot de-brief
Practical Examples

Safety Team Meeting
- Safety Huddle - AAR conducted every Friday
- Facilitated by Safety Mgrs

Emergency Department
- End of Shift
- Post traumas
- Difficult Shifts
- Facilitated by ED Consultant
Practical Examples

Safety Reviews
- Cervical Check Review evaluation
- Complex issues
- Disparate services
- Facilitated by Safety Mgrs
- Superb learning

Discharge Planning
- Collaboration – SJH / CHO PH ADoN
- Better planning
- Improving the patient experience
- Reducing the gaps
What works well

• Have a champion
  • Keeping it centre stage
  • Team meets to debrief

• Break it down
  • Triangulate the Hospital
  • Bite size pieces
  • Laminated posters

• Recharge
  • Keep the team energised
  • Practice liberally
  • Share the wins
Questions and Discussion