iTS AAR Guidance for Healthcare Providers: October 2022
By Judy Walker

The PSIRF Learning Response Tools explained

There is a long list of tools* developed to support healthcare staff learn from the experiences of "work done" as opposed to "work imagined", when patient care does not go as expected, to learn about team working and to enhance the effectiveness of simulation training. Many tools have been developed locally and not spread beyond their organisational boundaries, while others have been adopted more widely.

The new Patient Safety Incident Response Framework (PSIRF) published by NHS England in August 2022 has included four Learning Response Tools (LRTs) in its recommendation for a more "considered and proportionate response" to support learning after events. The PSIRF signals a significant shift from the approach taken in previous decades as it recommends a decrease in the quantity of formal, lengthy Patient Safety Incident Investigations (PSII) and an increase the use of other more agile and inclusive approaches, specifically the After Action Review (AAR), the MDT Review and the SWARM huddle. Whilst we have many years of experience of leading AARs and training others to do so, we are aware that each of these four tools has something to offer and there are many similarities between them, to enhance learning from incidents that affect the safety and wellbeing of patients, families and staff. Such similarities include the intention to create a safe, no-blame learning environment, a series of questions to guide the process and a process facilitator of some kind.

Yet it is the differences between each of the LRTs that help us see more clearly the benefits of each process and when it is best to use each one. It is by seeing the distinct qualities of each that we can understand how to use to LRTs correctly. This will not only increase the quality of the outputs of each but will also build trust in the approach and create that all-important virtuous cycle where people use the tool regularly because they trust it, and so it becomes more effective and impactful on patient safety, so they trust it even more.

After Action Review (AAR)	A structured facilitated group discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement
Patient Safety Incident Investigation (PSII)	An in depth review of a single patient safety incident or cluster of events to understand what happened and how, undertaken by an investigator
SWARM Huddle	"A novel rapid approach to RCAs....to establish a consistent approach to investigate adverse or other undesirable event" People "swarm" together to review an event and identify mitigations for risks (Jing Li et al 2015)
MDT Review	An in depth process of review with input from several different disciplines to identify learning from multiple patient safety incidents and to explore a safety theme, pathway, or process

Table 1 – the four LRTs explained

Responsibility for change: with people or the organisation?

Where does the responsibility to change sit with each of these LRTs? In other words, what will actually lead to improvements in patient safety? The Patient Safety Incident Investigation (PSII) is undertaken by one (or more) people, through a series of one-to-one interviews, whereas the other three LRTs are group events where everyone is in the room at the same time (or in a virtual room). This distinction is important, because it describes where the opportunity and responsibility for change lies as a result of the learning.

The PSII process generates learning that is the responsibility of the investigator and those in their chain of command to act on. The action plans arising from the investigation will be driven and monitored centrally. Since the other three LRTs are group events, they create the conditions for the participants to learn from each other. In the MDT Review, the responsibility for change still lies primarily with the facilitator and person who set up the review, rather than with the participants because those people invited to the MDT Review are there to contribute expertise and details to build the complete picture of the events for the review report. Learning within the group of participants is still possible but is secondary to the primary aim of reporting and recommending.

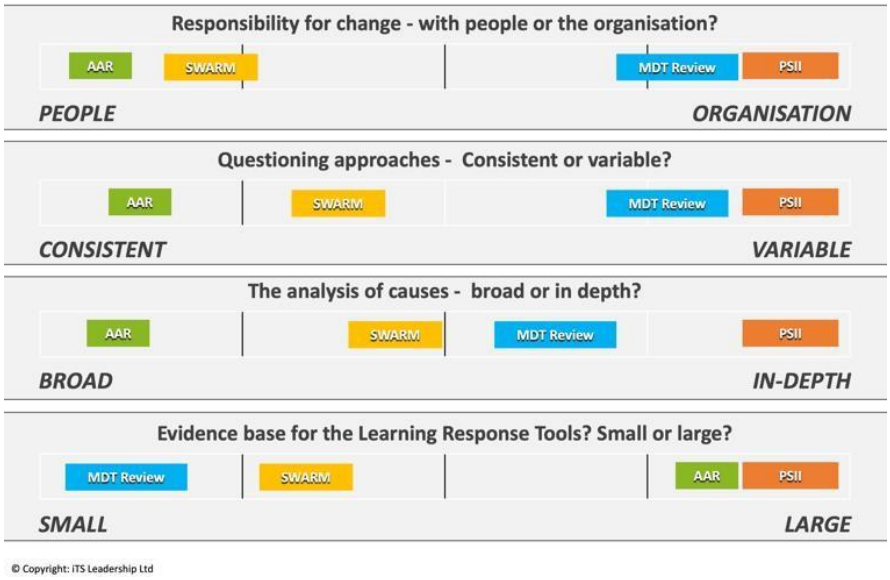

Table 2 Differences between the LRTs summarised

In contrast, the After Action Review (AAR) and the SWARM huddle are primarily aimed at enabling the participants to learn for themselves from the more complete picture built during the process of sharing experiences of all those involved. The focus in these two LRTs is on improving safety by engaging with those at the patient-end of the process so that they can learn and create solutions within their own sphere of control, including changing their own beliefs and behaviours. Both AARs and SWARMs create this opportunity for immediate change and mean patients are potentially safer as soon as the AAR or SWARM is completed.

This focus on the group learning process and the maintenance of psychological safety during it, which is so characteristic of the AAR in particular, means that its value in terms of depth and "stretch" is significantly enhanced by the skill and professionalism of the AAR process facilitator (called the "Conductor") and it is why formal training to be an AAR Conductor is of such benefit.

> *"I've learned that AAR translates the emotions and opinions into learning."*
> ~ European Communications manager - AAR Conductor training June 2022

Questioning approaches: consistent or variable?

How do the LRTs processes work to facilitate learning? Are the questions used the same?

The AAR has the most consistent questions of all the LRTs, following a four-question model for every AAR whatever the length or topic. Having consistent questions means the process is familiar to staff whatever the location of the AAR, from one hospital to another, from one context to another. The questioning in the other LRTs will vary depending on the requirements of the event, the local processes and the facilitators' preferences. Guidance is available on the types of questions that can be used in each of the tools on the PSIRF webpages here.

All patient safety reviews, whatever the process used, are taking place because care was not delivered as expected and a gap emerged between the expected clinical outcomes, policy procedures or established best practice and the reality experienced by the patients.

Unlike the other LRTs, the AAR process asks questions about the expectations of everyone involved in the event because this is where significant breakthroughs in understanding can be made. By starting out by listening to the expectations about activities, roles, behaviours and processes held by each participant we get to understand the differences and similarities amongst those involved as well as revisiting the intended outcomes and this builds a rich picture of the assumptions and misconceptions contributing to the "action" under review.

> *"I've learned how the normal tendency is to allocate responsibility outside circle of control and how the AAR is to bring people back to what they can do differently."*
> ~ Technical Lead - European business -AAR Conductor training May 2022

The analysis of causes: broad or in-depth?

Another difference which emerges is in the amount of evaluation and assessment of the causes of the event undertaken in each of the LRTs. The limited published information about SWARMs positions them as a type of collective Root Cause Analysis (RCA) done as a response to an event, lasting not more than 30 minutes, where the aim is to identify immediate learning about gaps in processes that need to be addressed. Due to their short nature, the emphasis is on making a rapid assessment.

After Action Reviews in clinical settings take about one hour and are usually planned a few days after an event and explore causes, especially in terms of gaps in communication, teamwork and leadership, as well as processes. In our experience of leading hundreds of AARs in NHS settings, this amount of time provides that all important "proportionate response" to an event, where the structure and process of reflection ensures valuable learning is obtained at sufficient depth for meaningful change to occur.

MDT Reviews and PSIIs are designed to go a lot deeper than SWARMs and AARs, seeking to determine as many causes as possible analysing the risks of reoccurrence. They are therefore more suitable for the most complex, recurring and serious patient safety events.

Evidence base of the Learning Response Tools. Large or small?

Only two of the recommended LRTs have a large evidence base to support their effectiveness. There has been extensive research into the structures, process and outcomes of both PSIIs and AARs which means we can be confident that when correctly applied, the time and effort given to them will deliver the planned outcomes and improved patient safety.

This does not mean to say the MDT Reviews and SWARMs do not have value but that the use of them has not been extensively documented or evaluated.

> *"Learning about expectations has been eye opening today. 100s of patient complaints come from expectations not being met. So, to use this AAR, I feel will help me understand and improve our response."*
> ~ Safety Lead - NHS Acute Provider AAR Conductor training Jun 2022

Other differences

The PSIRF is very clear that there should be "compassionate engagement and involvement of those affected by patient safety incidents" and that this includes patients and their families. There is good evidence from the BSUH study using AARs after patient falls, that patients and their families can be involved in AARs with good effect. There is other research evidence available to endorse this and several AAR Conductors have reported including family and patients in their AARs for a wide range of incidents. The structured and facilitated nature of the AAR creates a professional yet personal context for those affected to be part of the learning journey and ensures the patients' voice is heard. PSIIs can and do include patients and family members in the interviewing phases but it is only AAR that can include them directly in a collaborative learning process.

> *What I like most is the more informal approach of AAR – not being constrained by need to generate lengthy action plans.*
> ~ Risk Manager -NHS Acute Provider -AAR Conductor training Nov 2021

Reporting responsibilities for each of the LRTs vary as well, although there will be a great deal of local variation within the quantity and quality of reporting required for all (apart from the PSII which is largely standardised). The value of the PSII to the organisation rests heavily on the quality of the report generated and the MDT Review will also generate most value from the report of the findings. The AAR and the SWARM may generate reports and action plans, but these are likely to be brief and serve only to remind participants of the ground that was covered during the process and to assist with tracking actions arising as a result. Keeping the reporting light and brief for AARs and SWARMs reduces the "barrier to entry" and situates the responsibility for change where it needs to be, with those participating.

In summary

Using these LRTs, and any others that you choose to include in your patient safety incident response policies and plans, should provide reassurance to patients and the public, as well as your staff, that learning and change *does* happen as a result of events that cause harm to patients. Not to learn and not to improve in these circumstances is negligent and unethical. Without such tools little useful learning can take place, so the choice and application of the correct approach is important. As with any tool, the greatest value comes when the LRT is used by a trained and experienced facilitator, and when the Learning Response Tools are trusted and valued by the participants and the organisation.

Please get in touch to find out about ensuring you have staff trained to expertly use the AAR LRT.
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*Other types of tools used to debrief or learn from an event

1. *LFD - Learn From Defect tool*
2. *Adverse event Debriefing and Huddles*
3. *CIA - Concise Incident Analysis*
4. *Aggregate RCAs and the multi-incident analysis*
5. *Comprehensive frameworks for incident report investigation and analysis*
6. *PEARL -Patient Experience And Reflective Learning*
7. *Schwartz Rounds*
8. *The London Protocol*
9. *Significant Event Audit*
10. *STOP5*
11. *Pluses/Deltas*
12. *The 3D Model of Debriefing: Defusing, Discovering, and Deepening*
13. *TALK -Target, Analysis, Learning, Key Actions*
14. *PEARLS - Promoting Excellence and Reflective Learning in Simulation*
15. *REFLECT - Review the event, Encourage team participation, Focused feedback, Listen to each other, Emphasise key points, Communicate clearly, Transform the future.*
16. *Balint groups*
17. *TAKE STOCK*

Also see - *https://bmjopenquality.bmj.com/content/bmjqir/8/3/e000646.full.pdf*