Introducing After Action Review (AAR) within services
Guidance for Service Managers
Creating individual, team and service learning opportunities.
Introduction

The HSE has developed a number of review methodologies which will assist in the provision of a graduated and proportionate response to the review of incidents as identified in the HSE’s Incident Management Framework (2018). AAR has been identified as one such methodology. This guidance should therefore be read in the context of the Incident Management Framework.

It should be noted that although AAR has been identified for use in Incident Management, its use should not be confined to solely to this. In fact the four questions, upon which AAR is based, can and should be used on a routine basis by individual staff and teams as a mechanism for both briefing and de-briefing. Its use as a de-briefing tool should also not be confined purely to events with a negative outcome but also for learning from complex events that went well to better understand those elements of team performance that lead to the positive outcome.

What is AAR?

After Action Review (AAR) is most commonly used as a means of framing a structured facilitated discussion of an event that has occurred. The outcome of this discussion enables the individuals involved in the event to understand what went well and why and what didn’t go well and why. This allows them to agree on what they would do differently in the future and what learning can be identified to inform improvement.

AAR is an intervention that is undertaken before or soon after the event occurs and seeks to understand the expectations and perspectives of all those staff involved. It generates insight from the various perspectives of the multidisciplinary team, leads to greater safety awareness, changes team behaviours and assists in identifying actions required to support safety improvement. In teams with a strong culture of safety AAR is embedded as a normal part of the work of the team where it is used on a daily basis either after challenging events or as a mechanism at the end of the shift for reflecting on the day as a whole.

AAR used in this way exists to create both individual and team opportunities to improve personal, team and organisational effectiveness, to deliver safer, better patient care and improved service user and staff experiences of care.

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1 Reviews of patient safety incidents involve a structured analysis and are conducted using best practice methods, to determine what happened, how it happened, why it happened, and whether there are learning points for the service, wider organisation, or nationally. *National Standards for the Conduct of Reviews (HIQA/MHC 2017)*
In what circumstances is it used?

AAR is a flexible tool which can be applied in a number of situations e.g.

- As a briefing tool when planning for a specific event or more generally at the start of the team’s work day. In this case the team will use AAR to gain a common understanding of the plan, critical steps to be taken and expected results. They will ask ‘what if’ questions, agree actions, confirm the teams understanding of these and plan for a de-brief after the event or shift.

- For use as a process for teams to debrief/learn in the immediate aftermath of an incident. **Note:** Where AAR is used by the team to de-brief in the aftermath of a serious incident and where a comprehensive review is also required, the AAR meeting and its outcome should not be used as a primary source of evidence for the comprehensive review process.

- For use as a review methodology for incidents which do not reach the threshold of rating as ‘serious’ or for serious incidents which, following an initial assessment, a decision has been taken that a comprehensive review is not indicated i.e. where it has been determined that a concise review is more appropriate.

- To review and debrief on situations where there was a positive outcome i.e. to better understand what were the key factors/actions that led to the positive outcome so there is an opportunity for the team to reflect the learning this event offers.

It is generally used at the earliest opportunity after the occurrence of the issue which is the subject of the AAR. It is therefore a mechanism for staff to brief/de-brief/review the event in a manner that focuses on what can be learnt and where improvement opportunities lie.

It works best in situations where there is a positive, psychologically safe, multidisciplinary team dynamic and an openness to discuss the event.

Where AAR is used as an incident review methodology a short report is developed (See Appendix 1). In circumstances where AAR is used routinely by the team for reflective learning or as a briefing mechanism, a report is not required.
Benefits of AAR

The benefits associated with the use of AAR accrue to the service as a whole, to staff and to service users.

Service benefits

The use of AAR within a service assists in the development of its safety culture as it encourages multidisciplinary teams to critically plan for/reflect on events. Undertaken in advance of an event it can be used to identify vulnerabilities and agree plans and roles to ensure success. Used retrospectively it can be used to both identify, what went well and what could be improved. Such conversations assist teams in developing resilience and a focus on learning for improvement.

Staff benefits

Delivery of healthcare is complex and safety requires teams working together with a common purpose. AAR used as part of team planning can increase team effectiveness and improve patient safety.

The psychological effects of incidents on staff are well documented and can lead to a sense of guilt and isolation for many. Used retrospectively, AAR provides staff with a psychologically safe space to discuss and process what happened and why it happened. This can reduce individual stress and creates a positive team dynamic which places a focus on learning.

Service user benefits

The proactive use by teams of AAR will benefit service users in reducing the risk of incidents occurring by creating a culture where their safety is a priority.

Used in the aftermath of an incident AAR can assist in creating a timely response to service users and their families and can provide them with information about what happened, why it happened and what is going to change to reduce the risk of a similar incident harming someone else. In terms of Category 1 incidents, though a more detailed review may also be required, the conduct of an AAR will enable the service to respond in the short term in respect of preliminary findings and also to assure them that any immediate actions required have been identified for implementation. For other categories of incident AAR can be used as the approach to review and enable a full and detailed response to service users and their families.
Engaging with Service Users and Families

In cases of a patient safety incident there exists a requirement for services to engage in Open Disclosure with service users and families in the aftermath of that incident. Part of this process is to provide the service user or family with information as to how the service intends to review the incident. This meeting therefore provides an opportunity for the service to explain to them the AAR process and for the family to raise any issues/questions that they may have. These questions may then be reflected in the discussion at the AAR meeting.

The outcome of the review process is normally fed back at a meeting with the service user/family, at which they will be provided with a copy of the final report.

The key benefit for service users/families lies in the responsive nature of the approach thereby giving them a timely report which they know will have a high level of team ownership. In many cases therefore, particularly where trust is maintained between the service user and the service, AAR may be an acceptable approach especially if the independent role of the facilitator is stressed.

What is involved in the conduct of an AAR?

As previously referenced in this guidance AAR can and should be used by teams as a means of reflecting on in day to day practice to improve the quality and safety of their practice. This section however deals with the use of AAR in a more formal context e.g. as a concise review methodology.

There are a few key ingredients to a successful AAR including:

- an appropriately trained and impartial facilitator i.e. someone not involved in the issue under review,
- a suitable safe private environment,
- allocated time,
- a willingness of the multidisciplinary team members to participate and that, regardless of grade or profession, all valid contributions of staff involved will be recognised.

The process starts with the identification of a suitable event for review. This can either be from a service or by way of an incident reported to the QPS Department. The QPS lead will identify a suitable person to facilitate the AAR and the service will arrange for;

(a) the participation of relevant multidisciplinary staff and
(b) a suitable date, time and venue for holding the AAR session.

To ensure that the facilitator is able to focus on the conduct of the AAR it is recommended that they be supported by a person (a scribe) to summarise, on a flipchart, the key points arising from the discussion.

In advance of the session, the facilitator is provided with detail of the topic for the AAR e.g. a brief summary of the event and its outcome and the staff who are due to attend receive details of the session and information about the process i.e. a copy of the AAR Staff information Leaflet.
Every AAR follows the same structure with the facilitator getting agreement on the ground rules at the outset and ensuring everyone is clear about the specific purpose of the AAR.

The process is centred on the facilitator asking the team the following 4 questions;

1. What did we expect to happen?
2. What actually happened?
3. Why was there a difference?
4. What have we learnt?

The team will be facilitated to work through the four questions with all present being encouraged to offer their perspective. In some ways it is like getting a 360 degree view of the event.

The scribe uses a flipchart to record the key points arising from the discussion along with detail of any actions required for improvement which the team has identified. The outcome of the process is written up into a short report (2-3 pages) the draft of which is circulated to those who attended the session for feedback prior to finalisation. (See Appendix 1 for a template for this report).

The report when finalised is provided back to the Manager who requested the AAR and to the service manager(s) responsible for the development of the action plan required to implement the learning from the AAR (actions and due dates assigned to named persons) and arrangements for monitoring implementation are put in place. A copy should be retained in the QPS Department so that it can be considered by the relevant QPS Committee to inform learning within the wider organisation/service.

**Timeframes for completion of the process**

The time required for the facilitated session is dependent on the complexity of the issue to be reviewed and the number of staff attending but is generally between 1 and 3 hours.

The report will generally take a further day to draft and circulate. Ideally this should occur shortly after the AAR takes place. One to two weeks (depending on the number of staff attending) is provided for feedback and the report is then finalised and provided back to the manager of the service. Where the AAR relates to an incident a meeting should be arranged with the service user/family in order to provide a copy of the report and discuss its findings.
Introducing AAR in your organisation

Locating AAR
As AAR is a tool being introduced in the context of the Incident Management Framework and will be used for staff to debrief after serious incidents and as one of the tools for the concise review of incidents\(^2\), it is appropriate and recommended to locate the co-ordination of AAR under the direction and advisement of the local QPS Department. This will enable the QPS Lead the opportunity to draw on a pool of trained facilitators on a rotational and as needed basis.

Identifying suitable AAR Facilitators
Though AAR is supported by the QPS Department the identification and training of AAR Facilitators should not be confined to QPS staff.

One consideration for identifying suitable facilitators is the need for a flexible and responsive approach to requests for an AAR. It is therefore recommended that whilst AAR is located in the QPS Department that consideration is given to training a wider cohort of staff to act as facilitators.

Persons who are experienced and in jobs which can allow them to schedule a facilitation session within their working day without adversely affecting delivery of services to service users, are ideally placed to be trained.

Good facilitators can make a difficult process seem very natural and intuitive and tend to exhibit the following traits:

- value people and their ideas
- think quickly and logically
- are active listeners and excellent communicators
- are both service and process oriented

The choice of persons to train as AAR facilitators is therefore critical, particularly if they are engaging with staff in the aftermath of an adverse event as research indicates that staff at this stage can be psychologically vulnerable. The person chosen therefore needs both to be empathic to the needs of staff, whilst being able to manage the session so that it does not become contentious and focused on blame or inward looking and fail to surface important process issues that require discussion. They should also be able to distill from the discussion and gain agreement of those attending, the key issues and actions required by them to improve safety.

The wellbeing of staff involved in AAR must be foremost in the minds of facilitators. Information should be available to facilitators to advise staff on how they can access emotional support if required following the AAR. AAR facilitators must also be supported through the process within the QPS function, to ensure their wellbeing is protected and their professional development is enhanced during their involvement in the AAR programme.

\(^2\) It can also be used for reviewing and understanding events that had good outcomes to understand what aspects of the teams' performance contributed to the outcome.
Promoting the use of AAR within services

It is vital that AAR is introduced as a positive approach to staff within services in order to encourage their positive participation in an AAR should this be required. The positive active promotion of the use of AAR through newsletters, information leaflets and staff engagement is therefore important. Such promotion will also assist in the identification of persons for training as facilitators.

As the coordinating department for AAR, the QPS Department should also be able to utilise trained facilitators to engage with clinical teams to assist with the promotion of organisational awareness of the existence of the methodology. This will also serve to increase their confidence in engaging staff, as in meeting with teams they will learn to clearly articulate what AAR is, how the sessions work and when and where it can be used.

Monitoring the use of AAR in your service

The work of the AAR programme should be subject to quality assurance and QPS governance processes within the organisation.

It is vital for any service utilising AAR as a methodology that it is subject to on-going monitoring from the outset.

In order to monitor the use of AAR it is recommended that the QPS Department put in place a mechanism which tracks the logging of all formal AARs. This log should include:

- The purpose of the AAR i.e.
  - Staff de-brief after a serious incident,
  - A concise review of an incident,
  - A de-brief after an event with a largely positive outcome or
  - A briefing in advance of an event.
- Where the AAR relates to an incident, the NIMS number and the Category of the Incident (Category 1, 2 or 3),
- The date the decision to hold an AAR was taken,
- The name of the AAR facilitator,
- The date the AAR was held, and
- The date the final report was completed.

This log will allow for an analysis of the uptake and use of AAR for de-briefing/review of incidents and the utilisation of trained facilitators.

To ensure continuous improvement evaluation should occur from the perspective of both participants in AARs and the facilitators of AARs.

The perspective of participants in the process is best achieved by the facilitator taking 10-15 minutes at the end of the session to conduct a mini-AAR on the process itself i.e.

1. What did staff expect would happen at the session
2. What actually happened at the session
3. Why was there a difference
4. What have they learnt about the process

The outcome is captured on a flip chart and can be subjected to analysis to inform on-going improvement.

AAR facilitators should be encouraged to write a reflective diary after each session again based on the 4 AAR questions. Their learning should be shared with other AAR facilitators at a learning session held on a periodic basis e.g. bi-monthly. The holding of such learning sessions will assist both in further enhancing their skills and also to maintain a sustainable AAR team.

**How do we apply for AAR training?**

The Office of Quality, Risk and Safety, QAVD seeks to work in partnership with services/hospitals and their Quality and Patient Safety Departments to ensure that After Action Review (AAR) is introduced in a sustainable manner.

As AAR is a skill based training programme sustainability is dependent the creation of an environment that supports the practice of those trained.

It is therefore essential that organisations wishing to avail of training have, in advance of the provision of training, taken time to consider how they intend to support and deploy trainees in the post training period.

The organisational readiness checklist below sets out the elements, which services must confirm are in place in advance of them being allocated places on the AAR Facilitators Training Programme.

On receipt of the completed check-list QRS will allocate services places on the next available training programme.
<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1.</td>
<td>Is there evidence that the AAR Managers Guidance has been received, circulated and discussed at Management Team?</td>
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<td>2.</td>
<td>Is there evidence of senior manager sign-off in relation to the commitment to support the introduction and use of AAR into the service?</td>
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<td>3.</td>
<td>In line with the AAR Managers Guidance, has the service nominated a person to act as AAR Co-ordinator?</td>
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<td>4.</td>
<td>Has a member of the Office of QRS, QAV Division engaged on-site with the management team in order to provide advice on the introduction of AAR and met with the nominated AAR Co-ordinator?</td>
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<td>5.</td>
<td>Is there evidence that the service has committed to supporting trained facilitators to attend AAR Network meetings. These meetings are designed to maintain and build skills and will be organised by QAV?</td>
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<td>6.</td>
<td>Are there arrangements in place to maintain a register of trained AAR facilitators and to monitor the use of AAR in line with the Guidance provided?</td>
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**Sign off:**
Senior Accountable Officer:
Title: 
Date:

AAR Co-Ordinator:
Title: 
Date:

Please return completed checklists to siobhan.young@hse.ie

**For QRS Office Use only**

Date completed checklist received from service
Date approved for allocation of AAR Training places
Date of training course allocated
The responses included in *italics* below are sample text only. Please replace with your own responses.

### After Action Review Learning Report

<table>
<thead>
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<th>NIMS Number:</th>
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<tr>
<td>Date of meeting:</td>
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### Background to AAR

*Provide a brief summary of the issue to which the AAR relates i.e. key chronological points here*

### Key Learning Points Identified

*Provide a brief summary of the learning points - these can be both items that worked well and those which could be improved. It is important to acknowledge both*

### Actions Agreed

*The actions agreed should be linked to the learning points identified above*

1. Set out the actions agreed here
2. etc