Approaches to Incident Review

Guidance for Consultation

NOTE: When you have reviewed this guidance please open the hyperlink at the end of the document to provide your feedback
Approaches to Incident Review Guidance

Introduction
Key to the development of safe service is creating a culture where safety is seen as a priority to all staff. The manner in which an organisation responds in the aftermath of an incident provides an insight into the extent to which such a culture exists.

Services therefore need to align their response to incidents to the HSE values of Care, Compassion, Trust and Learning. This is of particular importance when it comes to the review of incidents and we need to move to a position where review is seen as logical next step for the team in the aftermath of an incident rather than negative or even adversarial. Whilst there will be occasions where a formal approach to review independent of the service will be requires, this should be the exception rather than the rule.

This guidance seeks to set out a range of ways that incident review can be carried out in a manner that is proportional and seeks to place an emphasis on the participation of staff in the identification of issues which may have contributed to the event and may consequently need to be addressed to reduce the risk of recurrence.

Finally incident review should be something teams do rather than something that is done to teams.

Incident Review (levels and approaches)
The HSE’s Incident Management Framework identifies three levels of review as follows;

- Level 1: Comprehensive
- Level 2: Concise
- Level 3: Aggregate

It goes on to identify a number of approaches to review as set out in Table 1 below;

<table>
<thead>
<tr>
<th>Level of Review</th>
<th>Approaches to Review</th>
</tr>
</thead>
</table>
| **Comprehensive** | 1. Systems Analysis (Using HSE Guidelines for the Systems Analysis Investigation of Incidents 2016)  
2. Systems Analysis (Independent Review Panel approach)  
After Action Review can be used for staff to debrief after serious incidents but is not a comprehensive approach to review i.e. Systems Analysis is also required |
| **Concise** | 1. Systems Analysis (Facilitated MDT Approach)  
2. Systems Analysis (Desktop approach)  
3. Incident Specific Review Tool e.g. Falls and Pressure Ulcers  
4. After Action Review (AAR) |
| **Aggregate** | 1. Systems Analysis (Aggregate Approach) |

With the exception of AAR all approaches are based on the principles of Systems Analysis though they utilise differing methods of its application.

The purpose of this guidance is to provide services with an overview of each approach.
Systems Analysis Review of Incidents

Systems Analysis is a well-recognised way of reviewing incidents that has been adopted by the HSE as an approved approach to incident review.

Systems Analysis is a review methodology which focuses on finding out;

- What happened?
- How it happened?
- Why it happened?
- What the service can learn from the incident and the changes the service could make to reduce the risk of future harm arising from those causes?

The use by healthcare organisations of systems analysis as a preferred review methodology is due to its focus on system-level vulnerabilities and putting in place actions to reduce the risk of recurrence. Such an approach has been shown as most effective in improving safety. Internationally, systems analysis though the most common incident review methodology used in healthcare, is applied at a number of levels and a variety of approaches similar to those set out in Table 1 above.

Steps in the Systems Analysis Review Process

Irrespective of the approach used, the process consists of six steps.
Step 1: Organise the review and gather the data
Step 2: Determine the incident chronology
Step 3: Identify the Key Causal Factors and Incidental Findings
Step 4: Identify the Contributory Factors
Step 5: Make recommendations
Step 6: Prepare a report¹ and submit to the person requesting the review². All reports are pseudo-anonymised in relation to the names of persons and the locations of services.

¹ The type and detail of the report will vary according to the approach used.
² In the case of a serious incident the person requesting the review will be the SAO (the commissioner) in other instances it may be relevant service manager.
What is the difference between a Comprehensive and a Concise Systems Analysis?

Table 2 below sets out the key differences between the Comprehensive and Concise\(^3\) approaches.

**Table 2**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Concise</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should include person(s) with knowledge of incident analysis, human factors, systems approach and effective solutions development</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Often facilitated by an individual with the relevant input of others.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Conducted by a review team</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Time taken for analysis</td>
<td>Short timeframe (2-6 weeks)</td>
<td>Long timeframe (120 days)(^4)</td>
</tr>
<tr>
<td>Identifies causal and contributing factors as well as remedial actions(s) taken (if any)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Recommendations for improvement</td>
<td>Yes (if applicable)</td>
<td>Yes</td>
</tr>
<tr>
<td>Principles of incident analysis (begins as soon as possible, includes all involved in the incident [including involvement of the service user/family], is objective and impartial, is thorough, considers relevant literature and evidence)</td>
<td>Reflects the intent, but may not address all principles</td>
<td>Incorporates all principles</td>
</tr>
<tr>
<td>Is cognisant of the principles of natural justice and fair procedures</td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>

\(^3\) Adapted from the WHO Patient Safety Programme, Concise Incident Analysis Draft Methodology, October 25, 2012

\(^4\) Whilst 120 days is the timeframe for completion of all commissioned reviews it is accepted that due to the nature of some reviews this timeframe may be breached. The HSE will therefore set an annual target for completion of reviews within 120 days.
Comprehensive approaches to systems analysis


This approach consists of the formal commissioning of the review by the SAO i.e. development of a TOR and the appointment of a review team. The Review Team consists of at least two people, one of whom is trained in systems analysis. It involves subject matter expertise if required. This approach follows the HSE’s Systems Analysis Investigation Guideline 2016.

**Strengths**

- It is comprehensive and thorough and incorporates all the principles of systems analysis
- It supports patient safety by identifying the key causal factors of incidents and the factors that contributed to these
- It makes recommendations which when implemented will improve safety
- It adopts a high level of impartiality and rigor.

**Weaknesses**

- It is resource heavy and requires significant ‘man hours’ to complete which can mean that areas requiring improvement may not be identified and addressed in a timely manner
- It can be perceived as adversarial if applied without due consideration of the support requirements of persons affected
- Due to the length of time it takes to complete it is not responsive to persons affected
- The reports can be technical and persons affected may not perceive them as accessible or personal.

2. **Independent Review Panel Approach**

This approach consists of the formal commissioning of the review by the SAO i.e. development of a TOR and the appointment of an Independent Review Panel, consisting of senior clinicians/managers relevant to the incident under review is established and a member of the panel is appointed as Chair.

Following its establishment

- A meeting of the panel is scheduled for 6-8 weeks and members of the panel are asked to reserve this date.
- A person is appointed as a case manager to the incident. The case officer should have knowledge of incident analysis, human factors, systems approach and effective solutions development. The role of the case officer is to liaise with the Chair and to gather all relevant information and to prepare a case report for presentation at the scheduled meeting of the panel. The information gathered should include;
  - a copy of the clinical/care record,
  - a copy of the incident report,
  - the written recollection of events from staff,
  - the notes relating to any meetings held with any staff to clarify aspects of their written recollection of events (if required)
• the output of a meeting with the service user/family to ascertain their perspective on the incident and any key questions they would wish to see the review answer
• copies of any PPGs relevant to the incident
• any other information that may be relevant to the incident e.g. equipment maintenance records, phone logs etc

The case officer then prepares a report for presentation to a review panel. The report should outline a short background to the service user to include their clinical/care history, a chronology of events leading up to the incident, detail of the immediate steps taken in relation to the management of the incident and the outcome of the incident.

One week prior to the Independent Review Panel meeting, each member of the Panel receives a file consisting of the information gathered and the case report prepared by the case manager. They are required to read and consider this information in advance of attending the Panel meeting.

At the Panel meeting the case is presented by the case officer. The Independent Review Panel, supported by the case officer, discuss the case and the evidence provided and agree the key causal factor(s) and the factors that contributed to these. The Panel then move to consider any recommendations required to reduce the risk of recurrence.

Following the meeting the case officer completes the case report to include the analysis and recommendations agreed at the panel meeting. The draft report is provided to members of the Independent Review Panel for consideration and feedback. The amended draft report is, in keeping with the principles of natural justice and fair procedures, provided to staff who participated in the process for review and factual accuracy checking.

Following receipt of the feedback the case officer meets with the Chair of the Independent Review Panel to finalise and sign off the final draft report for consideration by the SIMT per the governance approval process for finalising review reports.

Note: the Independent Review Panel should where possible be constituted from within the Hospital Group/CHO or NAS. Though the Panel can be made up of a number of Senior Clinical/Care staff, the time commitment required from them is not onerous i.e. they are required to read the case file in advance of the Panel Meeting, to participate in the Panel Meeting and to review the draft report developed following the Panel Meeting.

Strengths

• It is comprehensive and thorough and incorporates all the principles of systems analysis
• It supports patient safety by identifying the key causal factors of incidents and the factors that contributed to these
• It adopts a high level of independence
• It involves the perspectives of an independent multidisciplinary panel of subject matter experts

Weaknesses

• It requires the establishment of an independent panel of subject matter experts which could be challenging for some services.
Concise approaches to systems analysis

Systems Analysis (Facilitated Multidisciplinary Team Approach)
The Facilitated Multidisciplinary Team Approach recognises that incident review should be embedded as part of the normal business process of a multidisciplinary team and as such the approach engages with all members of the team, including those involved in the incident, in a dynamic problem solving approach in which all team members contribute equally. It tends therefore to result in an analysis that is ‘owned’ by the team and produces recommendations that team members commit to implementing. Its success relies on pre-meeting preparation by the facilitator (a person possessing both, knowledge of systems analysis and skills in group facilitation) to draw up the chronology of events from available documentation along with any other relevant information.

Prior to the meeting the terms of reference (scope and aims of the review) should be documented and circulated to those invited to attend.

The facilitator should open the meeting by setting the ground rules and ensure all participants indicate by their agreement to them.

The following ground rules are suggested;

- Leaving hierarchy at the door – everyone in the room is equal right to be listened to and have their experience heard.
- Everyone contributes and all contributions are respected
- The purpose of the meeting is to learn from the issue under review and is therefore improvement focused.
- Discussing what happened objectively should not lead to assigning blame.
- Everyone will have a different perspective to share about the same event
- Contributions should reflect what staff factually witnessed or experienced
- Respect time pressures but all must be fully present and engaged in the process
- Make no assumptions, be open and honest

The aim is, through open discussion, to agree the key causal factor(s) and the factors that contributed to these so that any areas for improvements can be identified and agreed. Following the meeting the facilitator writes up a draft concise report (Appendix 1 Concise Report Template) for circulation back to relevant staff for factual accuracy checking and comment. Following receipt of any feedback the report is finalised and submitted to the relevant service manager.

Strengths
- It applies the principles of systems analysis in a way that is proportional and responsive.
- It supports patient safety by identifying the key causal factors of incidents and the factors that contributed to these
- It engages with the team in a way which is inclusive and solution focused.
- It assists in developing the culture of safety within the team as it requires them to reflect on the issue in a manner which takes account of the incident from multiple perspectives.
- As the analysis and any improvements identified are ‘owned’ by the team it will assist with their implementation.
- It is practical and results in a concise report which can be provided to relevant stakeholders
Weaknesses

- Whilst saving time and effort, the compromises involved may mean that more subtle causes of the incident or issue aren’t detected and therefore aren’t corrected.
- It may not be perceived by service users/families as sufficiently independent.

Systems Analysis (Desktop approach)

Application of systems analysis using this approach is most commonly used for incidents which have occurred in the significant past and therefore are unlikely to be able to utilise staff testimony either by way of available written recollections or by interview owing to the passage of time or staff availability e.g. many staff may have since retired or left the service.

The review will be conducted ‘at the desktop’ by a single reviewer experienced in systems analysis who has been provided with a terms of reference (scope and aims of the review).

Consideration should be given to whether an independent Healthcare Record review of the clinical/care record may usefully augment the process.

The review results in a concise report which should, where in the absence of staff involvement, at a minimum be reviewed by the relevant service manager prior to finalisation. (Appendix 1 Concise Report Template)

Strengths

- It supports patient safety by identifying the key causal factors of incidents and the factors that contributed to these
- It identifies areas for improvement
- It results in a written report

Weaknesses

- The analysis is limited by the lack of direct testimony
- It is dependent on the availability of good records
- Whilst saving time and effort, the compromises involved in using a desktop approach may limit review to known risks and that the more subtle causes of the incident or issue aren’t detected and therefore aren’t corrected.
Incident Specific Review Tool

These are tools that relate to specific incident types particularly when there has been a moderate harm outcome. They take a concise systems analysis approach and apply it to the best practice guideline for a specific area of practice e.g. pressure ulcers or falls. They are developed using a co-design approach involving persons with a subject matter expertise in the area to which they relate and persons with the technical knowledge of systems analysis. They result in a standardised incident specific concise report.

The tools when used to review an incident should be applied through an approach which involves a person with training in systems analysis and a person with the subject knowledge in the area under review. This can be the same person e.g. in the case of pressure ulcers it could be a tissue viability nurse who is trained in the application of systems analysis.

Strengths

- It supports patient safety by identifying the key causal factors of incidents and the factors that contributed to these
- It provides a consistent approach which can be applied easily to the incident type to which it relates
- It is resource light
- It is quick to apply and results in a timely standardised report
- The availability of a standardised facilitates the aggregate analysis of incidents across the specific incident type.

Weaknesses

- Whilst saving time and effort, the compromises involved in using a specific tool may limit review to known risks and that the more subtle causes of the incident or issue aren't detected and therefore aren't corrected.
Aggregate Review of Incidents (Systems Analysis Approach)\(^5\)

In addition to individual incident analyses (comprehensive and concise), consideration should be given to the aggregate analysis or meta-analysis of multiple incidents that are identified by a particular theme. For example:

- A group of individual patient safety incidents, similar in composition and/or origin that caused no harm or lesser degrees of harm i.e. **Category 3 incidents**.
- A group of individual patient safety incidents that are similar in type and/or origin that may have caused varying degrees of harm (**Category 1**, **Category 2** and **Category 3 incidents**) e.g. service user falls in an older persons residential setting.
- A group of patients that are impacted by a similar causal or contributing factor(s) e.g. inadequate clinical handover or failure to recognise and respond to clinical deterioration, and who experience the same harmful incident (to greater or lesser degrees).
- A group of completed comprehensive and/or concise incident analyse

Common features of any aggregate analysis include:

- Pre-defined theme or scope;
- Involvement of a multidisciplinary team
- Use of quantitative and qualitative methodologies

A benefit of aggregate analysis is it has the potential to reveal trends or patterns of causal and contributing factors that were not previously perceptible. These analyses can also reveal previous recommended actions that were or were not effective e.g. if despite the implementation of recommendations the frequency or severity of the incident occurring has not improved.

**Steps in Conducting an Aggregate Review:**

**Preparing for the review**

- Determine the theme and inclusion criteria
- Gather applicable data
- If applicable, conduct interviews with the service(s), patients/families, and others with knowledge of the incidents and/or care processes involved in the incidents.
- Review literature and obtain expert opinions to collect additional background and contextual information and lend perspective to the analysis
- Review other reporting and learning systems (such as the **Global Patient Safety Alerts**) to see if similar incidents have been studied by other organizations.
- Develop the analysis plan, which will include both qualitative and quantitative analysis elements.

**Conducting the Review**

- Review the patient safety incidents and/or previous comprehensive and concise analyses to look for common trends, patterns and issues. This will include comparing and contrasting timelines, factors which caused including factors which contributed to those causes, and recommended actions from previous incident analyses.
- Process mapping can also be used to support the identification of system weaknesses when conducting an analysis of multiple incidents.
- Note the frequency of system issues or failure points and if applicable, recommended actions. This is the quantitative portion of the analysis and will include classifications

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\(^5\) Adapted from the Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012.
such as: severity of harm, type of incident, patient diagnosis, etc.

- The qualitative analysis involves focusing on the identified causal and contributing factors as well as similarities that may not have been apparent through an individual incident review. Narrative descriptions are particularly helpful for this portion of the review. As common patterns are identified, the team may need to further sub-categorize to clarify trends or issues.
- When a group of comprehensive and/or concise analyses are reviewed both the causal and contributing factors and the recommended actions may be included in the qualitative analysis.

**Preparing the report**

- Summarize findings including causal and contributing factors and previously recommended actions that may lead to system improvement. Include any trends, patterns of causal or contributing factors, and any other findings.
- Develop recommended actions that will lead to system improvement, giving consideration to available supporting information, including evidence-based guidelines and leading practices. Identify both short term and long-term strategies for effective recommended actions to reduce risk.
- The findings (causal and contributing factors, trends and themes), recommended actions and their outcomes should flow into and be coordinated with the service’s risk management and improvement processes, including processes for communicating and sharing learning.
After Action Review

An After Action Review (AAR) 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. AAR is intervention that is undertaken soon after the incident occurs that seeks to understand the expectations and perspectives of all those staff involved. It generates insight from the various perspectives of the multidisciplinary team, enables lessons learned to be identified and leads to greater safety awareness, changes to team behaviours and assists in identifying actions required to support safety improvement.

AAR exists to create both individual and team opportunities to improve personal, team and organisational performance.

- For use as a debriefing/learning process for teams in the immediate aftermath of a incident (including serious incidents for which a comprehensive review is planned). This however is a separate process, the report from which should not be fed forward into the comprehensive review.
- For use as a review methodology for incidents which do not reach the threshold of serious. The perspective of the service user/family can be integrated into the approach so that these can be considered as an integral part of the AAR meeting.
- 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 on their performance.

It works best in situations where there is a positive multidisciplinary team dynamic and an openness to discuss incidents.

Once the need for an AAR has been agreed a suitable facilitator should be assigned and arrangements put in place for the relevant staff to attend.

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 & 3 hours.

The report (usually 2-3 pages) will generally take a further day or two to draft and circulate (Appendix 2 AAR Template Report). Two weeks is provided for feedback and the report is then finalised and provided back to the service. A meeting should be arranged with the service user/family to present the report and discuss its findings.

Strengths

- It is a responsive and timely approach to review.
- There is a high level of team involvement in the process which results in a high level of ownership in the outcome.
- If it is facilitated by a person independent of the service it can be seen as more independent
Weaknesses

- It is not suited as a review methodology for incidents with a serious outcome
- If it is not facilitated by someone of sufficient remove from the incident it can be seen as lacking independence
- It does not result in a detailed analysis of the factors which caused or contributed to the event.
- It may not be suitable if there is not a positive multidisciplinary team dynamic and an openness to discuss incidents
### Appendix 1 Concise Report Template

**Feidhmeannacht na Seirbhíse Sláinte**  
**Health Service Executive**

**SYSTEMS ANALYSIS REVIEW REPORT**  
**CONFIDENTIAL**

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NIMS NUMBER</td>
<td></td>
</tr>
<tr>
<td>Hospital /Service / NAS Area / Other</td>
<td></td>
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<tr>
<td>Hospital Group/CHO/NAS /Other</td>
<td></td>
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<tr>
<td>Requestor of the Review</td>
<td></td>
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<tr>
<td>Lead Reviewer</td>
<td></td>
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<tr>
<td>Date Report Completed</td>
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</table>
# Executive Summary

To include: Detail of the incident type and the impact on the service user/person affected, (do not use names) / other  
System issues identified with the causal factors outlined  
Learning points  
*This summary can be used as the basis for sharing learning with other services.*

# Outline of the Review Process

Who commissioned the review? Remit of the review (scope and aims) and brief points as to how this was conducted including naming the approach used. Mention that service user/family and staff liaison persons were appointed. Include detail of how the service user and family was involved in the process e.g. was there a meeting with them to outline the plan for review and to ask them if they had any particular questions that they would like to see the review address?

# Summary of the Incident

Provide brief detail relating to the background of the service user and relevant detail of their care episode leading up to the incident e.g. the service user was an elderly person with a history of multiple admissions for treatment of chronic respiratory problems. He was admitted 5 days prior to the incident for..... Outline what happened and provide detail of the immediate management of the incident to include how persons affected (service user/family/staff) were cared for/supported, whether and when open disclosure occurred, what steps were taken to address any immediate risks identified that may affect others.

# Persons involved in the conduct of the Review

Name of lead reviewer and others who assisted in the process, including any subject matter experts (if involved)

# Methodology

Document the approach used: e.g. concise systems analysis and what information/material was considered e.g. documentation reviewed (incident report, review of health records (medical case notes, nursing records, laboratory and radiological reports), site visits, written recollection of events from staff, interviews with staff (if any), duty rotas, PM/Coroner reports, equipment reports including serial number, relevant local or national PPPGs, Yorkshire Contributory Factors Framework etc.  
Make reference to the process used to ensure natural justice and fair procedures for all parties.

# Findings of the Review Team

To include:  
- Key Causal Factors and the Contributory Factors (see Yorkshire Contributory Factors Framework Guidance) that relate to each Key Causal Factor (list these)  

Incidental Findings (Note anything that requires attention but which had no real impact on the event e.g. illegible/untimed records, procedures not followed)  

Good/Notable Practice  
(Highlight any good practice identified e.g. good record keeping, the services immediate response to the incident, the support of persons affected etc)

# Review Outcome (Indicate which of the following outcomes best applies)

1. Appropriate care and/or service - well planned and delivered, unavoidable outcome and no Key Causal Factors identified.  
2. Indirect system of care/service issues - No Key Causal Factors identified but Incidental Findings were identified i.e. improvement lessons can be learned but these were unlikely to have affected the outcome.  
3. Minor system of care/service issues - a different plan and/or delivery of care may have resulted in a
different outcome, for example systemic factors were identified although there was uncertainty regarding
the degree to which these impacted on the outcome.

**4. Major system of care/service issues** - a different plan and/or delivery of care would, on the balance of
probability, have been expected to result in a more favourable outcome, for example systemic factors
were considered to have an adverse and causal influence on the outcome.

<table>
<thead>
<tr>
<th><strong>8.0 Recommendations</strong></th>
</tr>
</thead>
</table>
| (What is recommended to address each causal factor? These may be for Local, Service or National action)
These should be SMART (see Guidance on Developing Recommendations) |

<table>
<thead>
<tr>
<th><strong>9.0 Communication</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9.1 Service Users/Family</strong></td>
</tr>
<tr>
<td>Describe how the service user/family were involved at the outset of the review.</td>
</tr>
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<td>Describe how they were kept updated during the process e.g. reference to the appointment of a nominated liaison person.</td>
</tr>
<tr>
<td>Describe how it is planned to feedback to them on the outcome of the review and how the report is to be provided to them.</td>
</tr>
<tr>
<td>If the service user was <strong>not</strong> involved, document any reasons for this</td>
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</table>

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<tr>
<th><strong>9.2 Staff</strong></th>
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<tbody>
<tr>
<td>State how staff (those involved and wider organisation) were involved and supported following the incident and for the duration of the review process, State also how it is planned to make staff aware of the review outcome and lessons learned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>9.3 Sharing Learning</strong></th>
</tr>
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<tbody>
<tr>
<td>State how the Service will deal with this</td>
</tr>
<tr>
<td>Amongst staff in the area where the incident occurred</td>
</tr>
<tr>
<td>With the relevant Hospital/Service QPS Committee e.g. Case Presentation at meeting, etc</td>
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<tr>
<td>Whether it is planned to share the report more widely</td>
</tr>
</tbody>
</table>
APPENDIX 1 CHRONOLOGY

List dates and times of key events or actions taken in chronological order (For a concise review the detail required is that which relates to key events and actions only)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Source</th>
<th>What happened</th>
<th>Reviewer Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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**REVIEW REPORT**

**PSEUDOANONYMISATION CODES**

Note: Whilst it is important to maintain the confidentiality of the names of staff participating in the review process, it is also important to maintain a record of staff involved in the care of the service user to which the report relates.

Please complete the table below but do not attach to the final report. This page should be provided only to the Commissioner and should not be filed with the report.

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<th>NIMS Number relating to the Review:</th>
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Appendix 2 – Sample AAR Summary Report

After Action Review (NIMS Number)
Learning Report
Date of meeting: <insert date here>

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
Provide your feedback on this document here