



QI TALK TIME

Building an Irish Network of Quality Improvers

Incident Management Framework 2018:

After Action Review

1pm Tues February 19th
2019

Connect

Improve

Innovate

Speakers

Siobhan Young

works in the HSE's Office of Quality, Risk and Safety, QAVD. She started her career as a clinical speech and language therapist before spending ten years in a policy role in the Civil Service. Siobhan has a number of post graduate qualifications including an MBA in Health Services Management and a PhD by research in social policy.



Una Healy

trained as a nurse in Our Lady of Lourdes Hospital, Drogheda She has since accumulated over 20 years' experience before moving to Risk Management in St. James's Hospital where she is currently the Safety Lead in the Quality & Safety Improvement Directorate. She has a Fellowship in Healthcare Safety & Quality, MSc in Leadership & Management Development, BSc in Nursing Management and Quality & Safety in Healthcare and a Diploma in Project Management.



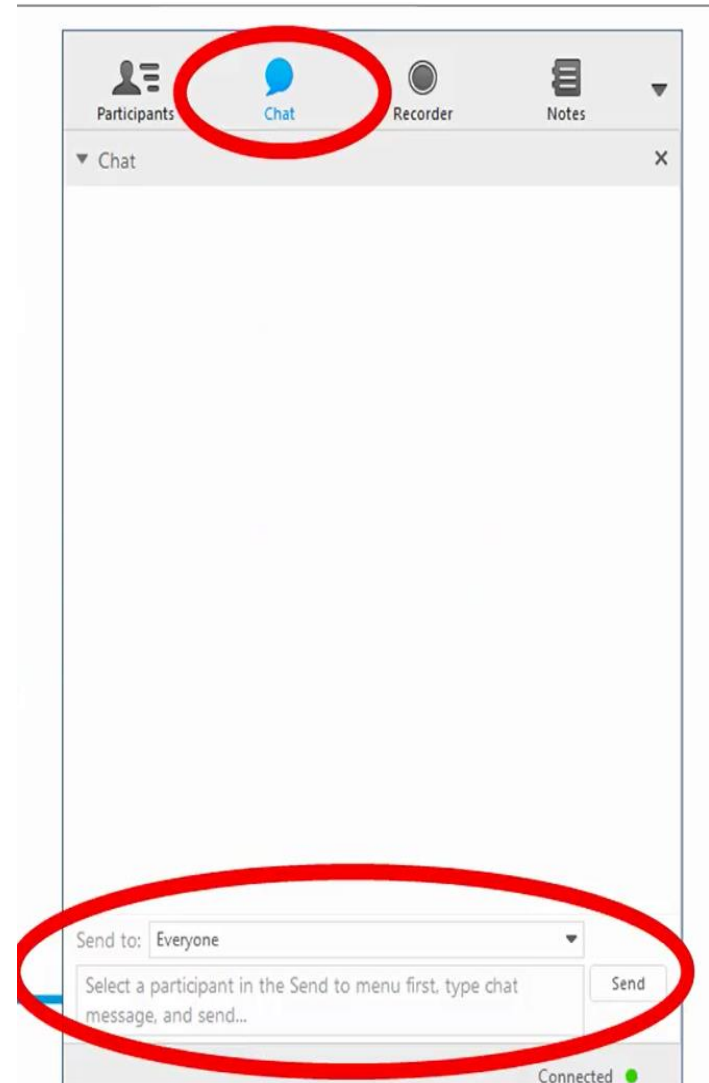
Áine Clyne

is the Quality & Patient Safety Lead of CHO Dublin North City & County. Áine has been working in Quality & Patient Safety with the HSE since 2012. She has a clinical background in Occupational Therapy. Áine has a Masters in Equality Studies from UCD and has more recently completed the Quality & Leadership Diploma in RCPI in 2018.



Instructions

- Interactive
- Sound:
Computer or dial in:
Telephone no: 01-5260058
Event number: 842 823 197#
- Chat box function
 - Comments/Ideas
 - Questions
- Keep the questions coming
- **Twitter: @QITalktime**



Overview

- Context / Incident Management Framework
- Service perspectives
- Q&A

Incident Management Framework

The IMF applies to all incidents occurring in publicly funded health and social care services provided in Ireland including but not limited to:

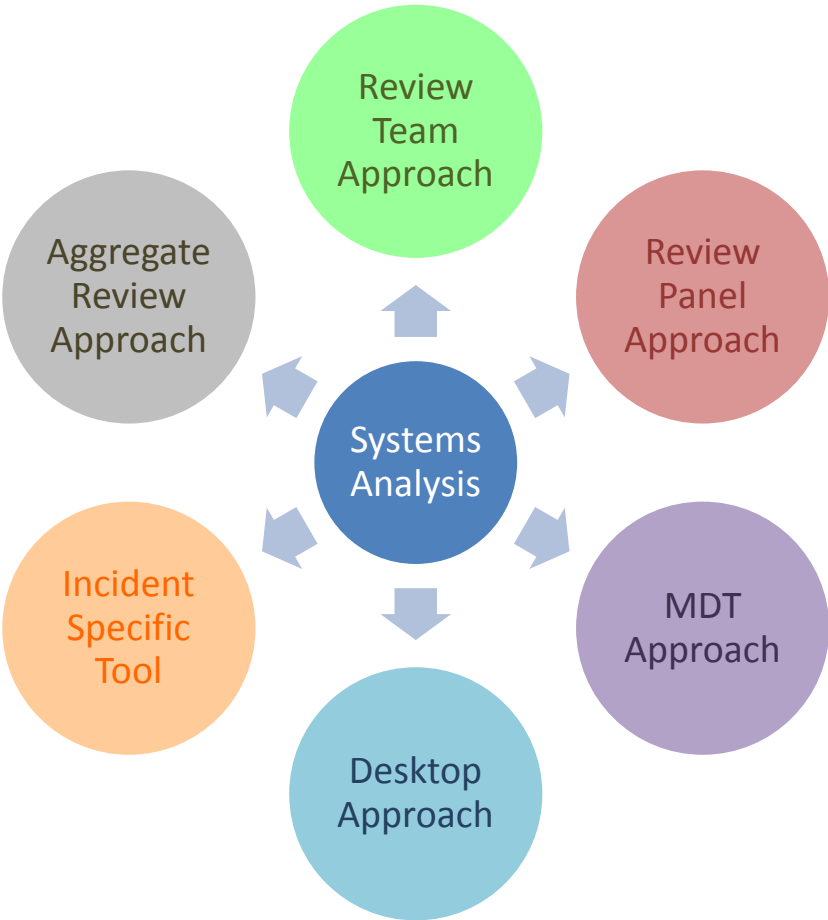
- Hospital Groups
- Community Health Organisations
- National Ambulance Service
- National Services e.g. National Screening Services, National Transport Medicine Programme
- HSE Funded Care e.g. Section 38/39 agencies

Incident Management - Six Step Process

1. Prevention through supporting a culture where safety is a priority
2. Identification and immediate actions required
3. Initial reporting and notification
4. Assessment and categorisation
5. Review and analysis
6. Improvement planning and monitoring



Approaches to Review



AFTER ↺

ACTION ↻

REVIEW ↺

After Action Review

- ‘Arguably one of the most successful organisational learning method yet devised.’¹
- Adapted for use in healthcare by University College Hospital London.²

1. <http://www.gurteen.com/gurteen/gurteen.nsf/id/why-after-action-reviews-fail> - Senge P author of *The Fifth Discipline: The Art and Practice of the Learning Organisation* Random House Business 1993.
2. Walker J et al (2012) ‘Life in the slow lane: making hospitals safer slowly but surely’ at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3407393/>

What is After Action Review?

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 **(HSE, 2018: 21)**.



Circumstances where you can use AAR

Positive Outcome

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

Review of less serious incidents

- Incidents which do not reach the threshold of Category 1

After a serious incidents

- AAR should not be used as a primary source of evidence where a comprehensive review is required for a Category 1 incident

What is it about AAR that makes it so suitable for use in healthcare?

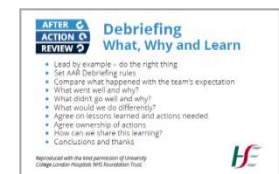
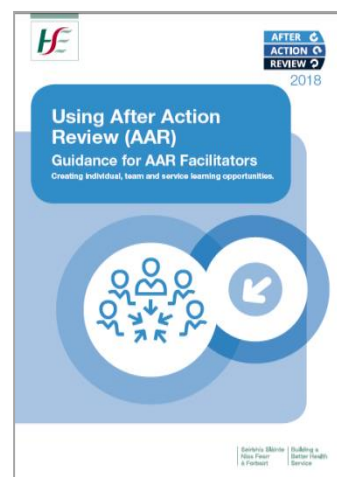
AAR

- Provides teams with a structured mechanism for talking about incidents
- Involves listening to multiple perspectives
- Focuses on learning and not blame
- Can be led by anyone with good facilitation skills
- Easy to remember
- Applicable to almost any event (i.e. positive or negative)

Adopting and adapting AAR for the HSE

- Discussions with University College Hospital London (UCLH)
- Access to training provided by UCLH
- Establishment of a co-design group including rep from UCLH
- RCSI Institute for Leadership appointed to help design and deliver the course
- Development of support materials

Materials developed to support use



<https://www.hse.ie/eng/about/qavd/incident-management/>

Deploying AAR in an acute hospital setting

Ms Una Healy, Clinical Safety Lead, Quality and Safety Improvement Directorate, St James's Hospital Dublin.



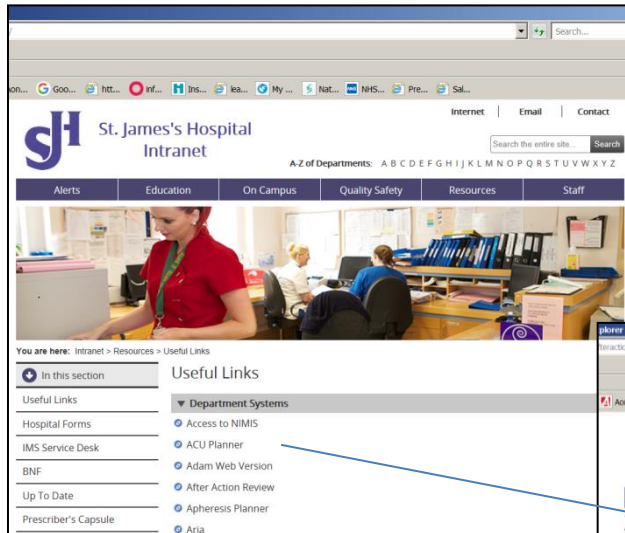
Where we started

- 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 planning training evaluation
coaching

Improvement

briefing

shift change/handover Events / Incidents debriefing

project evaluation

reviewing positive events

Hot de-brief

patient satisfaction

Reviewing unexpected events



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



hello my name is...

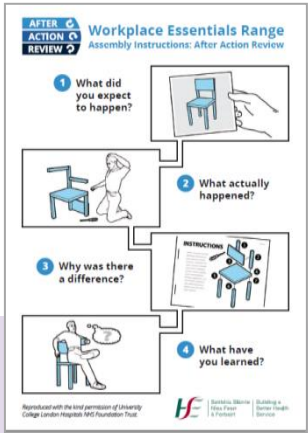


Áine Clyne, Quality & Safety Lead, CHO DNCC

- My Experience of participating on the course
- How our Area is supporting training
- How AAR has been applied within the Community Services:
 - Mental Health
 - Primary Care, Addiction & Social Inclusion
 - Social Care

Introducing AAR to the Community Health Care Services, Dublin North City & County Experience of Training

- Opportunity to be an observer at Day 1 Training, January 2018
- Previous System Analysis Training for serious incident reviews
- Curious about new and alternative approaches
- Enticed by simplicity of AAR Approach
- Had questions about how it would work for incident reviews
- Could it be as simple as putting an Ikea Chair together?



Introducing AAR to
the Community Health Care Services, Dublin North City & County

Experience of Training

- Impressed with organisation and professional delivery of course
- Challenging but worthwhile experience of 'role play' with professional actors
- Privilege to have learning opportunity to participate in RCSI
- Enthusiastic
- Wanted new QPS Team to become facilitators!
- **Governance**
- Support of Chief Officer and Senior Management Team
- ie Training and facilitation not happening in vacuum

Introducing AAR to the Community Health Care Services, Dublin North City & County Experience of Training

- QPS Team commenced training September 2018
- Good ‘team building’ experience
- Balance of ‘fun’ and seriousness
- 1 full day, 1 half day follow up
- **Homework – Putting Learning into Action**
- Carrying out an AAR meeting
- Working in pairs recommended

Introducing AAR to the Community Health Care Services, Dublin North City & County Putting AAR into Practice

How have we used AAR in Incident Management?

Example 1

- Facilitating a reflective meeting with senior managers following death of a service user in the community
- Focused on governance and responsibilities when more than one agency involved in care of service user
- **How was AAR helpful?**
- Steered constructive conversation
- Focus on learning/Actions
- **NB:** this was not an incident 'review', contributed to learning cycle

Introducing AAR to the Community Health Care Services, Dublin North City & County Putting AAR into Practice

Example 2

Moderate incident review in Acute Mental Health Service

What made it work well?

- Formal Review pathway inkeeping with IMF
 - Safety Incident Management Team decision making
 - Terms of Reference
- Good Chronology – Facilitators knew the facts
- Formal invitations, timeframes agreed, draft report sent out to participants for factual accuracy
- Combined ‘due process’ and procedures from system analysis
- Facilitator and Scribe - work in pairs

Introducing AAR to the Community Health Care Services, Dublin North City & County Putting AAR into Practice

Feedback from Participants

- Positive
- Liked being in 'circle' vs interviewed in front of desk
- Shorter than system analysis

Outcome

- Practical actions that came from staff
- Four page report

Introducing AAR to
the Community Health Care Services, Dublin North City & County
Putting AAR into Practice

Other Examples

- **Debriefing**
- Heating system broke down in residential unit
- Staff had very stressful weekend in residential unit

Introducing AAR to the Community Health Care Services, Dublin North City & County Putting AAR into Practice

Where are we at now?

- Encouraging MDT Clinical staff to train
- So far,
 - Director of Nursing x 1
 - Assistant Directors of Nursing x 2 (Older Persons Services & Mental Health)
 - Hospital Manager x 1
 - Health & Safety Advisor x1
 - Quality & Patient Safety Team x 5

Reporting on Training & Activity via CHO Quality & Safety Governance Committee

Helpful links

Framework for Improving quality

www.qualityimprovement.ie

<https://www.hse.ie/eng/about/who/qid/aboutqid/strategic-plan-2019-2021.pdf>



Please give us your feedback

**National
Quality Improvement Team**



Strategic Plan 2019 - 2021

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Missed a webinar – Don't worry you can watch recorded webinars on HSEQID
QITalktime page

Next QI Talktime:

**Frailty Teams – hear all about the growing movement
in Ireland**

Tues March 5th 1-2pm

Thank you from all the team @QITalktime

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