Case Study: Introducing After Action Reviews (AAR) Stockport NHS Foundation Trust

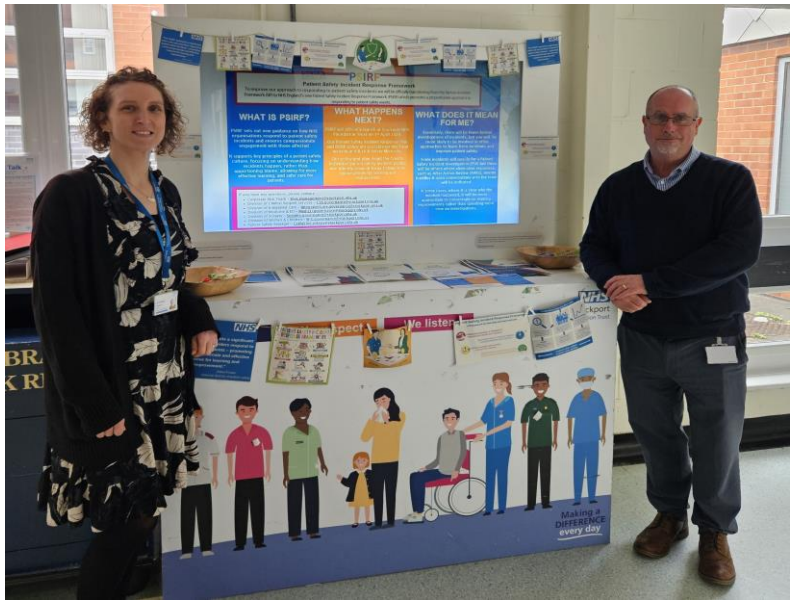
BACKGROUND

The Patient Safety Incident Response Framework (PSIRF) replaces the Serious Incident Framework. PSIRF is a new approach for responding to patient safety incidents for the purpose of learning and improving patient safety.

A new learning response toolkit has been developed to bring about more proportionate responses to incidents, to encourage learning and improve safety culture.

Trusts are now in the process of learning these new response toolkit techniques and spreading them among staff.

PSIRF GO LIVE WEEK



SOLUTION

Part of developing the plan was to look at local priorities and looking at different types of responses and the AAR was one of those responses.

The Divisional Quality and Risk Managers alongside the Patient Safety Manager are leading on PSIRF and the introduction of new learning responses. They have started to introduce AAR as an additional response toolkit and are taking an iterative and pragmatic approach to implementation. They are trialing using the AAR template with teams and after each session considering what works well and less well.

AARs have been used with planned responses e.g. junior doctor and consultant strikes, as well as patient safety incidents, this enabled testing AARs to see if they were beneficial and made any necessary tweaks. Senior Managers were involved in the reviews, so they had an understanding of AAR methodology. Stockport FT tested AAR using the template provided by NHS England, asking the questions:

1. What was expected?
2. What actually happened?
3. Why was there a difference?
4. What are we learning?

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LEARNING

- ✓ **Set ground rules at the start of the sessions**. E.g. everyone is equal, everyone to have their say and others to listen, and learn and be respectful. This has started to change the culture in a positive way.
- ✓ **Getting engagement from the senior team is key**. Communicating to Directors the AAR methodology and making sure they are part of the process has been really helpful. Giving a clear message on why full Patient Safety Incident Investigations (PSII) are not always the best use of resource has helped with understanding and buy-in to PSIRF.
- ✓ **Preparation work has been vital**. Communicating to staff that the focus is learning lessons from incidents to ensure the incident doesn't happen again rather than blame.
- ✓ **It can be difficult to facilitate the AAR sessions** as well as transcribing the notes so where possible having two people: one to facilitate the meeting and the other to take notes but understand this isn't always possible due to capacity.
- ✓ **AAR can be successfully applied to other types of events**, not just patient safety. Learning from the doctors' strikes was used to help with staff wellbeing and dealing with operational pressures.

CHALLENGES

- There isn't one size fits all, using PDSA cycles to adapt and develop over time is a good approach.
- Capacity of the team. It has been hard for the team to carry out and undertake training as well as doing the day job, this has added pressure on the team.

CONCLUSION

- There are some really good examples so far that have been tested e.g. medication incidences.
- The culture is now starting to change in a positive way and team members find the AAR a valuable learning response.
- AAR appears to work well within the organisation and looking forward to using it more often.