After action reviews: a new model for learning

Gerard Cronin and Steven Andrews explain why after action reviews are an ideal model for healthcare professionals to analyse and learn from events.

Summary
University College London Hospitals NHS Foundation Trust is committed to developing a learning culture for its staff and, to achieve this, the organisation recently developed the after action review (AAR) model as a way for people involved in specific incidents to explore what happened and what they have learned. This article explains the concept of AAR and uses case studies to illustrate how it can improve patient care.

Keywords
Events, learning, discussion

Changes in health care require both learning and action to ensure that patients always receive safe and high-quality care.

For such changes to succeed, it must be understood that all aspects of practice can be improved and that learning cycles are continuous.

Declaring this as an organisational philosophy is one thing, but making it happen in busy, stressful care environments such as emergency care settings is another.

However, a practical representation of this philosophy has been developed at University College London Hospitals NHS Foundation Trust (UCLH) to encourage individual and organisational change through the exploration of what people and teams learn from specific events.

This 'after action review' (AAR) model was pioneered in 2008 to allow staff to come together to reflect, discuss, share plan and reflect again in safe environments.

Since the launch, staff from more than ten other NHS organisations have requested information about the model, while Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) has begun to introduce AARs throughout one of its directorates.

Meanwhile, one-day workshops in the AAR model for nurses, doctors, managers, healthcare assistants, directors and allied health professionals, all of whom take part together, continue at UCLH.

After action reviews
An AAR is a discussion of an event that enables the individuals involved to learn what happened, why it happened, what went well and what can be improved.

Thus, AAR is a timely intervention that seeks to understand the expectations and perspectives of all those involved. It generates insight and leads to greater awareness, changed behaviours and agreed actions.

Implementing AARs in organisations requires a sense of ownership of the model among front line staff and the support of managers and leaders in its implementation.

Everyone involved in the implementation should understand how the model works and can achieve results, rather than being told simply to apply a set of questions to each situation.

The purpose of AARs is to encourage among participants an understanding of the lessons to be learned from events, as well as greater self-awareness and agreement on further action to be taken.

Fundamental to the success of AARs, therefore, are strong leaders who can create open, honest and safe environments in which people can speak honestly and with confidence.

After action reviews should not be undertaken simply to fix problems or allocate blame, but to ensure that individuals involved in events have a...
After action reviews should be organised by people who have leadership and communication skills, and who understand the principles of the model and how it works.

- The environments in which AARs take place must be safe, and discussions must be open and honest.
- Courage is required by all participants.
- Everyone involved in AARs should be encouraged to contribute. The truth about an event can be established only after all participants have told their stories.
- All professions and grades should contribute equally to AARs, which should take place in adult learning environments so that hierarchical pressures do not prevent the truth from being established.
- There must be a ‘no blame’ culture in which all that is learned is valued.
- Mistakes and poor performance, as well as excellence, should be discussed.
- After action reviews are professional forums, not opportunities for participants to complain about issues that cannot be influenced by the people involved.
- Discussions should be about the behaviours of participants during the events under discussion and the changes in practice they can make.
- Disagreement is welcome in AARs. Performance can be questioned, therefore, as long as environments remain safe for all participants.

This personal insight is a key aspect of the AAR concept because change is more likely to occur in individuals who have experience of the subject under discussion.

The role of AAR facilitators, therefore, is to help participants ‘take ownership’ of the issues being discussed, so that they can understand the changes and actions required of them.

After action reviews can be undertaken when everyday events or large organisational issues must be explored, and can be applied to all disciplines. They are not ways of measuring success or failure, but can extract what must be learned from events.

Much can be learned immediately from the insights generated during AARs, and this can then be shared with others. Examples of the sort of AARs that take place at UCLH include:

- Five-minute sessions at the end of meetings.
- Explorations of major projects.
- Discussions of clinical events such as the sampling of blood.
- Discussions of patient complaints and responses to these.
- Debriefing sessions after ward rounds.
- Discussions of untoward incidents and what can be learned from these.

It is essential that the people who lead AARs create the right environments for them to take place.

Some simple ground rules for creating, supporting, and protecting the open and honest environments required for AARs are listed in Box 1, and some of the ways that AAR sessions can be implemented are described in Table 1.

A simple enquiry framework is also crucial for each AAR to become an effective learning opportunity. This framework is based on four questions concerning the events to be discussed. These questions are asked to help participants in AARs analyse their experiences and share the lessons they have learned with their teams and across their organisations.

The four questions are:

- What was expected to happen?
- What actually happened?
- Why is there a difference between these?
- What has been learned?

These questions can be applied to situations, meetings, projects, daily events and personal experiences, but the objective of asking them is always to learn rather than to attribute blame or find fault because the expected outcomes were not produced.

Participants in AARs should understand that, by sharing narratives concerning specific incidents or events, rather than simply stating their outcomes, they can encourage others to learn from them.

During an evaluation of complaints, for example, it is often the issues raised by incidents, such as communication, teamwork, leadership or organisational culture, that must be addressed. The incidents themselves, which are often the subjects of AARs, simply enable these issues to be discussed.

Guiding teams through the framework requires of AAR facilitators a sound understanding of how
An emergency department (ED) sister was concerned about the level of cleaning on her unit, in particular the delay involved in cleaning a side room that had been occupied by a patient with an infectious illness.

The regular cleaner was on annual leave and his replacement, who was engaged in other activities on the unit, had failed to notice the sister's request for the room to be cleaned. The sister was unable to contact the cleaner's supervisor because her bleep number and extension appeared to be 'not valid'.

The sister contacted the ED matron, who visited the supervisor in her office and was told that the supervisor would do the job herself. Later that day, however, the matron discovered that the job had not been completed. She called for an after action review of the event and asked the ward manager and domestic supervisor to attend.

**What was expected to happen?**
The replacement ED cleaner should have followed the ED sister’s instructions, stopped what he was doing and cleaned the side room.

**What actually happened?**
The replacement ED cleaner did not follow the sister’s instructions and his supervisor could not be contacted by telephone. The ED matron was obliged to visit the supervisor, who agreed to take control of the situation. It was noted that the supervisor’s bleep and extension numbers had been changed without the ED sister being told. The matron later returned to the area to find that the side room had not been cleaned.

**Why was there a difference between these?**
The replacement ED cleaner was temporary and unaware of the hospital rules. He did not know that he should have taken instructions from the ED sister. After agreeing to clean the side room, the supervisor had become distracted and had forgotten to do so.

**What has been learned?**
The supervisor apologised for forgetting what she had agreed to do and promised to share her contact numbers with all clinical areas. She agreed to ensure that, when regular ED cleaners are on leave, replacements who are familiar with the unit will be hired, and to advise all agency staff to follow the ED sister’s instructions. She also agreed to raise the issue of cleaning in the ED at the next cleaners’ meeting.

**Summary**
After an open and honest discussion among participants who wanted to improve patient care and to respect each other’s views, an apparently simple change was achieved.

Ground rules set an expectation of behaviour while the enquiry framework acts as the agenda and helps facilitators and the group understand the process of each session.

Even when AARs become a regular part of a team’s routine, it is worth repeating these rules at the start of each session.

**Topics for discussion** All participants should agree on the topics for discussion before the sessions begin. These topics should be relevant to...
participants' practice; after all, there is no point holding AARs on topics over which participants have no influence.

**Discussing expectations** Understandably, participants usually want to tell their own stories during AAR sessions. But, in doing so, they can mount defences of their performance, which can create conflict if other participants do not agree with their versions of events.

How these stories are told often depends on the emotional involvement and personal values of the tellers, and so can be open to interpretation. Conflict and blame must therefore be kept at bay during these sessions.

Asking participants ‘what was expected’ of them, focuses their attention on the steps leading to events: what went on before, what they had planned to do, and how they had thought they would do it.

This helps to reduce the emotions involved in discussing aspects of the events, and reduces the need to judge these right or wrong.

Working through narratives in this way also provides opportunities for the ‘real’ issues behind events to be revealed, and the points at which events began to occur.

Encouraging people to think about whether they all shared the same expectations, ensures that perceptions and long-held beliefs are disclosed, and that the principles and values that guide and influence decision making are discussed openly.

**Recognising ‘grab moments’** Although the primary role of AAR facilitators is to guide participants, it is important that they can become aware of the key points in discussions. These ‘grab moments’ are often indicated by no more than a comment, a look or a gesture.

Ensuring that participants agree on the importance of these moments is vital. Such agreements allow consensus to be built among participants, which in turn helps participants understand why events have occurred and what can be done to prevent them from happening again.

**Reflecting and consensus forming** When facilitators have identified the important moments of narratives, they should find out whether the other participants agree. To form such consensus, participants must be able to reflect on what has been said.

In each case, the facilitator should first confirm what the speaker has said and then ask the other participants whether they agree that this represents a key moment of the narrative.

**Appropriate AARs** Although the creation of safe environments in which contentious issues can be discussed is fundamental to AARs, facilitators must be aware that disciplinary issues can arise and that these require different procedures.

An AAR does not offer an appropriate forum in which to discuss breaches of the Nursing and Midwifery Council’s code of conduct, for example; instead, the individuals concerned should be referred through their organisations’ disciplinary processes.

The lessons that can be learned from such breaches or other serious situations can be discussed in AARs, however. An example of an AAR session is described in the Case study.

**Conclusion**

Introducing new processes to teams or organisations can be difficult, and suggesting a new learning model such as AAR requires leadership, vision and courage.

In some cases, senior nurses may think that their teams are too busy to learn new processes or may assume that AARs have insufficient value to be accepted.

By hosting brief AARs, however, and by showing that these offer participants learning environments in which they are respected and valued, these judgements can be challenged. By ensuring that the experiences of staff are valued, AARs can inform and guide future action to improve patient safety and care.

**Implications for practice**

After action reviews (AARs) change behaviours and action through a process of reflection and of learning from the meaningful moments revealed during discussions of events or incidents. They are intended, not to replace, but to enhance formal clinical incident reporting systems by the use of traditional methods such as story telling to explore and analyse situations. Although AARs are inappropriate for managing staff who have acted unlawfully or unprofessionally, they can ensure that much can be learned from these situations.

**Further reading**

The NHS Evidence website on after action reviews can be accessed at www.library.nhs.uk/knowledgemangement/viewResource.aspx?resID=70306

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