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|  | **Organisation logo** |

After Action Review (AAR) summary report

**When you have finished writing your report, do remember to delete all guidance in the blue information boxes and green text.**

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| **Notes on the AAR summary report template** This template standardises the reporting of AARs. It is not intended to be an AAR facilitation guide. The template has been co-designed with staff leading AARs in a range of healthcare organisations. The structure is purposefully simple so that AARs can focus on reflective conversation and do not become a bureaucratic documentation exercise. This structure will continue to be evaluated and developed by the National Patient Safety Team.**General writing tips** An AAR report must be accessible to a wide audience and make sense when read on its own. Assume the report may be shared both internally and externally.Refer to the [Learning response review and improvement tool](https://www.hssib.org.uk/education/learning-response-review-and-improvement-tool/) when reviewing this summary report. The report should: * use clear and everyday English whenever possible
* explain or avoid technical language
* use lists where appropriate
* keep sentences short
* avoid including tick boxes to demonstrate compliance (for example, with Duty of Candour).
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| Safety event ID: |  |
| Date of AAR: |  |
| Facilitator name: |  |
| AAR participants | If sharing externally you may wish to only record participating departments and professional groups |

# About After Action Reviews

An After Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement. AARs are structured around four questions:

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| 1. **What was expected?** Participants describe what they would expect to happen in situations such as this.
2. **What actually happened?** Participants describe what they did, saw or experienced during the event.
3. **Why was there a difference?** Participants explore what got in the way of expectations being met and what enabled expectations to be achieved or exceeded. This includes consideration of the work environment, technology and tools, tasks, people, organisation and external influences.
4. **What has been learnt?** Participants describe what they have learnt – this may be about themselves, about the team(s) and/or about the wider organisational context that influenced the event.
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AARs are led by trained facilitators and follow the guidance set out in the [Patient Safety Incident Response Framework](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/) and in the national [patient safety incident response standards](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-5).

Further information on AARs are provided in the ‘AAR essentials’ table at the end of this report.

# Safety event summary

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| **Notes on writing the ‘Safety event summary’** Add a brief, plain English description of the safety event. Use third person language and do not include people’s names.  |

# Scope of AAR

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| **Notes on writing the ‘Scope of AAR’** Add a brief, plain English description of why the AAR was held. This may be no more than one or two sentences or a bullet point. In some cases, multiple AARs may be called in relation to a single safety event, and the scope of the AAR may change over time. For example: * The AAR was called to learn from a patient fall that resulted in a late diagnosis of a hip fracture.
* The AAR was called to learn from family engagement following a patient’s fall that resulted in a complaint.
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# Key learning points

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| **Notes on writing the ‘Key learning points’** This section can be completed as text or using a bullet point list.The discussion will have been structured by the four questions, but it is not necessary to capture verbatim the discussion under each question. Do not use language that directly or indirectly infers blame of individuals, teams, departments or organisations and/or focus on human failure – for example, the nurse failed to follow policy. Instead use system focused language – for example, we learned that there were challenges in following the policy in practice, because…, we learned that out of hours a number of factors affect the quality of escalation, including…Focus on what happened and how it happened, and **not** what people, departments or organisations could or should have done during or before the event. Include adaptations, trade-offs or behaviours that helped everyday work. |

# Outputs

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| **Notes on documenting ‘Outputs’**It may be helpful to share insight gathered during an AAR with other groups across the organisation (for example, at a monthly governance meeting, weekly matron meeting, ward safety huddle). The person taking responsibility for sharing insight and at which meeting should be defined in the first table below. No actions may arise from an AAR. However, when **actions within the sphere of control** of the participants are agreed, these should be described and a responsible lead named. Any areas for improvement **outside the sphere of control** of the participants to be shared with oversight groups should also be defined. As well as these outputs, participants may identify learning for themselves (for example, about their behaviour or way of interacting with colleagues). These are valuable outputs from an AAR but do not need to be detailed in the AAR report. Refer to the [safety action development](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf) guide for further information on developing actions.  |

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| Where to be shared | Responsible lead |
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Who else needs to know about this learning?

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| Actions | Responsible lead |
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Individual and team actions within the sphere of control of participants

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| Area for improvement  | Responsible lead |
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Areas for improvement outside the sphere of control of participants to be shared with oversight groups

**Attach the ‘Essentials of AAR’ on the next page when sharing this report. You might also want to send it to AAR participants ahead of the AAR and share it widely on your intranet.**

# Essentials of AAR

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| **AAR is** | **AAR is not** |
| A method for enabling an open and honest conversation about an event that can be used on its own or as part of a wider suite of methods  | The same as an investigation  |
| A debrief for those involved, led by a skilled facilitator  | A meeting undertaken by an untrained person  |
| Primarily for those directly involved in an event although others may attend if helpful to aid learning | A managerial meeting about an event without those directly involved present |
| A conversation structured around four AAR questions that is allowed to evolve for the purpose of learning | A bureaucratic documentation exercise to collect information about an event to be reported through governance structures |
| An opportunity to involve patients, families and carers in the learning conversation providing doing so maintains a psychologically safe space for all those affected | A space where patients, families and carers are expected to attend without considering the psychological safety and welfare of all those affected |
| A psychologically safe space where people can speak openly without fear of blame or judgement  | A debrief that drifts into a scrutiny of people’s actions and decisions  |
| A space where all those present are heard and all contributions are valued equally, irrespective of rank or status | An opportunity for a few individuals to ‘have their say’ and dominate the conversation |
| Focused on exploring ‘work as done’ by asking ‘What would you **expect** to happen? | Focused on what **should have** happened (for example, as described in policy and protocols) |
| A debrief that **may** result in a written document that summarises collective learning and is written in the third person (we learnt that….) | A minuted meeting where information shared by participants in the AAR is detailed in a written report  |
| An opportunity to talk about everyday work and the lived reality and experiences of participants  | A place where people are judged or blamed for the expectations and experiences that they describe |
| A space to understand the perspectives and experiences of those in the room | A space for rigid exploration and theming of different elements of a ‘work system’ (that is, organisation, work environment, task, technology and tools, external influences, person) |
| An opportunity to develop and agree actions that can be agreed and enacted by people participating in the review | An opportunity to dictate actions for others to complete |
| A space to highlight concerns about the wider system that may need to be shared with and taken forward by relevant safety/governance groups | A place to decide actions outside the sphere of control of those present |