# Life in the slow lane: making hospitals safer, slowly but surely

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## Summary

Recognition that serious deficiencies in mutual respect and team work were hampering safe and effective patient care led to the creation of the cultural change initiative described here. We feel this has widespread applicability to other healthcare settings. The After Action Review (AAR) concept was adapted for use in the NHS for the first time as it provides a deceptively simple vehicle to structure healthy blame free team interactions with the aim of improving practice and team behaviours. The organizational and psychological barriers to being able to do this in multi-professional teams are accentuated by the hierarchical nature of the clinical context, but this project has begun to make lasting change so that AAR is an approach that is now widely understood and frequently used.

This year sees the 12th anniversary of the publication of 'An Organization with a Memory', the Department of Health report published with a foreword by the then Secretary of State for Health, Alan Milburn.[1] Based upon 8.5 million inpatient episodes, an estimated 850,000 admissions were associated with harmful adverse events of which an estimated 50% were preventable. This seminal report demanded a fundamental re-thinking of the way the NHS approaches the challenge of learning from adverse healthcare events. Much has been accomplished as a result of this and subsequent publications. However, one of the fundamental principles espoused in this document has been worryingly hard to embed. Changing the culture within organizations so that teams are open to learning, willing to acknowledge where lessons have been learned and put changes into practice is still far from being the norm. 'The biggest lesson learnt over all these years is that there is invariably more emphasis on analysis than implementation, on elegant prescription than on specific curative actions'.[2] Here we describe the 'After Action Review' concept, a deceptively simple team process for changing culture and enhancing openness. We explain the process of implementation in one NHS organization and illustrate the substantive impact that can be anticipated if all members of healthcare teams participate in such a process.

## The impetus for change

In 2004, the NPSA said 'it is vital that we confront two myths that still persist in healthcare:

Trust for their support of the AAR programme

> The perfection myth: if people try hard enough, they will not make any errors; and the punishment myth: if we punish people when they make errors, they will make fewer of them.'[3]

This message is reinforced by research undertaken at the Lucian Leape Institute at the National Patient Safety Foundation in the USA 'too many healthcare organizations fit James Reason's definition of the "sick system syndrome." They are hierarchical and deficient in mutual respect, teamwork and transparency. Blame is still a mainstay solution.'[4] Four years ago, a group of senior leaders within University College London Hospitals NHS Foundation Trust (UCLH) acted on the realization that these issues were present and active in their own organization. Bullying and blaming behaviours were impacting on safe and effective care. They commissioned the University College London Hospitals NHS Foundation Trust (UCLH) education service to be the 'change agent' to tackle the people and relationship issues and gave it the freedom to work in innovative and imaginative ways. Change leadership expert, Kotter,[5] says successful major transformation requires a clear compelling statement that is easy to communicate. The After Action Review (AAR) communicates a simple concept, in both word and deed, that we will prioritize learning over blaming. Another key principle from Kotter[6] that has underpinned this project is that lasting change is only achieved if actively managed over a significant period of time; in our case, we choose the slow lane.

## After Action Review

Originating in the US Army 30 years ago, the AAR has been adopted by other armed forces and rescue services and moved into the business world. It has been described as 'arguably one of the most successful organization learning methods yet devised'.[7] The education service adapted the AAR for use in healthcare settings for the first time as it structures the healthy team behaviours of listening and asking questions and uses the 'free lessons'[8] of everyday events, as well as serious incidents to improve services. The added advantage of the AAR is its simplicity, universality and scalability; anyone can lead an AAR and as the US army demonstrate, it has the potential to become a way of life, where individuals or platoons routinely reflect on how things did or did not go according to the way they planned and what they might do the same or differently next time, without the need to find fault with others.

To bring the AAR alive to hospital staff, a multiprofessional training programme was designed using filmed experiential methods to enable staff to become skilled in leading AARs, to see the limits to the blame model and crucially to become leaders in the organization for change.

AARs are applicable to almost any event, clinical or otherwise, and whilst the emphasis is on learning after less than perfect events, AARs after successful experiences can also provide rich benefits. Prerequisite to the success of a formal AAR are a few key ingredients, including a trained 'conductor', a suitable safe private environment, allocated time and the assumption of equality of everybody present. Every AAR follows the same structure with the conductor getting agreement for the ground rules at the outset and ensuring everyone is clear about the specific purpose of the AAR and the four apparently simple questions to be used. (Box 1)

It is made clear at the outset that the first two of the questions will be asked of each participant so that people do not need to compete for airtime. Most reviews of events, whether formal investigations of a serious incident or informal conversations, begin with the retelling of the story of what actually happened. The AAR takes a different starting point, one which is usually less emotive and therefore, more constructive in commencing an open discussion. Each member of the team in the AAR is asked 'What did you expect to have happen?' The 'expect' here can describe the normal process, the protocol, or the expectation of the individual about what should happen.

**Box 1**

The Four After Action Review Questions

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

When this question is posed, there is often a pause, whilst the individual retrieves the information from their long term memory. Sometimes the participant registers surprise as they realize the assumptions that they were operating under before the event. With this may come a realization that other participants may have different but equally valid expectations or assumptions. The much more complete picture which emerges is one which is powerful in getting team members to have insight into each other's position and to identify system weaknesses.

Once the conductor is satisfied that all aspects of participants' expectations have been explored and each has contributed what actually happened from their own experience, then the conductor invites the AAR participants to discuss why they thought there was a difference between these two aspects. The generation of ideas of how things might be done differently in future follows easily once the participants have the full picture of the event and are engaged in realizing what they have learnt. This is when the conductor moves into facilitating the group to reach agreement on the best of the solutions they have created and enables decisions to be made on the actions to follow.

It is essential that participants in an AAR feel psychologically 'safe' to speak and participate. The personal risk in revealing oneself and one's actions to others is immense and not to be underestimated. It was observed that once AARs became embedded in military settings, an environment even more explicitly hierarchical than healthcare, senior officers voluntarily disclosed poor behaviour or decisions and began to expect scrutiny about their actions from the junior ranks. This practice was embraced because it was improving the effectiveness of the mission or task. Until such a cultural shift has occurred in healthcare, the AAR Conductor plays an important role in actively discouraging those behaviours associated with hierarchy in order to facilitate the safety and equality of everybody present. In practice, higher status individuals are more likely to speak and to do so for longer in a group context and therefore AAR Conductors are trained to ask all participants the same questions and to encourage everybody to contribute equally. This principle must be applied if the team are to co-create workable solutions. The research is very clear that enabling staff to contribute to deciding what might work better in future, creates energy and ownership for change in a way that imposed solutions do not. At the heart of the AAR philosophy, and a fundamental reason why it was chosen, is this approach to involving all staff in taking responsibility for their own contribution to the team's past and future performance.

## Implementation of After Action Review

Although on the face of it a very simple tool to use, implementing the initiative has been anything but straightforward and has involved a blend of courage and foolhardiness as well as deep insight into the components required for generating a lasting cultural shift. In this 'initiative weary' world, a new tool to help staff learn to do it better for patients when less than perfect events have happened was always likely to meet resistance. Add the time constraints that most staff operate under and the fluid nature of clinical teams, and you have some idea of the barriers to introducing an 'improve through experience' model.

Even after attending AAR training, once staff move away from the theoretical concept to the present reality of an AAR occurring in their own clinical or team setting, the response can be surprisingly hesitant. The culture of attaching blame to others for the problems which we encounter in everyday work is a 'comfort zone' which we all show varying degrees of reluctance to leave. To leave our default position of others being to blame, means we have to risk the reality that we ourselves may be part of the 'problem'.

Psychologists recognize this as part of normal human behaviour: 'Our attachment to our own sense of rightness runs deep and our capacity to protect it from assault is cunning and fierce. It is hard, excruciatingly hard, to let go of the conviction that our own ideas, attitudes and ways of living are the best ones'.[9] Given that humans find it so difficult to accept the limits to their rightness, how much more complex is the acknowledgment of this in healthcare settings, where individuals have learnt to act according to a professional hierarchy and with acute consciousness of status. What being in an AAR creates, is an

experience of learning together after difficult experiences that is safe enough to actually allow us to adjust our ideas about ourselves, or change our behaviour and engage in discussion about creating better ways of working.

The initial AAR conductor training was opened up to all areas of the organization, every professional group and level of seniority and participants were encouraged to act as 'champions for change' within their departments. To step outside formal boundaries and try something different in any public forum can be difficult for the individual, but to do it in the socially conservative environment of the hospital takes both courage and conviction. Our healthcare settings are full of highly intelligent, highly skilled professionals, but being able to manage the complex dynamics between self, team and the organization for the benefit of patient care requires something else. The 'Demonstrating Personal Qualities' criteria emphasized in the Medical Leadership Competency Framework[10] create a picture of the high level of emotional and social intelligence required to be a clinical leader and deliver effective services. The AAR training is specifically designed to challenge delegates in this leadership domain, to see themselves more clearly in their interactions with others and how their values, position and personality will impact on team functioning. If the feeling and reacting part of our brain, the limbic system, and its accompanying associations, feelings, and impulses can be explored and accommodated, then our staff are better prepared for the reality of leadership. It is not always a comfortable experience, but remaining in the comfort zone is not an option if significant change is to occur.

Crucially, AAR is a democratic tool which can be and is, led by all levels of staff in a very wide variety of contexts within the organization. As the NHS Institute says, 'Acts of leadership can come from anyone in the organization, as appropriate at different times, and are focused on the achievement of the group rather than of an individual'.[10]

Getting to the point in an organization when most staff members are aware of and comfortable with the idea of meeting to discuss difficult experiences has taken time and the careful nurturing of ideas and skills. It has also required many small acts of courage and leadership to do something different. Kotter wrote that cultural change '…… generally demands activity outside formal boundaries, expectations and protocol',[5] and part of the strength of this project was that the energy to drive it forward came from those closest to patients.

Our message, that the last major hurdle to significant improvement in patient safety is within our reach, and involves working in well functioning teams who learn together rather than blame each other, resonates strongly with AAR training delegate's own experiences of a good day at work. In other words, healthcare professionals instinctively know that the secret to getting it right for patients first time around, is good relationships with other people. The 'how' to achieve this, through using the AAR tool and its principles, can only be achieved if the simplicity of the four AAR questions is overlaid with an understanding of the complexity of context in which hospital staff operate and which might prevent them from engaging in the process.

## The Impact of After Action Review

There is evidence that AAR is in widespread use throughout UCLH, although the AAR methodology itself means that the level of AAR activity is hard to capture accurately. Being largely paper free and supremely adaptable, staff will recognize an AAR as both a 5-minute talk about the care of a neonatal patient which did not go according to plan, and a 2-hour review of a major departmental relocation. AAR is understood by staff as being a specific intention to seek learning out of a shared event rather than find fault and apportioning blame. Fifty-three percent of externally reported serious incidents last year had an AAR conducted, as well as the formal investigation, so that all those involved could identify immediate issues, create some collective insights and contribute to the wider investigation. Several other hospital Trusts or teams within other organizations have recognized and understood its value to improve the dialogue around difficult events and the benefits for collaborative learning, and have invested in AAR training for their staff.

In a survey at UCLH, out of 160 respondents (of a cohort of 800 staff who had attended AAR training), 72% said that they have participated in an AAR and 50% said that they have led one.

Forty-nine percent have seen or participated in an AAR that made a clear difference to patient care. Interestingly, 57% of these delegates reported feeling more confident since attending training about discussing ways of preventing errors from happening again. Sixty-five percent of delegates felt that AAR benefited the Trust because it increases effective communication and improves their own listening skills. While there are limits to the widespread applicability of such self report surveys, these figures and numerous anecdotal reports indicate the potential of the training itself and the AAR tool, to provide staff with a meaningful alternative to the status quo.

Over ten years ago, Professor Marc de Laval speaking to the Public Inquiry into Children's Heart Surgery at Bristol Royal Infirmary said 'whilst regretting them, we must all learn to treasure mistakes….it means an abandonment of the easy language of blame in favour of commitment to understand and learn. It calls for significant leadership'.[11] The need for 'significant' leadership who can create highly functional teams which learn together and maintain their resilience to stress is only going to grow in these difficult times. Yet the pull to revert to familiar behaviours when under stress is ever present, so the AAR training programme is still very active. Four years in the slow lane has taken us a long way forward but there are many more years ahead of us.

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