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SWARM Huddle

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
"A novel rapid approach to RCAs [root cause analysis]… to establish a consistent approach to investigate adverse or other undesirable event" (Jing Li et al 2015)	After any event where patient safety was at risk	No more than 30 minutes	Normally chaired by a senior lead who generates a report	There is some research literature on its use in healthcare	People directly involved in the incident

STRENGTHS?

- Immediate learning occurs with early actions identified.
- Connecting immediately after event may reduce social isolation/ ruminating/stress for staff.
- Evidence shows it can increase the reporting of incident.
- Quick and responsive.
- Quick and easy to undertake so increases likelihood of being done.
- Reduces key information being lost by its immediacy.

WEAKNESSES?

- Scope of learning narrowed by limits on who is participating.
- Learning is focused on a single event rather than the interactions in the system that come with wider participation.
- Psychological safety is assumed to be present so full participation may not be achieved.
- It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.
- Weak governance arrangements for tracking actions and collating learning through many SWARMs.

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MDT Review

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours	Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme	No specific research on the structures, processes and outcome of MDT reviews has been carried out	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

STRENGTHS?

- The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
- Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.

WEAKNESSES?

- Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence.
- Whilst participants will contribute and learn, it is not the specific purpose of the activity.
- It is a planned event and it may take many weeks to set up and ensure full MDT representation is available.
- Resource intensive to undertake.

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After Action Review (AAR)

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating	Led by a trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants	Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety	Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included

STRENGTHS?

- The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
- Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement.
- It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.
- It is highly adaptable, suitable for a wide range of events.
- Psychological safety is actively created and maintained throughout.
- Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.

WEAKNESSES?

- Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority.
- There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR.
- Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

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Patient Safety Incident Investigation (PSII)

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research & evidence available to confirm its efficacy?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how	When there has been serious harm to a patient or patients	20 to 80 hours, over several weeks	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report	Extensive research has been undertaken into the structures processes and outcomes of PSII across the world	People directly involved in the incident and senior clinicians

STRENGTHS?

- It is a well-established approach which is widely recognised and valued by patients and their families.
- PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified.
- Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements in each provider.

WEAKNESSES?

- Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed.
- Outcomes are less system focused than other tools.
- The quality of PSIIs varied before PSIRF mandated training for investigators.
- Staff are only involved when they are interviewed and this can feel very stressful.

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Further Reading

- iTS AAR Case Studies
- Patient Safety Learning Hub
- iTS AAR LinkedIn Articles

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