

Evaluation of After Action Review process in PSIRF in Maternity Clinical Governance

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Objective

The implementation of After Action review in the follow up of adverse events in Maternity clinical governance in our hospital has been received with mixed emotions. Apprehension about a 'new system,' fear of blame culture and hierarchy are the few factors contributing to this unease. The aim of the study is to evaluate the effect of implementation of AAR undertaken in our organisation on staff satisfaction and safety culture.

Design

This is a prospective study in progress to be conducted for 18 months at Oxford University Hospitals NHS foundation trust. The study is done via an anonymous online survey which will be sent out to all staff who participated in the AAR process in our organisation.

Method

There have been 10 AARs between October 2023 to March 2025 for events which had an adverse outcome. Online questionnaires were sent to all the healthcare professionals (40) who participated in the AAR process. We received 26 responses. The questionnaire included 10 elements, which were based on staff participation, the ease of the process, whether they were able to honestly share the experience and contribute without fear of blame or retribution and whether they feel that the learning obtained has the potential to have a positive impact on patient and staff safety. The survey was completely anonymized with the aim of achieving impartial view of the team members.

Results

Did you know what an AAR was when you received intimation to attend one?



Did you feel comfortable to open and honestly share your experience?



Do you think everyone had equal opportunity to speak and express themselves?



Three quarters

of the respondents were apprehensive regarding the AAR process; similar number of people felt they could openly share their experience

96% respondents felt that there was learning from the AAR process, and it will be useful for reducing future incidents of adverse outcomes

Three quarters of the participants think AAR process will help reduce the effect on second victims during incidences with adverse outcome



88% participants felt AAR will help improve the safety culture within the organisation

Discussion

AAR is a Quality and Safety innovation process involving patient safety incidents and culminating in achieving following outcomes

1. Service – Enhanced safety culture and enhanced organizational support for second victims
2. Staff and Patient – Improved second victim experience and reduced adverse events.

Conclusion

After Action Review (AAR) is a non-hierarchical facilitated structured discussion of a serious event and our results were promising, highlighting the fact that 96% participants felt it will be useful in reducing future incidents of adverse outcome. Our study results can motivate various organisation to implement this practice in their maternity clinical governance process for stronger patient and staff safety.

Reference

McCarthy SE, Keane T, Walsh A, Mellon L, Williams DJ, Jenkins L, Hogan C, Stuart C, Rafter N. Effect of after action review on safety culture and second victim experience and its implementation in an Irish hospital: A mixed methods study protocol. PLoS One. 2021 Nov 18;16(11):e0259887. doi: 10.1371/journal.pone.0259887. PMID: 34793495; PMCID: PMC8601442.