Leadership

The after-action review, adapted for the operating theatre

For aesthetic services in India that want international patients to trust them, it is one of the quieter disciplines that separates a busy theatre from a team that improves.

The after-action review, adapted for the operating theatre

An after-action review for a surgical team is a short, structured conversation held soon after a list ends, in which the people who did the work compare what was planned with what actually happened and agree who will change what.

Where the method sits, and what it is not

NHS England's patient safety learning response toolkit lists the after action review among its learning response methods, alongside the swarm huddle, the multidisciplinary team review and the patient safety incident investigation.

Attach it to the end of the list

The WHO Surgical Safety Checklist asks the whole team to pause at three points: before anaesthesia, before incision and before the patient leaves the operating room. That final pause concerns the patient on the table.

Four questions, in order

I would ask four questions and keep them in sequence, because skipping ahead to fixes is the usual way these conversations fail. What did we plan?

The facilitator should not be the most senior clinician in the room. I would train theatre coordinators and operations staff to facilitate, and ask the most junior person present to describe what happened first.

Across a network, read the actions rather than the scores

A single theatre can improve on its own. A network of clinics needs something more: a shared log where every action from every review lands in the same place. The pattern worth finding is repetition.

What an overseas patient gains from a meeting they never attend

A patient who travels to India for an aesthetic procedure will never sit in a theatre review.

The full method

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