Guidance for Peer-Review Visits: Working-Age Adult Services (AIMS-WA/AIMS-AT)

February 2018

Contents

Introduction

The primary role of Peer-Review Teams is to carry out Peer-Review Visits to NHS and independently-funded inpatient mental health services in the United Kingdom. This guidance is for all members of Review Teams, and for those services being reviewed (Host Teams).

This document should be read with reference to the following documents:

- AIMS Standards (for the type of service being reviewed)
- AIMS Accreditation Process
- Peer-Review Booklet (for the service being reviewed)

The AIMS Accreditation Process

The Peer-Review Visit is just one part of the accreditation process, which has three stages:

- Self-Review
- Peer-Review
- Royal College of Psychiatrist's Combined Committee for Accreditation (CCA)

Self-Review

Services being Peer-Reviewed will have already completed their Self-Review, using the College Accreditation and Review System (CARS) and the following data collection tools:

- Senior Clinicians Checklist
- Health Record Audit
- Questionnaires:
  - Carer Questionnaire (abbreviated to CQ in the Peer-Review Booklet)
  - Patient Questionnaire (PQ)
  - Staff Questionnaire (SQ)

The Peer-Review Booklet is compiled from the Self-Review data. The booklet needs to be completed on CARS using the login details provided to you when you were registered.

Peer-Review

The data gathered from the Self-Review is compiled into the Peer-Review Booklet, which forms the basis of the Peer-Review Visit. The Peer-Review Visit:

- takes place on one day;
- involves a visiting team of five – two or three professionals (one of whom will be designated Lead Reviewer; at least one of whom will be a nurse) and one CCQI Service User and/or Carer Representative with Working Age Adult Inpatient experience
- is primarily a means to validate the results of the Self-Review.

The Peer-Review Visit enables service staff to demonstrate the quality of their service, will enable the sharing of information and advice, and will contribute towards a service's accreditation rating. Peer-Review Teams therefore have an essential role in assuring a successful visit, which is supportive to service staff and which aims to enthuse and educate.

The Peer-Review Visit is **not** an inspection.

During and following the Peer-Review Visit, the Peer-Review Booklet is amended to include the Peer-Review Team's comments

Combined Committee for Accreditation

The results of both the Self-Review and Peer-Review are then discussed by the Combined Committee for Accreditation (CCA). The CCA:

- consists of representatives from key stakeholder and professional bodies;
- reviews the results of the Self- and Peer-Review;
- decides an accreditation status for the service.

Roles and Responsibilities of Peer-Review Teams

Each member of a Peer-Review Team must have undergone Peer-Review Training at the Royal College of Psychiatrists' Centre for Quality Improvement. Reviewers will be expected to undertake two to three Peer-Review Visits each year; where possible these will be in the reviewer's local area.

The primary responsibilities of members of Peer-Review Teams are:

- **to validate the Self-Review data**;
- to provide the service being reviewed with opportunities for discussion;
- to share ideas and suggestions with the service being reviewed;
- to give advice and support;
- to feedback comments or suggestions regarding the review process to the Project Team;
- to help to promote AIMS to existing and potential members.

It is most important to remember that **the Peer-Review visit is NOT an inspection:**

- it enables service staff to demonstrate the quality of their service;
- it enables the sharing of information and advice;
- it contributes toward the service's accreditation rating.

Train tickets for travelling to Peer-Review Visits must be booked and expenses should be claimed back from your Trust/Organisation. All reasonable expenses incurred for Service User and Carer Representatives however should be booked via the AIMS-WA project Team who will contact such reviewers in advance to make arrangements. Expenses will also be reimbursed according to the policy of the Royal College of Psychiatrists.

Service User and Carer reviewers also receive payment for their time, again according to the policy of the Royal College of Psychiatrists.

The AIMS Standards

[NB: All examples given in this booklet are from the Working-Age Adult standards.]

Before attending a Peer-Review Visit, reviewers should be familiar with the relevant set of AIMS Standards for the type of service being reviewed, and in particular the three Types of standards:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
- **Type 2:** standards that an accredited ward/unit would be expected to meet;
- **Type 3:** standards that an excellent ward/unit should meet or standards that are not the direct responsibility of the ward/unit.

Type 1 Standards are highlighted in the Peer-Review Booklet in **BOLD**. Regardless of whether the Self-Review data states that these standards are 'Met' or 'Not Met', reviewers must either:

1. Verify that the data is accurate and note this in the Peer-Review Booklet, or;

2. Decide that the data is not accurate and change the Peer-Review Booklet accordingly.

Where Type 2 and Type 3 Standards are concerned, it will not be possible for members of Peer-Review Teams to look at every standard. Peer-Review Teams should therefore focus on where standards are 'Not Met', or where the Self-Review data indicates possible inconsistencies. If, upon speaking to the service staff, carers or patients, reviewers decide that the Self-Review data is not accurate, they should change the score in the Peer-Review Booklet accordingly and supply a comment.

Before the Peer-Review Visit

All reviewers will receive the following:

- the Peer-Review Booklet;
- contact details for the other members of the Peer-Review Team and the service being reviewed;
- a copy of this guidance;
- an expense claim form for Honorary Lead Reviewers, Service User and Carer Representatives only.

Reviewers should read through the Peer-Review Booklet, highlighting areas they would particularly like to discuss at the Peer-Review Visit, in particular:

- Type 1 Standards that have not been met;
- any other standards that have not been achieved 100%;
- areas of inconsistency in the Self-Review data.

Reviewers may wish to contact other members of the Peer-Review Team to flag up these areas. The Lead Reviewer should co-ordinate this and is also responsible for making contact with the service in advance of the Peer-Review Visit to finalise arrangements.

At the Peer-Review Visit

All reviewers should bear in mind the following at the Peer-Review Visit:

- Ensure accurate and comprehensive data are recorded – a scribe and time-keeper (where possible) should be appointed for each session of the day.
- Provide constructive criticism as well as positive feedback to service staff.
- Keep sessions on-time and focused.
- Ensure reviews are supportive to service staff.
- Ensure reviewers work together as a team.
- Ensure an open-minded approach to the review day.

Reviewers should also ensure that they **DO NOT** do the following:

- Don't suggest an accreditation rating on the day – this is for the CCA to decide.
- Don't discuss your own service or your own experiences at the expense of discussing the service being reviewed.
- Don't let one person dominate the discussions (either another reviewer or someone from the service being reviewed).
- Don't judge the people – judge the data.
- Service User and/or Carer reviewers should not conduct any portion of the review day alone – they must always be accompanied by at least one professional reviewer.

Always alert the AIMS-WA Project Team on the day if a serious problem is identified:

- Inform the Host Team that a problem has been identified.
- Inform the Host Team that this will be fed back to the AIMS Project Team and explain that the normal procedure in these circumstances is for the AIMS Project Team to give the ward a stated amount of time to rectify the problem.
- Advise the Host Team that the AIMS Project Team will be in touch very shortly with further details of this process.

After the Peer-Review Visit

At the end of the Peer-Review Visit, the Lead Reviewer should collect all the reviewer copies of the Peer-Review Booklet. They should then collate everyone's notes and comments into one copy, photocopy it, and return the completed Peer-Review Booklet to the AIMS-WA Project Team within three working days.

The Lead Reviewer should also consider contacting the other members of the Peer-Review Team to de-brief, particularly if there were any aspects of the Peer-Review Visit that were difficult. The project team will email out a feedback form for the Peer-Review Team to complete, this should be done by all members of the team, as it is vital feedback that contributes to the development and continual improvement of the Quality Network.

Key Points

- The Peer-Review Visit is just one part of the accreditation process.
- Its primary goal is to validate the Self-Review data.
- Amend the booklet if the Self-Review data is not accurate.
- Be supportive at all times.

NB: Peer-Reviewers and DBS Checks

The CCQI Human Resources Department ensures all CCQI project staff who attend peer-reviews have valid DBS checks. The Network assumes that peer-review team staff members have valid DBS checks by virtue of being employed in mental health settings and review members' employment details are provided in peer-review packs. The Network assumes that service users and carers who may form part of the peer-review team do not necessarily have valid DBS checks. Those members of the peer-review team who do not have valid DBS checks will be accompanied by a local member of staff or a checked visiting team member when in proximity with service users or other vulnerable people.

Lead Reviewers

In addition to the general responsibilities described above, the reviewer designated as Lead Reviewer is responsible for:

- contacting local staff and the rest of the Peer-Review Team in the lead-up to the Peer-Review Visit;
- introducing the day and explaining the role of AIMS;
- allocating roles to other reviewers, including a scribe for each session of the day;
- finalising the timetable for the day;
- ensuring one complete Peer-Review Booklet is posted back to the AIMS Project Team within three working days of the review;
- commenting on the resulting draft report.

Please see Appendix 2: Lead Reviewer Checklist.

Preparing for the Peer-Review Visit – Guidance for Host Teams

Once a Host Team has scheduled the date of their Peer-Review Visit, they should begin to make preparations for the day itself. Of particular importance are the following:

- Ensure that all members of staff are aware that the visit will be taking place, what the day will – and will not – involve, and when their attendance at specific times in the day will be required (details below).

- Designate members of staff to conduct the various sections of the day, in particular:

    - who will lead the tour for the Environment and Facilities Review;

    - who will lead the Health Records Review.

- Make sure that suitable rooms are available for each section of the day.

- Make sure that lunch and refreshments are organised for the day.

- Where possible, ensure that patients are aware that the visit will be taking place, what the day will – and will not – involve, and that they are invited to join the Patient Meeting: you may wish to consider inviting recently-discharged patients (within the last two months) to attend this meeting, if acuity levels are such at that current patients will find this meeting difficult. One patient should also join the tour for the Environment and Facilities Review.

- Ensure that Carers are invited to attend the Carer Meeting, if the time is not suitable for carers to attend and to ensure minimal disruption to Carers' employment, where relevant, please inform the project team as soon as possible and we may be able to make some adjustments to the timetable, where possible

- Host Teams should consider offering to cover travel expenses for Carers (and recently-discharged patients, if you are inviting any).

Once a Host Team is in receipt of its Peer-review Booklet, they should:

- Ensure that photocopies of the Peer-Review Booklet are made and disseminated to all relevant members of staff (a PDF version will be emailed to the Host Team).
- Highlight areas that will need to be discussed on the review day. It is vital that Host Teams read this guidance, so they know exactly what the Peer-Review Team will be looking for (e.g. Not Met Type 1 Standards, areas of inconsistency).

<u>IMPORTANT INFORMATION FOR HOST TEAMS</u>

The Peer-Review Visit is your opportunity to make changes to your Self-Review data.

If your Self-Review data is indicating that a standard is Not Met, but you have evidence to show that the standard *is* Met, you must provide this evidence on the day of the Peer-Review Visit for it to be validated by the Peer-Review Team.

Peer-Review Timetable and Booklet

Timetable

Appendix 1 is a suggested timetable for Peer-Review Visits. Host Teams may make adjustments to the timetable if necessary, to suit their own working day, but it is important that the project team and/or the Lead Reviewer is notified as soon as possible in advance of the visit of significant changes.

Changes to the start and end times should be avoided, as reviewers may have already made transport arrangements.

The project team will also discuss any final adjustments with the Host Team in advance of the Peer-Review Visit and will communicate any changes to the Lead Reviewer (if external to the AIMS-WA project team) and to the rest of the team.

Booklet

The Peer-Review Booklet is divided into sections, relating to the data collection tools used in the Self-Review, and each section has at least one dedicated slot in the Peer-Review Timetable. At the end of each section, there is space to note areas of achievement and action points.

When working through the booklet, please focus on:
- Type 1 Standards;
- any unmet standards;
- any areas of discrepancy.

It is important to note that many standards are informed by more than one data source (see Example 1 from Ward Manager Questionnaire). If there is more than one source of data, it may not be immediately obvious whether a standard is 'Met' or 'Not Met' as the data may highlight inconsistencies. This is an example of a standard which should therefore be flagged up for discussion. Since the discrepancy is between the Ward Manager and the Staff, the standard should be discussed during these two meetings. Following this, the review team should make a judgement and decide whether the standard is Met/Not Met.

Example 1: Ward Manager Questionnaire and Staff Questionnaire Data

1.30 [1]	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	**Met**		
	AIMS WA Staff 2017: Q72 Have you received an annual appraisal and personal develo...	22 answers: 19 (86%) Yes 3 (14%) No		

IMPORTANT INFORMATION FOR PEER-REVIEWERS

Where an additional source of data comes from either the Patient or Carer Questionnaires, these standards will appear twice within the booklet. In Example 2 below, in the Senior Clinicians Checklist section of the booklet informs that this question was posed to Carers as part of the Carer Questionnaire
. Reviewers should therefore use the feedback obtained during the Patient Meeting to inform this Checklist standard, and mark the decided Met/Not Met decision within the Checklist section as per the instruction '[See Checklist]'.

Example 2: Duplicated Senior Clinicians Checklist and Carer Questionnaire Data

Senior Clinicinas Checklist Section:

2.47 [2]	The team provides each carer with a carer's information pack. *Guidance: This includes the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	**Met**		
	AIMS WA Carer 2017: CQ4 Were you provided with a carer's information pack?	4 answers: 4 (100%) No		

Introductory Meeting – Review Team

Staff Required – Essential	Staff Required – Desirable	Facilities Required
Ward/Unit Manager	**Other members of the MDT**	• **A comfortable, quiet, private room large enough to accommodate the Review Team and the Host Team** • **Tea and coffee.**

At the beginning of the day, the Peer-Review Team will meet together for 15 minutes, and then meet with the Host Team during the Morning Brief for introductions, timetable review and preliminary questions. The Ward/Unit Manager must be in attendance during the Morning Brief and other members of the MDT are welcome to attend, although this is not compulsory.

Host Teams should provide a comfortable, quiet, private room large enough to accommodate both the Review Team and the Host Team. It is recommended that this room be kept available throughout the day, for the regular Review Team Meetings and the Final Meeting. Refreshments should be provided for the Introductory Meetings, and Final Meetings.

In the meeting with the Host Team, the Review Team will particularly cover the following:

- The Peer-Review Visit is just one part of the accreditation process
- The purpose of the visit is to validate Self-Review data, provide the opportunity for discussion, to share ideas and suggestions and to give advice and support. It is *not* an inspection.
- The Peer-Review Team will be able to give feedback at the end of the day, but *will not be able to suggest an accreditation level*.
- Any last-minute amendments to the timetable that might be necessary.
- Each section of the day centres on a section of Self-Review data, and discussion will focus on two main areas:
    - Type 1 Standards;
    - any other standards that have not been met 100%.

Tour of the Unit

Staff Required – Essential	Staff Required – Desirable	Facilities Required
• **1 qualified nurse** • **1 patient**	**None**	**Access to all areas of the service**

During this part of the day, the Peer-Review Team will be assessing the ward on the Environment and Facilities. One qualified nurse and one patient (wherever possible) will take the Review Team on a tour of the service. It is important that the Review Team has access to all areas of the ward/unit, and that other patients are aware that the tour is taking place.

As it may be difficult to write descriptive notes in the Peer-Review Booklet during this tour, it is advisable that reviewers do the following in advance of the Peer-Review Visit:

- highlight the 'Not Met' standards, and ensure that these are discussed;
- read the Self-Review Comments – they may answer some of the questions reviewers have.

Where applicable, reviewers must remember to make Met/Not Met decisions whilst considering the feedback obtained from the patient/carer meetings, as per any guidance note.

<u>Please note that if the ward ever uses seclusion and the seclusion room is located elsewhere on site, it must be viewed by the Peer-Review Team.</u>

Example 3: Environment & Facilities Audit

4.49 [2]	All patients have access to lockable storage, which may include their own individual rooms or access to a safe on the ward/unit.	**Met**		
	AIMS WA Patient: PQ26 Are you able to lock items away, either in your own room or to a safe on the ward?	0 answers:		

Ward/Unit Manager Questionnaire

Staff Required – Essential	Staff Required – Desirable	Facilities Required
Ward/Unit Manager	**None**	**A comfortable, private room large enough to accommodate the Review Team and the Ward/Unit Manager, preferably with access to a computer.**

Two members of the Peer-Review team will meet with the Ward/Unit Manager to discuss the results of the Ward/Unit Manager Questionnaire and the Self-Review data. A training matrix should be accessible during this meeting, as this may be required to evidence/verify any staff training.

The training matrix should be used in conjunction with the self-review data to support the Met/Not Met decisions made for this section.
For the Ward Manager Questionnaire, the Review Team should focus on Type 1 standards, Not Met standards, as well as any areas of discrepancy.

The Peer Review team must amend the Staff Training percentages in the booklet to state whether the standard is Met or Not Met.

Patient and Carer Questionnaires:

Patient Meeting

Patients Required - Essential	Others Required - Desirable	Facilities Required
3 patients (minimum)	• **As many other patients as possible** • **An independent advocate**	**A quiet, comfortable, familiar room, within easy reach of service staff.**

Carer Meeting

Carers Required – Essential	Carers Required - Desirable	Facilities Required
2 carers (minimum)	**As many other carers as possible**	**A quiet, comfortable room.**

Two meetings are scheduled on the Peer-Review Timetable to discuss the results of the Patient and Carer Questionnaires. It is important that reviewers keep these sessions as informal and non-threatening as possible and allow the patients and carers the opportunity to talk. No members of service staff, or anyone employed by the service or Trust, must be present at these meetings. If Carers are unable to attend to the Carer Meeting, then the Host Team are required to make arrangements for Carers to be available by phone, so that the Peer-Review Team can contact them at a time suitable to them. Any amendments must be made clear to the Peer-Review team during the Morning Brief.

Comments from the Patient and Carer Questionnaires relate to the questions immediately above, and these may explain some of the responses given (please see example 5).

Example 5: Patient Questionnaire

2.11 [1]	On admission to the ward/unit staff members introduce themselves and other patients.	**Met**		
	AIMS WA Patient: PQ1 Did staff members introduce themselves and other patients to you when you were admitted?	0 answers:		
	AIMS WA Staff 2017: Q37 On admission to the ward/unit, do staff members introduce themselves and other patients?	2 answers: 2 (100%) Yes		

During these meetings, the review team should work through the questions set-out in the document "Questions and Guidance for Patient/Carer Meeting", which are based some of the the Type 1 standards from the booklet. The Peer-Review Team should also ask any additional questions that they think are relevant relating to pieces of information that have been flagged up based on the self-review data.
Some questions within the patient and carer sections also appear within other areas of the booklet, with a guidance note detailing where (see Example 5). In these instances, the review team should ensure that feedback obtained from patients/carers is used to inform the overall standard decision, which should be recorded in the section referenced by the guidance note.

Example 6: Carer questionnaire

4.68 [1]	Patients and carers are offered written and verbal information about the patient's mental illness. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.*	**Met**		
	AIMS WA Carer 2017: CQ10 Were you offered written and verbal information about the patient's mental illness?	0 answers:		
	AIMS WA Patient: PQ47 Were you offered written and verbal information about your mental health condition?	0 answers:		

Having covered all the questions in the separate guidance document, the Review Team should invite patients and carers to share any compliments or concerns they have about the service, including anything on their 'wish list', and these should be appropriately noted as areas of achievement/action points.

Senior Clinicians Checklist and Policy Documentation Review

Staff Required – Essential	Staff Required – Desirable	Facilities Required
Ward/Unit Manager **Other senior members of the MDT (e.g. Consultant Psychiatrist, lead OT etc.)**	**Senior members of the MDT**	**A comfortable, private room large enough to accommodate the Review Team and the Host Team**

The Review Team will meet with the Host Team to discuss the Checklist. The Ward/Unit Manager and other senior members of the MDT must be present in this meeting, together with as many other senior members of the MDT.

In this section, reviewers should concentrate on:

- Type 1 Standards;
- areas of inconsistency.

One professional member of the review team should use this time to review the documentation provided and note the Met/Not Met decisions.

The other members of the review team should discuss the remaining standards. Upon reaching a conclusion, reviewers must fill in the shaded boxes with 'Met' or 'Not Met', and note any comments they wish to make in the 'Peer-Review Comments' box.

Example 7: Senior Clinicians Checklist

1.31 [1]	The ward/unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee.	**Met**		
	AIMS WA Senior Clinicians: Q9 The ward/unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee.	0 answers :		

Where applicable, reviewers must remember to make Met/Not Met decisions whilst considering the feedback obtained from the patient/carer meetings, as per any guidance note.

Staff Questionnaire

Staff Required – Essential	Staff Required – Desirable	Facilities Required
• **2 qualified nurses** • **2 unqualified nurses** • **1 occupational therapist (if applicable)** • **1 pharmacist (if applicable)**	**As many members of the MDT as possible**	**A comfortable, private room large enough to accommodate the Review Team and the Host Team**

Please be aware that the staff meeting should not include management or senior personnel (e.g. Ward Manager, Modern Matron, Consultant Psychiatrist, Lead OT, etc.). Please ensure that this is outlined during the Morning Brief with the Host Team, and that this is checked through introductions during the staff meeting. Senior personnel should instead attend the Senior Clinicians Checklist meeting.

The job titles/designations of those who responded to the Staff Questionnaire are noted at the head of this section.

For this section, in the Self-Review, staff members and the Ward/Unit Manager were often asked the same question. Reviewers should compare the answers given by both. In some cases, patients or carers were asked similar questions, and reviewers should particularly pay attention to those standards where the staff and/or Ward/Unit Manager are saying one thing and the patients/carers another.

Where applicable, reviewers must remember to make Met/Not Met decisions whilst considering the feedback obtained from the patient/carer meetings, as per any guidance note.

Example 8: Staff Questionnaire

1.36 [1]	All staff members receive monthly line management supervision.	**Met**		
	AIMS WA Staff 2017: Q78 Do you receive monthly line management supervision? :	2 answers: 2 (100%) No		

Please note that the Friends and Family Test is not related to any standards, and is included to provide context, and a point of interest/discussion.

Having covered all necessary standards within the booklet, the Review Team should invite staff to share any compliments or concerns they have about the service, including anything on their 'wish list', and these should be appropriately noted as areas of achievement/action points.

Health Record Audit

Staff Required – Essential	Staff Required – Desirable	Facilities Required
1 qualified nurse	**None**	**A suitable room with a computer (if applicable)**

The purpose of this meeting is to discuss and verify results of the audit of patient notes completed at self-review. The Review Team should use this meeting to ascertain any improvements made to the service's Health Records or record-keeping systems since Self-Review, particularly where the data indicate that Type 1 Standards are Not Met.

Host teams can demonstrate their record keeping in different ways depending on their systems (electronic or paper-based): through presentation of anonymised case notes, demonstration of training modes for electronic record systems, results of internal audits, copies of local forms (e.g. admission checklists) etc. If Trust/Organisation information sharing protocol permits, host teams can use patient's case notes to demonstrate the structures in place.

The Review Team will focus on the standards highlighted within the booklet as less than 100% Met (see example 9). Having received the booklet, the Host Team should be prepared to discuss and appropriately evidence the systems in place regarding these, highlighting any changes/improvements made since self-review.

In the Self-Review, services were asked to include comments where the answer was 'No' or 'N/A' – these are included directly below the Self-Review results. The Review Team should check whether these answers are appropriate, i.e. checking that a 'No' response isn't actually 'N/A' (see example 9).

Type 1 standards must be 100% to be designated as 'Met'. If the percentage is less, the standard must be discussed, and a satisfactory notes system evidenced. If the peer-review team agrees that enough information is provided to evidence compliance with the standard, it can be designated as 'Met'.

Example 9: Health Record Audit

The aims of admission are agreed among the referring team, the ward/unit team and the patient and carers.	**Met**	
AIMS WA Carer 2017: CQ3 Were the aims of admission to this ward discussed with you?	4 answers: 3 (75%) Yes 1 (25%) No	
AIMS WA Patient: PQ8 Were the aims of admission to this ward agreed with you?	10 answers: 7 (70%) Yes 2 (20%) Can't Remember 1 (10%) No	

Where applicable, reviewers must remember to make Met/Not Met decisions whilst considering the feedback obtained from the patient/carer meetings, as per any guidance note.

Final Meeting/Final Summary

Reviewers should collate all the areas of achievement and action points from each section, summarise these on the 'Final Summary' page and feed back to the service staff at the Final Meeting.

Any Type 1 standards that are Not Met MUST be noted as action points, and this MUST be given as feedback during the final meeting, as well as any suggestions for improving these areas. The Host Team will be able to begin working towards these standards, and the AIMS team will provide support regarding how to appropriately evidence any changes made.

If anyone from the service being reviewed has comments about the visit, or anything else to do with the Accreditation Process, reviewers should note these in the 'Feedback from Host Team' box.

Example 8: Final Summary

FINAL SUMMARY
Areas of achievement.
Action points.
FEEDBACK FROM HOST TEAM
Feedback received from the Host Team at the Final Meeting.

Trouble-Shooting

Although most Peer-Review Visits should run smoothly, there is always a possibility of a difficult situation arising. The following should help reviewers to work through these situations – this list is not intended to be exhaustive, but the techniques outlined should be applicable to most situations.

1. There is a high level of anxiety during the day.

Especially at the beginning of a Peer-Review Visit, both the service being reviewed and the Peer-Review Team may be anxious. The Lead Reviewer needs to sense this and intervene to reduce the anxiety. Indicators of such anxiety may be silence and passivity in the team briefing meeting, an atmosphere of hostility or monopolising behaviour on the part of staff members or Peer-Review Team members (see below). The Lead Reviewer needs to use the briefing meeting to address this. You may emphasise that the review is not an inspection, that it is confidential and that the primary aim of the day is to provide a mutual forum for exchange and sharing of achievements, ideas and problems.

2. One staff member monopolises the discussion, and other staff allow the dominating member to speak for them.

This possibly indicates a somewhat defensive stance on the part of the staff member or the service being reviewed and can also indicate anxiety about the process. The Lead Reviewer

needs to intervene to attempt to open out the discussion by sensitively addressing this. One tack might be to say that you value what the individual is saying, but are also interested in hearing from the others to get a wider impression. Also, you may direct a specific question to another member of staff. If this fails it could indicate poor inter-staff relations and the Lead Reviewer may want to consider speaking to staff individually. This must be arranged very sensitively as part of the review timetable.

3. A patient monopolises the discussion, doesn't allow other patients to speak or speaks on their behalf, becomes intimidating towards others or is aggressive in any way.

This could occur for a variety of reasons, try the approach mentioned in scenario 2. If this is unsuccessful avoid any escalation of the situation if at all possible. Do not hesitate to ask service staff members to intervene. Do not put yourself or others at risk.

4. A member of the Peer-Review Team monopolises the discussion.

Again, this may show anxiety on behalf of the reviewer, who may also start to behave like an inspector in an overly judgemental way. The Lead Reviewer needs to intervene to attempt to open out the discussion to other members of the review team. It may be worth calling a brief review team meeting to reiterate the aims of the day, timetable etc.

5. A member of the review team makes personal, rude or overly judgemental comments about the service being reviewed.

This is a difficult and sensitive situation to manage and the Lead Reviewer needs to intervene swiftly here. The Lead Reviewer needs to address this by making it quite clear that the aim of the review is to reflect and explore the service in relation to the standards in a supportive non-persecutory way.

6. A reviewer makes continuous comparisons to their own service or their own experiences.

This can be both frustrating and possibly demoralising for the service being reviewed. The Lead Reviewer should intervene and again reiterate the aims of the day and refocus on the service being reviewed in a non-judgemental way.

7. You think that the service may be negligent or carrying out malpractice in the provision of their service.

This needs to be taken seriously and handled with care. Before feeding anything back to the service being reviewed, you should call the AIMS Project Team, at the first available opportunity during the day, to discuss your concerns.

This conversation should create a contingency plan and outline what further actions should be taken. Depending upon the concern, you may need to feed this back to the group at the end of the day with any action that may be taken. You should ensure that you document your concerns and ensure that you discuss the concern the day after the review with the AIMS Project Team, who may seek advice from other sources, and who will then follow up the concern in an appropriate manner.

8. The team does not agree with a standard or strays from the standards.

The Lead Reviewer needs to refocus the group to the standards being reviewed. If either team does not agree with a standard, do not get into a conflict. Document the concerns about the standard and ask the team to contact AIMS after the review day to discuss the standard. If the issue remains unresolved, contact the AIMS Project Team.

9. An essential member of staff is only available for a short time or not at all.

The Lead Reviewer should establish at the beginning of the day who is attending and when, and modify the timetable to ensure essential members of the team are available for pertinent parts of the day. If one essential part of the team is not available at all, it may be difficult for the review to go ahead. The Lead Reviewer should contact the AIMS Project Team to discuss the options.

Contacting the AIMS-WA Project Team

Please contact the AIMS Project Team if you have any questions regarding this guidance, or any other aspect of AIMS:

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Appendix 1: Suggested Timetable

AIMS-WA Accreditation Peer-Review Timetable

Time	Session
9.30am – 9.45am	**Introductory Meeting – Review Team** • Review Team meet for introductions, timetable review and allocation of roles.
9.45am – 10.00am	**Morning Brief** • Review Team meet with Host Team for introductions, timetable review and preliminary questions. • Host unit to give a brief description of their service.
10.00am – 10.45am	**Tour of the unit** • A member of the Host Team and a patient (where possible) take the Review Team on a tour of the ward/unit. • Reviewers will ask questions regarding the environment and facilities based on the Quality Standards.
10.45am – 12.00pm	**Senior Clinicians Checklist** • Members of the review team will meet with senior members of the Host Team to go through the standards in the checklist. **10.45am-11.30am Patient Meeting** • One professional and one Service User Rep meet with patients to discuss their experiences of using the ward/unit. • No members of staff to be present. **11.30am – Noon Documentation Review** • Review Team Member present in the patient meeting, to review the policy documentation.
Noon-12.15pm	**Review Team Meeting** • Meeting is an opportunity for the review team to share their notes and scribe their findings so far. • Lead Reviewer to collate Areas of Achievements and Action Points of the sections thus far.
12.15pm – 13:00pm	**Lunch**
13:00pm-13:45pm	**Staff Meeting** • All of the Review Team meet with frontline service staff. • Validate the self-review staff's questionnaire particularly in relation to the Staff Questionnaires section.
13:45pm – 14:30pm	**Carers Meeting** • One professional and one Carer Representative member of the Review Team meet with carers to discuss their experiences of using the services on the ward/unit. **Health Record Audit** • Two professional members of the Review Team meet with a member of the Host Team who will give a presentation on the service's Health Records/templates.
14:30pm-15:15pm	**Ward Manager Meeting** • 1-2 reviewers will meet with the ward manager to validate standards relating to Ward Manager Questionnaire. • Any copies of the unit policies/protocols and the training matrix that were not seen earlier should be made available
15:15pm-15:45pm	**End of Day Discussion** • Review Team to meet to discuss their findings throughout the day.
15:45pm-16:00pm	**Feedback to the Host Team**

Appendix 2: Lead Reviewer Checklist

Tick ✓ when you have completed each task

Before the review day

- ☐ **Email/call the host team** to introduce yourself and check whether they have any questions or want to make any changes to the timetable
- ☐ **Email the rest of the review team** to introduce yourself – you might like to exchange mobile phone numbers in case you need to contact each other on the day

At the start of the review day

Review Team Meeting:

- ☐ **Allocate roles** for the rest of the review team during the review team meeting.
  - Decide whether you'd like to lead discussions yourself or share this responsibility – you could each lead a section or two of the booklet
  - Ensure at least one person acts as a scribe in each meeting
- ☐ **Introduce the day** and check whether this is anybody's first peer-review: if so, support as necessary and give an overview of the peer-reviewer role.

Host Team Meeting:

- ☐ **Introduce the day** at the first meeting with the host team
  - Encourage everyone in the room to introduce themselves
  - Briefly explain the role of AIMS
  - Remind them that it is not an inspection
  - Encourage openness and honesty, remind staff to make the most of the peer-review and highlight areas they are proud of and areas they would like to improve
- ☐ **Finalise the timetable** – ask the hosts if they want to change anything
- ☐ Ask for a **brief overview of the service** (2-3 minutes)

At the end of the review day

Review Team Meeting:

- ☐ **Ensure <u>all</u> grey boxes** have Met or Not Met written in them
- ☐ **List achievements and action points** for each section

Final Meeting:

- ☐ **Feedback action points and areas of achievement** from each section
  - Ensure that this includes any unmet Type 1 Standards, along with suggested action
- ☐ **Outline** the next steps of the process
- ☐ **Thank the host team**
- ☐ **Collate and return the booklets** (unless a member of the AIMS team is present)

After the review day

- ☐ **Email the review team** to thank them, and debrief if it was a difficult review
- ☐ **Comment on the report's accuracy** when it has been typed up and returned to you by the AIMS team

Appendix 3: Documentation Checklist

Standard	Documentation Required	Reviewer Score (Met/Not Met)	Reviewer Comment
1.1[1] - There are written documents that specify professional, organisational and line management responsibilities.	Documentation outlining professional, organisational and line management responsibilities.		
1.13 [2] Managers audit the implementation of new policies and procedures relating to the ward/unit and provide feedback to MDT staff.	Copy of the latest audit.		
1.31 [1] The ward/unit has clear clinical supervision guidelines which incorporate supervision contracts between supervisor and supervisee.	Copy of the Clinical Supervision guidelines.		
1.64 [1] - There are clear policies and procedures for managing complaints.	Complaints policy and procedures.		
1.65 - Information is available for patients/carers about: - how to make a verbal complaint; - how to make a written complaint; - how to suggest service improvements/enhancements; - how to make a written compliment; - how to make a donation. This is publicised and readily available.	Evidence of the information made available to patients/carers.		
1.72 [1] - Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.	Inter-agency protocols for the safeguarding of vulnerable adults and children.		
1.73 [1] - There are protocols/procedures/strategies in place for the confidential reporting or 'whistleblowing' on abuse or inappropriate care.	Protocols/procedures/ strategies for the confidential reporting or 'whistleblowing'		

1.76[2] When staff members undertake audits they: – Agree and implement action plans in response to audit reports; – Disseminate information (audit findings, action plan); – Complete the audit cycle.	Exemplar copy of the action plans, audit findings and audit cycle.		
1.78 [1] There is support for staff and patients to assist with the smoking policy;	Smoking policy.		
2.1 - Clear information is made available, in paper and/or electronic format, to patients, carers and healthcare practitioners on: - a simple description of the ward/unit and its purpose; - admission criteria; - clinical pathways describing access and discharge; - main interventions and treatments available; - contact details for the ward/unit and hospital.	Evidence of the information made available to patients/carers/health care practitioners.		
2.4 [2] - There are protocols for transfer or shared care between learning disability and generic mental health services.	Copy of the protocols on transfer and shared care.		
2.6 - There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded.	A written copy of this process.		
2.14 [2] The patient is given an age appropriate 'welcome pack' or introductory information that contains the following: - a clear description of the aims of the ward/unit; - the current programme and modes of treatment; - the ward/unit team membership; - personal safety on the ward/unit; - the code of conduct on the ward/unit; - ward/unit facilities and the layout of the ward/unit; - what practical items can and cannot be brought in; - clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds; - resources to meet spiritual, cultural and gender needs.	Copy of the Welcome Pack.		

2.17[1] Patients are given verbal and written information on: – Their rights regarding consent to care and treatment; – How to access advocacy services; – How to access a second opinion; – How to access interpreting services; – How to raise concerns, complaints and compliments; How to access their own health records.	Copies of the information provided to patients.		
2.18 - Detained patients are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.	Evidence of the information provided and records of this being documented.		
2.40 [1] - The ward/unit organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: - assessment; - care and treatment (particularly relating to prescribing psychotropic medication); - referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	Details of the care pathway for the care of women in the perinatal period.		
2.47 [2] - The team provides each carer with a carer's information pack. *Guidance: This includes the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	Copy of the Carer's Information Pack.		
2.49 [1]- The team follows a protocol for responding to carers when the patient does not consent to their involvement.	Protocol for responding to carers when the patient does not consent to their involvement.		
2.53 [1] - There is a standardised process for the assessment of mental capacity, using a formal document/standardised assessment tool.	Copy of the Mental Capacity assessment tool.		

2.54 [1] - There are joint working protocols/care pathways in place to support patients in accessing the following services: - accident and emergency; - social services; - local and specialist mental health services e.g. liaison, eating disorders, rehabilitation; - secondary physical healthcare.	Copy of the joint working protocols/care pathways.		
2.55 [1] - The team follows a joint working protocol/care pathway with primary health care teams. *Guidance: This includes the team informing the patient's GP of any significant changes in the patient's mental health or medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP*.	Copy of the joint working protocol/care pathway.		
2.56 [1] - The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution team in ward/units/units that have access to one. *Guidance: This includes the team inviting the Home Treatment Team to attend ward/unit rounds, to screen for early discharge, to undertake joint acute care reviews and to jointly arrange supported leave.*	Copy of the joint working protocol/care pathway.		
2.60 [2] - The ward/unit has agreed standards for reviews.	A copy of these standards.		
2.74 [1] - Staff members follow a lone working policy and feel safe when escorting patients on leave.	Copy of the lone working policy.		
2.76 [1]- The team follows a protocol for managing situations where patients are absent without leave.	Copy of the protocol for managing situations where patients are absent without leave.		
2.78 [2]- Managers and practitioners have agreed standards for transfer/discharge planning.	Copy of the standards for transfer/discharge planning.		

2.81 [1] - The team follows a protocol to manage informal patients who discharge themselves against medical advice. This includes: - recording the patient's capacity to understand the risks of self-discharge; - putting a crisis plan in place; - contacting relevant agencies to notify them of the discharge.	Copy of the protocol for managing informal patients who discharge themselves against medical advice.		
2.83 [1] - The ward/unit has a referral process for outpatient psychology, CMHT-based or otherwise.	Details of the referral process for outpatient psychology.		
3.1 [1] An audit of the environmental risk is conducted annually, and a risk management strategy is agreed. Guidance: This includes an audit of ligature points.	Copy of the latest audit on the environmental risk management strategy.		
3.2 [1] - The team understands and follows an agreed protocol for the management of an acute physical health emergency. *Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.*	Copy of the protocol for managing physical health in an emergency.		
3.3 [1] - There is a policy on patient safety and the use of therapeutic interventions and observation that includes: - how activities, therapies and staff skill mix are used specifically, to improve patient safety; - how patients are informed about maintaining their personal safety including the use of alarms; - who can instigate observation above the general level and who can change the level of observation; - who should review the level of observation and when reviews should take place (at least daily); - how the patient's perspective will be taken into account; - the process through which a review by a full clinical team will take place if observation above the general level continues for more than one week.	Copy of the policy on patient safety and use of therapeutic interventions and observations.		
3.7 [1] - Staff members follow a protocol when conducting searches of patients and their personal property.	Copy of the protocol on searches of patients and their personal property,		

3.16 [1] - The team audits the use of restrictive practice, including face-down restraint.	Copy of the latest audit on the use of restrictive practice.		
3.20 [1] - The ward/unit has a policy for the care of patients with dual diagnosis that includes: - liaison and shared protocols between mental health and substance misuse services to enable joint working; - drug/alcohol screening to support decisions about care/treatment options; - liaison between mental health, statutory and voluntary agencies; - staff training; - access to evidence-based treatments; - considering the impact on other patients of adverse behaviours due to alcohol/drug abuse.	Copy of the dual diagnosis policy.		
4.6 [1]- There is a visiting policy which includes procedures to follow for specific groups including: - children; - unwanted visitors (i.e. those who pose a threat to patients, or to staff members).	Copy of the visiting policy.		
4.20 [1] - The crash bag is maintained and checked at least weekly, and after each use.	Records to demonstrate that the crash bags are checked weekly.		
4.24 [1] - There is a clear written policy on the use of seclusion, which complies with the MHA and NICE CG25.	Policy on the use of seclusion.		
4.55 [1] - Staff members follow a policy on managing patients' use of cameras, mobile phones and other electronic equipment, to support the privacy and dignity of all patients on the ward/unit.	Copy of the policy on managing patients use of cameras, mobile phones and other electronic equipment.		
5.13 [1] - The team follows a policy when prescribing PRN (i.e. as required) medication.	Copy of the policy for prescribing PRN medication.		
5.14 [1] - The team keeps medications in a secure place, in line with the organisation's medicine management policy.	Copy of the medication management policy.		

5.15 [1] - The safe use of high-risk medication is audited, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*	Copy of the latest audit on the safe use of high-risk medication.		
5.29 - There is a weekly minuted community meeting that is attended by patients and staff members. *Guidance: This is an opportunity for patients to share experiences, to highlight issues on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*	Copies of the minutes from the [2] weekly patient meetings.		
5.55 [1] - Clinical outcome measurement data is collected at two-time points (admission and discharge) as a minimum, and at clinical reviews where possible.	Records to demonstrate clinical outcome measurement data is collected. .		

AIMS-WA/AIMS-AT Staff Training Documentation Checklist

Standard	**Documentation Required**	**Reviewer Score (Met/Not Met)**	**Reviewer Comment**
1.35 [2] All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	Training Records to demonstrate supervisors have completed training to supervise.		
1.43 [1] - All staff members who administer medications have been assessed as competent to do so. Assessment is repeated on a yearly basis using a competency-based tool.	Training Records showing staff who administer medications have been assessed annually as competent to do so.		
1.44 [1] The team receives training consistent with their roles, on risk assessment and risk management. This refreshed in accordance with local guidelines. This includes, but is not limited to, training on: -safeguarding vulnerable adults and children; -assessing and managing suicide risk and self-harm; -prevention and management of aggression and violence.	Training records to demonstrate staff have received training on risk assessment and risk management.		
1.45[2] Staff members can access leadership and management training appropriate to their role and speciality.	Training records showing staff are able to access leadership and management training where appropriate.		
Staff members receive training consistent with their role, which is recorded in their personal development plan and is in accordance with local guidelines. This training includes:			
1.47 [2] Care planning as part of the care management programme including CPA (or local equivalent) and discharge planning;	**Training records demonstrating** staff have received training in care planning.		
1.48 [1] The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent);	Training records demonstrating staff have received training the Mental Health Act and Mental Capacity Act.		
1.49 [1] Physical Health	Training records to show		

Assessment. Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input;	that staff have been trained to conduct physical health assessments.		
1.50 [2] How to assess capacity;	Training records to show that staff have been trained in how to assess capacity.		
1.51 [1] Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities;	Training records to show that staff have been trained in how to Recognise and communicate with patients with special needs,		
1.52 [1] Statuary and mandatory training; Guidance: Includes Equality and Diversity and Information Governance;	Training records to show that staff have received mandatory training.		
1.53 [2] Clinical Outcome Measures;	Training records to show that staff have received training on clinical outcome measures.		
1.54 [2] Carer awareness, family inclusive practice and social systems, including carers rights in relation to confidentiality;	Training records to show that staff have received training on carer awareness, family inclusive practice and social systems, including carers rights in relation to confidentiality;		
1.55 [2] Procedures for assessing carers' needs, ensuring a carers assessment has been completed.	Training records to show that staff have received training on how to follow procedures to assess carers needs.		
1.56 [1] Clinical staff receive training and support from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions (including, but not limited to, conflict resolution/de-escalation, engagement activity scheduling, group facilitation).	Training records demonstrate that clinical staff have received training and support from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions.		
5.37 [1] All staff members who deliver therapies and activities are appropriately trained and supervised.	Appropriate training and supervision records.		

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