Quality Network for Inpatient Learning Disability Services (QNLD)

Review Process Document

QNLD Year II and Accreditation

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Introduction

What is the Quality Network for Inpatient Learning Disability Services (QNLD)?

QNLD is a standards-based quality network that facilitates the sharing of good practice, through a process of standards-based self- and peer-review and provides accreditation. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised. Services are supported to identify areas for improvement and set achievable targets for change.

Accreditation is offered to services that are fully prepared. It is recommended that a minimum of one year's membership is completed on the Quality Network before services transfer to accreditation.

Our Aims

- Enable inpatient learning disability services to engage in service evaluation and quality improvement using standards and methods that are agreeable to service users, carers, frontline staff and clinical and Trust management.
- Provide a strong network of supportive relationships.
- Accredit LD wards/units which offer a timely and purposeful admission in a safe and therapeutic environment against a set of standards.
- Promote best practice through shared learning and networking.

What we do

- Develop specialist service standards in consultation with members incorporating requirements and recommendations set out nationally.
- Manage the self- and peer-review cycles with an emphasis on quality improvement.
- Provide detailed local reports which identify action points and areas of achievement.
- Publish an aggregated report which presents an overview of collective performance, identifies common themes and allows for benchmarking.
- Host a number of events and opportunities for members to share their experiences, learn from others and gain support.
- Create a national network to support staff through to engage in quality improvement.

The QNLD standards

The third edition of the standards for the Quality Network for Inpatient Learning Disability Services (QNLD) was developed from key documents and expert consensus as well as drawing from previous editions of the standards and the Standards for Inpatient Mental Health Services[1].

The full set of standards are aspirational and it is unlikely that any ward would meet all of them. To support their use in the accreditation process, each standard has been categorised as follows:

- **Type 1:** criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;

- **Type 2:** criteria that a service would be expected to meet.

Note: In the event that QNLD finds evidence that the unit being reviewed threatens the safety, rights or dignity of patients, the Trust (or other organisation) will be informed in writing, and is expected to take appropriate action. If the Royal College of Psychiatrists is not satisfied that appropriate action has been taken, it reserves the right to inform the relevant regulatory body.

The standards have been used to generate a series of data collection tools for use in the self- and peer-review processes.

There are several data collection tools because it is important that each standard is evaluated using the most appropriate method(s) and source(s) of information. The methods are described more fully in the following which describe the phases of the accreditation process.

The College Website

LD wards/units which are members of the network and accreditation scheme will be listed on the Royal College of Psychiatrists' website (www.rcpsych.ac.uk/qnld). Once a final accreditation rating has been awarded, this will be posted on the website next to the LD ward/unit's name.

[1] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/corestandardsproject.aspx

Membership pathway

Generally, QNLD members initially sign up for a three-year membership which incorporates two annual cycles of review (QNLD Year I and QNLD Year II) and an Accreditation cycle. Members who joined the accreditation scheme initially but aren't performing up to the accreditation standards are encouraged to join the quality network to familiarise themselves with the standards and review process before attempting accreditation. Units who feel confident that they can meet the data collection and standard requirements can skip the quality network process and join accreditation directly. Members are encouraged to speak to the Project Team first if they feel this is the route they would like to take.

This document includes information about the review processes for QNLD Year II and Accreditation.

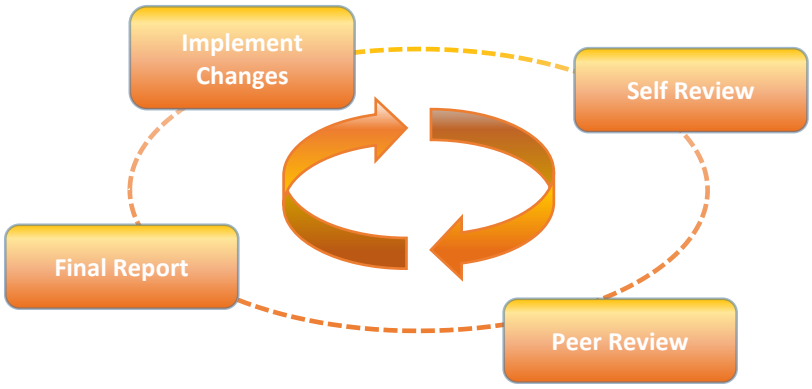
The Review Cycle

QNLD Year II

The QNLD Year II format follows the same format as the accreditation process and is intended to help members fully understand what is required once they progress to accreditation, and to identify any deficits in practice that might be barriers to accreditation.

Units are required to complete a self-review which includes feedback from patients, carers and staff, a senior clinician's checklist, an environment and facilities checklist, and a health record audit. A summary of the results from the self-review will inform discussions at the visit by the peer-review team.

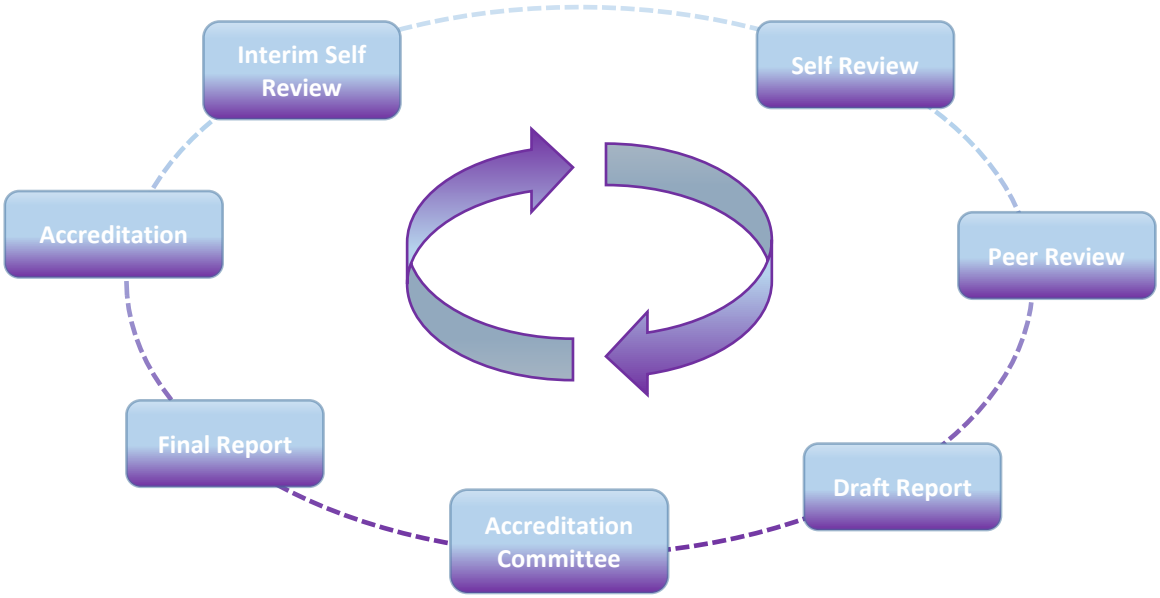
The peer-review visit covers all sections of the standards and meetings with different groups (senior clinicians, front line staff, patients and carers) take place as they would at an accreditation visit. This ensures the ward is familiar with the process and has identified any areas of improvement before taking part in a full accreditation cycle.



Accreditation Process

Members who successfully complete QNLD are invited to join the accreditation scheme. This is also possible for new member wards whose service is confident that they can meet the data collection and standards requirements. The time from entering the accreditation stage to a ward/unit's accreditation status being decided will be between six and nine months, assuming that data are collected and returned within the timeframes set out (see Appendix 2).

There are three main stages to the review process: self-review, a peer-review visit, and a decision about accreditation status. An interim self-review takes place 18-months after accreditation to ensure the service is still meeting the relevant standards.



Phase 1: Self review

The first part of the review process is the self-review. The unit will complete a number of data collection tools measuring themselves against all areas of the standards. Units have a three-month period to carry out their self-review and the process is designed to provide a framework for the unit team to holistically assess the quality of the service they provide, to identify its strengths and weaknesses. It is also an opportunity for the service to prepare for the external peer review and become familiar with the standards. It provides a space to reflect on service provision and acts as a useful team building opportunity.

The self-review toolkit includes the following questionnaires and checklists:

1. Carer questionnaires - Carers will return these themselves, directly to the QNLD Project Team, using the 'Postage Paid' envelopes provided. (Target return: 5)
2. Patient questionnaires - Patients will return these themselves, directly to the QNLD Project Team, using the 'Postage Paid' envelopes provided. (Target return: 2/3 of expected patient throughput over the three months).
3. Staff questionnaires (Target return: 100% of the ward staff team).
4. Senior clinicians' checklist including policies, procedures and protocols.
5. An audit of health records (Target return: 2/3 of expected patient throughput over the three months).
6. An environment and facilities checklist.

The data collected in the self-review is collated into a peer review workbook, which will form the basis of the review day. This workbook will be sent to the visiting peer-reviewers in advance of the visit so that they can familiarise themselves with the key issues raised. In order to get the most out of the self-review, it is recommended that protected time is set aside to ensure questionnaires are completed and submitted online via the QNLD links before the timelines set.

Key things to do at self-review:

- Arrange suitable time(s) when senior clinicians and managers can come together to work through the self-review checklists, scoring themselves against the criteria.
- Identify areas of particular achievement and areas for improvement and describe them at the end of each questionnaire. This will highlight practice that your review team may wish to learn from or be able to support you with.
- Ensure you complete the self-review toolkit by the deadline agreed with the QNLD project team.

Phase 2: Peer-review day

The purpose of the one-day visit by a peer-review team is to validate the self-review findings, provide a valuable opportunity for discussion, and for the review team members to share ideas, make suggestions, offer advice and give support.

The peer-review visit will be scheduled for six to eight weeks after the self-review data has been returned. Staff from other participating units will be invited to act as members of peer-review teams, and the team will typically consist of four or five members (including at least two professionals and one service user and/or

carer). The team attending accreditation visits will have undergone training at the Royal College of Psychiatrists' Centre for Quality Improvement.

Review visits which are cancelled by the ward/unit will incur a charge of £800 +VAT per day, as will reviews that are cancelled due to insufficient collection of data at self-review. Review visits which are cancelled by the Project Team, or due to extenuating circumstances, will not incur a charge.

Phase 3: Accreditation decision

The Project Team will draft the report based on self- and peer-review data and will highlight the unit's strengths and areas for improvement. Once this has been verified by the review team who visited the ward/unit and the host team, it will be taken to the next meeting of the Accreditation Committee (AC), which meets quarterly, where they will consider the data and award an accreditation status for the unit.

There are three categories of accreditation status:

Level 1: "accredited"

The unit would *at the point of peer-review*:

- meet all Type 1 standards;
- meet at least 80% of Type 2 standards, with no significant gaps in any particular section of the standards;

Accreditation at Level 1 is valid for up to three years, subject to satisfactory completion of interim self-review.

Level 2: "accreditation deferred"

The unit would *at the point of peer-review*:

- fail to meet one or more Type 1 standards but demonstrate the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 standards but demonstrate the capacity to meet the majority within a short time.

Level 3: "not accredited"

The unit would *at the point of peer-review*:

- fail to meet one or more Type 1 standards and **not demonstrate** the capacity to meet these within a short time;
- fail to meet a substantial number of Type 2 standards and **not demonstrate** the capacity to meet these within a short time.

The final report and accreditation certificate

Once a unit has been accredited, an electronic copy of the final report will be sent to the unit (a bound hardcopy can be sent upon request), and their accreditation status will be listed on the Royal College of Psychiatrists' website. The unit will be accredited for up to three years from the date of the meeting of the Accreditation Committee at which the accreditation was awarded. Accreditation certificates are initially issued for 18 months only. Upon successful completion of the interim self-review, a second certificate for the full accreditation period will be issued automatically, unless there are any significant changes. Please see the section 'Interim Self-Review Assessments' for more information.

Appeals process

The grounds for an appeal against a decision about accreditation category are that:

- the decision has been made on the basis of a summary report that contains **factual inaccuracies** about the evidence provided at the time of the review, and/or;

- the decision is not consistent with stated criteria that determine categories of accreditation.

Appellant services that wish to make representations with regard to their accreditation must initially submit them in writing to the Project Team within eight weeks of the accreditation decision having been communicated to the local QNLD lead. Appellants are asked to provide documentary evidence to support claims of factual inaccuracy and/or a clear statement of in what way(s) they consider the decision to be inconsistent with the stated criteria for the category of accreditation awarded. A detailed description of the stages of the appeals process is available on request.

Phase 4: Interim Self-Review assessments

In order to maintain their level of accreditation and ensure that accredited wards/units are continuing to meet standards, they are required to undertake an interim review, 18 months from the first accreditation committee meeting at which the ward/unit was considered. Units which fail to submit adequate interim self-review data may be considered for Category 3 (not accredited) accreditation decision.

Units are assessed using the most up to date version of the standards available, even if this is different to the version they were initially accredited on. This is to ensure that accredited units are continuing to meet the highest levels of best practice.

If an accredited unit does not meet one or more Type 1 Standards, the unit will be required to provide evidence that they have addressed these. If satisfactory evidence cannot be provided, they will have their accreditation suspended by the QNLD Programme Manager for a specified period in order to meet them. If a unit fails to meet the required standards within the specified time frame, the AC will reconsider their accreditation, recommending Category 3. The unit will then be asked to return their accreditation certificate. If a unit successfully meets the Type 1 Standards within the specified time period, the accreditation will be reinstated.

The Project Team or AC may require an additional peer-review visit if the interim data indicate a significant drop in the number of standards being met since accreditation was achieved. This will be charged at a rate of £800 + VAT.

The Peer-Review Day

Hosting a Peer-Review Team

The Peer Review takes a whole day. The timetable for this can be found in Appendix 1. If there are any problems with the proposed schedule, please let the project team know before the day of the review to discuss any potential changes that can be made.

Key things to do at peer review

- Choose a review date that enables maximum participation from staff members, patients and carers.
- Inform all team members about the visit as soon as your peer review date is confirmed by the Project Team, and make sure they understand its purpose and how they can contribute.
- Ensure members of your team are able to attend all or part of the review day. Make arrangements for bank staff or managers to cover frontline staff during the staff meeting.
- Inform service users about the review day, ask if they would be willing to take part, and let them know that the day involves a tour of the unit, to minimise any disruption this might cause. The review would love to speak to as many people as possible but understand that clinical priorities must come first.
- Liaise with carers/family members to inform them about the day and ask if they would be willing to attend a carers meeting to talk about their experience of the service.
- Prepare any documents and policies the review team will need to see on the day to ensure the Health Records Audit and Review of Documentation are completed within the allocated time. The project team will send you a list of what these documents are before your review.
- Arrange suitable rooms, facilities, food and refreshments for the review day.
- Invite members of the senior management team or hospital management to the feedback session.

Attending a Peer-Review visit

Visiting another service on their peer-review day allows individuals to share ideas about how their own service operates and assist the host team in problem solving. It also allows staff to gain insight into how other services function and how aspects of this may be applied to their own team's operations. This is one of the most important aspects of the review process, where valuable lessons are learned from hearing about good practice elsewhere. Dates of peer-review visits will be disseminated by the project team and staff will be able to choose the units they would like to visit, subject to availability.

The QNLD Year II peer-review team is made up of three members of staff (one medical, one nurse and an additional MDT representative) from other units taking part in the quality network cycle. The review team will be accompanied by an experienced lead reviewer from the QNLD project team/network.

The accreditation review team is made up of trained peer-reviewers of which two are professionals with LD experience, plus a service user or carer representative.

The role of the peer-reviewer is to:

a) Validate the results of the host team's self-review.
b) Engage with the host service in reflective discussions about their practice against the standards in the workbook, highlight areas of achievement and support them to think about areas for improvement.
c) Enquire and comment on improvements from previous cycles.
d) Contribute to the written record of the visit.
e) Review and comment on the accuracy and clarity of the draft local report during the consultation stage.

Before the visit the peer-review team should:

a) Receive a Peer-review Pack containing:
   - a copy of the host service's peer-review workbook;
   - a summary of their previous report (if applicable);
   - the timetable for the day.

b) Receive an email containing:
   - an electronic copy of the peer-review workbook and previous summary report (if applicable);
   - Contact details for the lead reviewer.

c) Receive a phone call or email from the lead reviewer who will introduce themselves and answer any questions you might have about the day.
d) Note that the peer-review workbook and previous reports are confidential and should not be shared.
e) Look through the workbook and make notes on issues you want to explore or clarify further, e.g. do the scores match the comments next to them?

f) Read the previous years' summary report (if applicable) paying particular attention to action points identified at last review.
g) Prepare a brief outline of your service to share with the host community during the introduction to the day.
h) Be familiar with the structure of the day.

On the day of the review the team should arrive on time. There is a lot to fit into the day and keeping to the schedule is important. If a reviewer is running late it is important that they contact the unit to let them know.

In the briefing session the lead reviewer will outline the process, introduce you to the rest of the team and what to expect for the day.

In the introduction to the day the peer-review team should:

- Briefly introduce themselves and their service. It may help the service being visited if you share any challenges that you are facing at the moment in order to help them relax and understand the supportive nature of the peer-review process.
- Support the host service to share information by asking questions.
- Spend some time exploring progress the service has made since the last cycle.

In the senior clinicians and managers' meetings the peer-review team should:

- Check the self-review scores agree with your observation and discussion through exploration and reflection.
- Spend some time exploring progress the service has made since the last cycle (if applicable).
- Ask questions of the host team to help them explain the challenges they have been facing, and what they have tried to do to overcome them so far.
- If possible, try and provide the host team with examples of ways they might try to overcome these challenges based on your experiences.
- Remember that you are not invited to contribute as an 'expert' or 'consultant', but as peers.
- Take notes of conversations and action points to discuss later.

In the patient and carer meetings the peer-review team should:

- Pay special attention to scores that are not fully met and ask questions to help clarify through exploration and reflection.
- If possible, try and provide the host team with examples of ways they might try to overcome these challenges based on your experiences.
- Remember that you are not invited to contribute as an 'expert' or 'consultant', but as peers.
- Take notes of conversations and action points to discuss later.

In the review of documentation the host team will have prepared a list of documentation to be checked (the list is provided by the project team).

- One professional member of the review team will review policies and documentation.
- The service user/carer representative will review documentation relating to service users/carers (e.g. welcome pack).
- The review team can ask for additional documentation/evidence if needed to score a standard.

The health records review is opportunity to verify the health record system used by the service.

Wards can evidence their record keeping in different ways depending on their systems, for example:

- presentation of anonymised case notes;
- demonstration of training modes for electronic record systems.

Please note that if the service has not prepared for this meeting, reviewers will have to see live patient records.

In the final review team meeting the peer-review team meet in private to:

- Discuss their observations and the points to be raised in the feedback session.
- Assist the lead reviewer to complete the workbook which means scoring the standards and ensuring that there are relevant comments to justify the scores.
- Identify areas of particular achievement and areas for improvement, suggesting SMART action points where possible.
- Produce a final summary to present to the host team.

In the feedback session the peer review team should:

- Thank the host team for their hospitality.
- Give brief feedback, noting aspects of the unit's practice against the standards that are areas of particular achievement, and offer suggestions for actions that the unit could take in order to improve their performance against the standards next year.
- Use this time to reflect on the experience of the day with the host service.

After the review, the QNLD project team will draft the report based on all the comments and scores from the day with the peer-review comments clearly identified. You will also be sent a feedback form or link to a feedback form on line. Please complete this as your feedback is valuable in ensuring that the process remains alive and relevant for everyone.

Troubleshooting

Most peer-reviews run smoothly and are an enjoyable and stimulating experience, but if any problems arise on the peer-review day it is the lead reviewer's responsibility to try and resolve them. If you have any concerns about anything you see or are told on the review, please highlight these to the lead reviewer.

How can you become more involved?

Standards revision

QNLD undertakes a regular revision and update of standards to take account of new developments and to encourage continual quality improvement. Once the updated standards have been published, all member services will be informed via email. Services are assessed against the set of standards that were in place when they commenced their self-review until the point of accreditation. Subsequent reviews are based on whichever set of standards is currently in place. If you would like to be part of the standards revision group, please contact the project team.

Join the LD email discussion group and Royal College of Psychiatrists social media platforms.

Staff from member units will have access to advice and support from the Royal College of Psychiatrists, and their peers through our email discussion group. Members will also receive relevant updates from other CCQI projects such as upcoming events and special interest information. Any member of staff from a member unit can join the group by emailing L.D@rcpsych.ac.uk with the word 'Join QNLD' in the subject line.

Join a peer-review team

Part of membership to QNLD is the expectation that staff from participating services will visit other services as members of review teams. This will normally involve spending a day at a unit and commenting on a draft of the unit's report. In order to attend a visit as a reviewer, staff, service users and carers must attend a reviewer training day. These take place at least twice a year, with dates advertised via the email discussion group. Upcoming reviews in need of professional reviewers will also be advertised through the discussion group and it is expected that staff from member services take part in at least one review every year.

Appendix 1

QNLD Year II and Accreditation review day timetable

9.15	**Introductory Meeting – Review Team** The Review Team meets for introductions, timetable review and assignment of roles	
9.30	**Introductory Meeting with Host Team** 10 minutes: Introductions, timetable review and preliminary questions 10 minutes: Host Team provides a brief overview of their service and main challenges and achievements over last year	
9.50	**Environment and Facilities Review** A member of the Host Team takes the Review Team on a tour of the service and answers questions	
10.40	**Review Team Meeting** The Review Team meets in private to consider recommendations following the Environment and Facilities Review	
11.00	**Senior Clinicians Meeting** Two professional members of the Review Team meet with senior clinicians and managers to discuss the results of the Senior Clinicians Checklist	**Patient Meeting (11.00am-11.45pm)** One professional and one Service User/Carer member of the Review Team meet with patients without service staff **Review of documentation (11.45-12.30pm)** The same team reviews policies/ documentation
12.30	**Review Team Meeting** The Review Team meets in private to consider recommendations following the Senior Clinicians Meeting, Patient Meeting and review of documentation.	
13.00	Lunch (this must be provided by the Host Team)	
13.40	**Staff Team Meeting** All of the Review Team meet with all available service staff to discuss the results of the Staff Questionnaire	
14.30	**Health Records Review** Two professional members of the Review Team A member of the Host Team will give a presentation on the service's Health Records and answer questions	**Carer Meeting** One professional and one Service User/Carer member of the Review Team meet with carers without service staff
15.15	**Review Team Meeting** The Review Team meets in private to consider recommendations following the Staff Team Meeting, Health Records Review and the Carer Meeting. The Review Team will also discuss the Final Summary. Refreshments should be provided for this meeting	
16.00	**Final Meeting** The Review Team and Host Team will meet to discuss the areas of achievement and action points. The Host Team will feed back to the Review Team	
16.30	**Close**	

Appendix 2

Accreditation Cycle – example only, assumes January start

<table>
<tr><th colspan="2"></th><th>Review Cycle</th><th>Accreditation Status</th></tr>
<tr><td rowspan="12">Year 1</td><td>January</td><td rowspan="3">Self Review</td><td rowspan="6"></td></tr>
<tr><td>February</td></tr>
<tr><td>March</td></tr>
<tr><td>April</td><td rowspan="3">Peer Review</td></tr>
<tr><td>May</td></tr>
<tr><td>June</td></tr>
<tr><td>July</td><td rowspan="3">Accreditation Meeting</td></tr>
<tr><td>August</td></tr>
<tr><td>September</td><td rowspan="6">*Accreditation starts from date of committee when successful accreditation decision is made.

Accreditation Period

First 18 months</td></tr>
<tr><td>October</td><td rowspan="9"></td></tr>
<tr><td>November</td></tr>
<tr><td>December</td></tr>
<tr><td rowspan="11">Year 2</td><td>January</td></tr>
<tr><td>February</td></tr>
<tr><td>March</td></tr>
<tr><td>April</td></tr>
<tr><td>May</td></tr>
<tr><td>June</td></tr>
<tr><td>July</td></tr>
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<tr><td>September</td></tr>
<tr><td>October</td></tr>
<tr><td>November</td></tr>
<tr><td>December</td><td rowspan="2">Interim Self Review</td></tr>
<tr><td rowspan="11">Year 3</td><td>January</td><td rowspan="11"></td><td rowspan="12">Accreditation Period

Second 18 months

(Subject to successful completion of interim self-review)

*Accredited status runs for three years from the date of the first committee the service was discussed at, including deferral decisions.</td></tr>
<tr><td>February</td></tr>
<tr><td>March</td></tr>
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<tr><td>November</td></tr>
<tr><td rowspan="12">Year 4</td><td>December</td></tr>
<tr><td>January</td><td rowspan="3">Self Review
*re-accreditation</td></tr>
<tr><td>February</td></tr>
<tr><td>March</td></tr>
<tr><td>April</td><td rowspan="3">Peer Review</td></tr>
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<tr><td>September</td><td rowspan="2">Accreditation Period</td></tr>
<tr><td>October</td><td></td></tr>
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