RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QNOAMHS
QUALITY NETWORK FOR OLDER ADULT MENTAL HEALTH SERVICES

Quality Network for Older Adult Mental Health Services

Member Information Pack Accreditation

March 2022

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
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Contents

Introduction

Welcome to the Quality Network for Older Adult Mental Health Services (QNOAMHS).

This pack is aimed at the person or persons within your service who will take the lead in the ward's accreditation process. It should help you to understand what is expected of you and what will happen throughout the self-review process, accreditation visit and other expectations of membership. If you have any questions, please do get in touch with the project team (details below).

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Background

The Quality Network for Older Adult Mental Health Services (QNOAMHS) works with wards and units providing services to older people to assess and improve the quality of care they provide. QNOAMHS engages staff, patients and their carers in a comprehensive process of self and peer review to enable services to identify areas of good practice and areas for development. Member services are encouraged to use peer review visits, and other member events, to share knowledge and ideas with others, thereby creating a mutually supportive environment which encourages learning, and leads to positive change. QNOAMHS also offers accreditation for those members who can demonstrate a high level of compliance with the standards.

The 5th edition standards are drawn from key documents and expert consensus, as well as from the 4th edition, and work completed within the College Centre for Quality Improvement (CCQI.) The standards have been subject to extensive consultation with multidisciplinary professionals involved in the provision of inpatient mental health services, and with experts by experience and carers who have used services in the past.

Sustainability Principles

This edition of QNOAMHS standards have also been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put the mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a focus on reducing the impact on the environment and the resources used in delivering health interventions. A Sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013) In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.'

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability, i.e., the resources needed for each

intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health.)

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care, e.g., emails instead of letters, tele-health clinics instead of face-to-face contacts. Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. . **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective team working facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will **not** affect the accreditation status of the service.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care.
Please see below for further information:

- Guidance for commissioners of financially, environmentally, and socially sustainable mental health services
- Choosing Wisely – shared decision making
  http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx

- Centre for Sustainable Healthcare
https://sustainablehealthcare.org.uk/

- Psych Susnet
  https://networks.sustainablehealthcare.org.uk/network/psych-susnet

Role of the Project Lead

As project lead there are a number of tasks for you to complete throughout your involvement with the project.

- Disseminate information from QNOAMHS to your service
  - It is important that everyone who works in the service, current service users and carers are aware of the fact that you are going through the accreditation process, what this means and what is expected of them.
  - As lead you will receive updates and information about the wider network (including events) please share these with the rest of your team, as appropriate.

- Maintain contact with the network team
  - The project team will contact you throughout your membership - please respond promptly.
  - If your details change or you are no longer the best person to contact as the project lead, please let the network team know.
  - If the ward is moving or undergoing any major changes that may affect your accreditation process, please contact the network team with details.

- Arrange the date of your accreditation visit
  - The project lead is responsible for arranging a date that all key staff are able to attend. You will then need to make sure that all staff and current service users are aware of the date and given the opportunity to attend.

- Ensure that your self-review (including all questionnaires) is completed on time

- Prepare for your accreditation visit

  - For more information, please see the Accreditation Visit section of this pack.

- Nominate reviewers and ensure that they attend reviews for other services
  - Your service is required to provide professional reviewers to attend at least two older adult reviews every year. Travel costs for attending reviews must be covered by your service.
  - Professional reviewers are categorised as Nursing, Medical or MDT (all other staff). You should have trained reviewers from at least two of these categories.
  - All professional reviewers have to attend training before they attend accreditation visits. If you do not have any trained reviewers or would like to train more, please contact the project team to find out when the next training dates are.
  - If a reviewer is no longer able to attend a review that they have signed up for it is your responsibility, as project lead, to find a replacement. If the review is unable to go ahead because a reviewer has cancelled at short notice your service is liable for any associated costs.

Project Lead Checklist for Accreditation	Complete
Set the dates for your accreditation review.	
Receive copy of current standards. Familiarise yourself with them and plan any actions.	
Inform all staff, senior management, service users and carers about the visit and ensure as many as possible are involved during the day.	
Self-review opens online 4 months before the visit. Log-on to the CARS system to ensure you can access it properly.	
Distribute questionnaire links to staff, referrers, carers and service users (where possible). If service users are unable to access questionnaires online arrange for them to complete a paper copy (see guidance for notes on confidentiality).	
If your service users are unable to complete the questionnaires due to cognitive decline you will need to arrange for the completion of the Bakkar Observation Tool (BOT).	
Host group discussions and prepare a copy of the self-review workbook. Ensure that you complete all sections with concise detailed comments.	
Collate all supporting evidence documents and upload to CARS	
Submit regulator reports and information on SUIs to the project team at least 4 weeks before your review date.	
Ensure a completed workbook, questionnaires, and supporting evidence are submitted via CARS at least 4 weeks before your review date.	
Invite all managers, staff, service users and carers to the relevant parts of the review day.	
Ensure that there are sufficient copies of the self-review for staff members to refer to during the day.	
Organise for a service user to be available to assist or lead the unit tour (see timetable for details).	

QNOAMHS Membership

In addition to the accreditation process which you have signed up to there are also a number of benefits to being a member of QNOAMHS.

Being a Peer or Lead Reviewer

Acting as a Peer or Lead Reviewer is a great opportunity to learn from other services, as part of the quality improvement process.

Annual Forum

The QNOAMHS Annual Forum is held every year. It is an opportunity for services across the country to come together to discuss findings from across the network and share service development initiatives. This is also an opportunity for your service to present on a topic of your choosing. If you would be interested in presenting at the Annual Forum, please contact the network team.

Annual Report

An Annual Report is published every year, with its findings and recommendations reported at the Annual Forum. The report presents national findings identifying trends and enabling benchmarking with other services.

Special Interest Days

Special Interest Days are run by the network and dedicated to a topic identified by the members. The day is then led by members to ensure that it is truly focused to the topics that are most important for those working within older adult mental health services. If you would like to suggest a topic for a special interest day or would like to know when the next one is being held, please contact the network team.

Email Discussion Group

The email discussion group provides access to experienced and knowledgeable professionals from a range of disciplines who work in or alongside older adult mental health services. The Project Lead(s) will automatically be added to the distribution list but any member of staff from the service is able to join by emailing opdiscussion@rcpsych.ac.uk with their details. Please ensure that you add this email address to your 'safe senders' list so that you are able to access the emails.

Peer Reviewers

Professionals Reviewers

Staff who work on your ward are able to act as a peer reviewer and attend accreditation/ peer review visits to other wards. It is a condition of your membership that you provide at least two professional reviewers for other visits every year. As well as being a vital part of the network and ensuring other services are able to have their visits, being a reviewer is a great opportunity for the reviewer and their service. Visiting other services is an opportunity to understand how they work and to pick up ideas and innovations that they are then able to bring back to their own team. This feeds back into your ward's process of quality improvement.

Staff are also able to use peer review visits as part of their CPD and we are able to provide a CPD certificate for every visit that they complete. Once reviewers have completed three visits, they are able to apply to become Lead Reviewers.

Services are required to arrange and fund travel and expenses for reviewers to attend visits as part of their membership.

Service Users and Carers

All QNOAMHS visits have a service user or carer representative as part of the review team. We are always on the lookout for people who have spent time on an inpatient older adult mental health ward or care for someone who has to apply for these roles. If you know someone who you think may be suitable for these roles please let us know, they will be asked to complete an application form and, if successful at that stage, an interview will be arranged. All successful applicants will be required to attend one day of reviewer training before attending a visit. QNOAMHS covers all travel and accommodation costs for service user and carer representatives and they receive a sessional fee for time worked. Please note that we are not able to accept applications from individuals who are currently residing on an inpatient mental health ward.

Self-Review

Overview

The first aspect of the accreditation process is the self-review. The self-review period is 3 months, however there is a lot of work to complete within this time so you will need to start work straight away. Therefore, we advise that any changes that you would like to make to the service are made before the start of the self-review period. The self-review consists of:

- Completing a self-review workbook via CARS (College Accreditation and Review System), assigning a score to each standard and commenting on ward performance.
- Completing contextual information, staffing and service data via CARS.
- Online questionnaires for staff, patients, carers and referrer/ partner agencies, as well as a health record audit.
- Completing the Bakkar Observation Tool if patients are unable to complete questionnaires.
- Submitting the services most recent regulators report and information on any SUIs.

All of the above will be added into the self-review workbook and used as the basis for the peer review day.

Aims, Purpose and Outcomes

Completing the self-review workbook provides a designated space for teams to reflect on service provision and acts as a useful team-building opportunity. The self-review forms the basis of the accreditation visit: the completed workbook will be sent to the visiting peer reviewers in advance of your visit so that they can familiarise themselves with the key issues raised. The audit and questionnaire responses provide an additional dimension of information which will be balanced in the context of the self-review workbook.

Step-by-Step Guide to the Self-Review

Please ensure that all staff, service users and carers are aware of the accreditation process and self-review by distributing the information sheets provided.

Completing the Workbook

In order to allow your Peer Review Team to prepare as thoroughly as possible you will need to provide comments against the standards, which you will do online through the CARS system. For more information on how to complete your workbook on CARS please see the CARS Handbook, Section 4: Completing the Self Review Workbook.

Please note that there are over 250 standards so allow plenty of time to complete this. You will be able to download and print a copy of the workbook to work through as a group, however you will need to complete and submit the workbook online through CARS.

The standards are split into three types:

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. These standards also include the fundamentals of care, including the provision of evidence based care and treatment

Type 2: standards that an accredited ward would be expected to meet.

Type 3: standards that an excellent ward should meet or standards that are not the direct responsibility of the ward.

You will be required to prepare evidence showing compliance against the standards for your review day. You do not need to submit this evidence as part of the self-review. However, you may wish to use your self-review period to start collecting this evidence. Please refer to 'Preparing for your Accreditation Visit' for more information.

Other Documentation

You will also be asked to complete contextual information, staffing and service data via CARS. Please ensure that you complete this using information from the time periods specified.

As part of your self-review, you will also be asked to submit your most recent regulators (e.g. CQC, Health Improvement Scotland, The Regulation and Quality Improvement Authority, Health Inspectorate Wales) report. This will be shared with the review team to provide them with further context about the service, areas of good practice and areas that require improvement. They may ask questions about the report on the day or ask to see evidence that action has been taken.

Once you have completed your workbook you will then be asked to provide an update on previous action points. If you have previously been through the accreditation process please complete this in relation to the action points from your previous accreditation report. If you are new to QNOAMHS please complete it in relation to actions that you have worked on within the last 12 months. These could be as a result of a regulators report, your preparation for the accreditation process, your own development processes or any other sources.

Surveys

During your self-review period it is your role to ensure that the following surveys are completed, the links to these surveys will be sent to you at the start of your self-review period. You can check your survey targets and progress at any time on your CARS review dashboard.

Staff Questionnaire: All staff who work on the ward, including the ward manager, should complete this questionnaire (apart from bank and agency staff). There are a significant number of questions within this questionnaire so please ensure that staff allocate an hour to complete it.

Health Record Audit: Your team will need to complete audits totalling at least 50% of your bed numbers. These audits should be completed using real service user health records and not templates. You should select health records of service users who are currently residing on the ward and who have been discharged within your self-review period. All service users whose records are used should have been on the ward for at least four weeks. At least half of the records audited should be from service users who have been discharged.

Carer Questionnaire: These should be completed by the person who has had most involvement with the patient and their care while they have been on the ward, this may be their carer, a relative or friend. Similarly, to the patient questionnaire, you will need 50% of your bed numbers and it is available online and on paper. If carers complete the questionnaire on paper please ensure that staff respect the confidentiality of the questionnaire and do not assist the carer in completing it or view their responses.

Please stress to carers that completing the questionnaire is entirely voluntary, entirely anonymous, and will not affect the care and treatment that their loved one will receive.

Patients Questionnaire: This should be completed by patients who are currently on the ward and those who have been discharged within the self-review period. The minimum number of patient questionnaires you will need is 50% of your bed numbers. As with all other questionnaires this is available online, however, if your patients are unable to complete it online, they are able to complete paper copies. Contact the project team for more information on this.

We recognise that some service users may not be well enough to complete the questionnaire; however, if the service user requires assistance understanding questions or recording their responses then an independent person (e.g. advocate) should be approached. Staff from your ward **may not** assist the service user. Please ensure that staff respect the confidentiality of the questionnaire by ensuring that responses are collected and returned to the team appropriately.

Please stress to service users that filling in the questionnaire is entirely voluntary, entirely anonymous, and will not affect the care and treatment they receive.

Bakkar Observation Tool: If the majority of your patients are living with organic illnesses which mean that they would be unable to complete the patient questionnaire you can instead ensure the completion of the Bakkar Observation Tool (BOT). While they may be involved in arranging it, **staff on the ward may not be involved in completing or recording the BOT**. A copy of the BOT will be sent to you, which will need printing.

You are required to find two people who will need to complete two 25 minute observations each. One of these people should be a healthcare professional from another

service, for example a doctor, nurse, healthcare support worker, OT, psychologist or another member of the MDT. They should not be from the ward itself but may work within the same trust/organisation. The other person should be a non-professional or lay person. They could be an advocate, carer or volunteer, they should not be employed by or work regularly on the ward.

There are four time periods that must be observed within the four observations:

- Morning in common area
- Afternoon in common area
- Lunch in dining room
- Dinner in dining room

Please arrange for the observers to be available during these times. The observations can be completed at any time during the three month self-review period.

Once the observation has been completed on paper the observers will be required to submit it online. The link for this will be sent along with your other survey links. Please ensure that you provide the observer with a computer to complete this.

If at any time you feel that you will not be able to complete the self-review (including securing the required number of surveys) before the deadline, please contact the network team as soon as possible.

Key things to do:

- Read through the CARS handbook, check you are able to log on to the system and familiarise yourself with the system
- Distribute the information letters/emails for staff, service users, carers and referrer/ partner agencies giving the web-link to the online questionnaires
- If you will be using it, arrange for the completion of the BOT
- Let the team know that ALL STAFF are required to complete the questionnaire
- Allocate staff members to conduct the health record audit
- Arrange suitable time(s) when the team can come together to work through the self-review workbook
- The team should work through the workbook together, scoring themselves against the criteria and making comments against all standards that will enrich the accreditation visit
- Submit the completed self-review online at least 4 weeks before your accreditation visit is due to take place

Accreditation Visit

Description

Once your self-review has been completed and returned and the online questionnaires and audits filled in, a peer review day follows. This involves a team of 2-3 staff from other older adult mental health units and a service user and/or carer representative visiting your team. Review days will be led by a member of the Project Team or another experienced lead reviewer. Accreditation reviewers will be experienced reviewers and have received accreditation reviewer training. There will be at least one nurse on the team and wherever possible a member of the MDT or a medic.

Aims, Purpose and Outcomes

During the accreditation visit, the visiting team will ask questions and discuss issues based on your self-review workbook and audit and questionnaire results. Over the course of the visit, the team will cover every section of the QNOAMHS standards. The purpose of an accreditation visit is to validate the findings of your self-review. They will do this by assessing individual standards and making decisions about whether the scoring is representative of their findings.

Evidence Triangulation

The accreditation process looks for evidence in each of the categories, combining what can be **seen**, what can be **heard** and what can be **read**. Therefore, the review team will be looking for the following evidence throughout the review day.

- **Seen** – This will involve the review team observing the day and interactions within the service.
- **Heard** – This includes information gathered through both formal and informal discussions.
- **Read** – This includes a review of written evidence such as policies, procedures, information on noticeboards, group minutes and individual case files. When preparing your documents ensure files are tracked to demonstrate meeting the standards.

Preparing for your Accreditation Visit

Preparing Evidence

In Appendix 1 you will find a Document Checklist, this details all of the evidence that you should upload to CARS. However, you may also want to prepare additional evidence, for example if a particular issue is highlighted within your previous action plan or has been noted elsewhere as an issue or success. You should upload clearly marked evidence to CARS for the review team to review.

Tracking

To track evidence, highlight issues relating to the standards and clearly mark what standard(s) these relate to. This can be done by attaching page markers to relevant documents e.g. individual case files, minutes of reviews, meetings, observation books, staff meeting minutes etc. This will enable the review team to quickly find evidence related to the standards.

Preparing for the day

In advance of the review day you will need to complete the following:

- Arrange the accreditation visit based on the timetable in Appendix 2. If you need to alter the schedule in any way, please contact the Lead Reviewer of your proposed timetable at least a week in advance of your review.
- Inform all team members about the visit as soon as your peer review date is confirmed and ensure members of your team are able to attend all or part of the review day.
- Invite service users and carers to the relevant interview sessions, and to lunch if you wish. Distribute information sheets about the purpose of the day. If people are unable to attend in person but would like to contribute ask them if they would be happy to talk to the review team over the phone. If they are, record their contact details and send to the lead reviewer as soon as possible.
- Invite a service user to lead the Tour of the Unit, alongside a member of staff.
- Ensure staff are informed which sessions throughout the day they should attend, including the morning brief and end of day feedback sessions.
- Ensure that rooms are booked for interviews.
- Book refreshments (for the morning brief and afternoon review team meeting) and lunch.

Health Record Audit

Within the Senior Staff sections of the day (see timetable) you will need to provide the review team with access to health records so that they are able to view the systems and processes in place as well as how they are used. You can do this by anonymising a set of health records. Please note that the you will be required to demonstrate evidence for a wide range of standards through the health records, therefore you may find it best to provide a number of records to the review team. If the review team is unable to find evidence for a specific standard within the notes provided they are required to score it as not met. If you are unable to do this because you use electronic notes you will need to provide the review team access to live health records. Please note that live health records will only be viewed by clinical members of the review team. It is advisable that an experienced member of staff shows the review team around the electronic notes system.

Guidance:

- Plan for the review day as far in advance as possible.
- Ensure that arrangements allow staff to fully participate.
- Liaise with service users and carers well in advance.
- Remember that the accreditation decision is based on a calculation of the number of standards your service meets; if you meet more standards between the time of the self-review and the peer review, inform the reviewers so they can do you justice.

The Pre-Assessment Process

We have introduced a process whereby some standards are now reviewed separately when there is more than one ward in a trust going through the accreditation process.

Who do the Pre-Assessment Process apply to?

Any ward that has signed up to the QNOAMHS Accreditation process with other wards in their trust or organisation. There are some standards that are likely to be scored the same across multiple wards within a single trust. These often relate to policies and procedures. If you are the only ward in your trust taking part in the accreditation process, or if you are taking part at different times (e.g. not within 1-2 months of each other) the pre-assessment standards do not apply to you. The pre-assessment process also does not apply to Developmental or Associate members.

What are the pre-assessment standards?

The standards are ones that relate to processes and protocols that would be expected to be the same for all older adult wards within a trust or organisation. The list of Pre-Assessment Standards can be found on the next page. You may want to use this as a checklist to ensure you have included all the relevant documentation, and that the documents are ratified (not in draft format) and up to date. Policies must be ratified and in date to be accepted as evidence.

What should you expect if the Pre-Assessment process applies to your ward?

If your ward is one of many in your trust/organisation going through the Accreditation process at the same time, the Project Team will contact all wards to make you aware of the process and to find a convenient date for this documentation to be checked. This might be on one of the ward's peer review visits or may be a separate date.

The wards should work together to put that portfolio of evidence together, and it should be presented to the peer review team either in a labelled file (either in paper or on a computer).

On the pre-assessment visit a small team of reviewers (1 to 2 people) will visit to review documentation relating to the pre-assessment standards and will give each standard a single score. This score would then be used in all reports relating to the wards within that trust currently going through the accreditation process.

This process ensures that scoring of the pre-assessment standards is the consistent for all wards. It also means that documentation is checked just once and not multiple times.

The Pre-Assessment Standards		
No.	Standard	Is the document ratified and in date?
2.5.6	Protocol for managing informal patients who discharge themselves against medical advice.	
2.5.7	Protocol for admission to general hospital.	
3.3.3	The team follows a policy when prescribing PRN (i.e. as required) medication.	
3.3.6	There is an agreed policy and procedure for the covert administration of medicines of which all staff are aware of.	

The Pre-Assessment Standards		
No.	Standard	Is the document ratified and in date?
3.4.3	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.*	
2.4.3	Protocol for managing situations where patients are absent without leave.	

After the Accreditation Visit

Draft Report

Within 30 days of the visit you will receive your draft report, you then have 30 days to respond to this report. Spend the time to read through the report to ensure that you are happy that it is an accurate representation of your service. As a team you should develop an action plan (using the template provided within the report) to address some of the areas that have been highlighted for improvement. This should be returned to the project team before the end of your 30-day period, along with notification of any factual inaccuracies within the report.

If you think that you could provide any additional evidence for criteria scored as 'not met' you will need to send this to the Project Team within this 30-day period. If you would like support from the project team about accreditation committee precedents please contact them well before the end of your 30 day period. Please do not submit evidence in relation to standards scored as 'met' or those that will not affect your accreditation status (see Accreditation Committee) as these will not be considered by the Accreditation Committee.

Key things to do:

- Bring the team together for an open discussion around the areas identified for improvement in your local report.
- Make decisions on how to address these and draw up an action plan – who, how, and when by.
- Return your action plan to the project team within 30 days of receiving your draft report.
- Carry out actions and monitor progress on a regular basis (this will be important for your interim review).

Guidance:

- Include the entire team in the action planning process to encourage a sense of ownership.
- Outline clear responsibilities for taking action points forward so that all staff know their obligations and level of commitment.
- Develop a clear timescale for working on action points so that progress can be monitored on a regular basis.
- Minimise the burden on staff by providing allocated time within regular job hours to work on the relevant actions.
- Email the QNOAMHS email discussion group for advice on planning and implementing new initiatives: opdiscussion@rcpsych.ac.uk

Accreditation Committee

Once you have submitted your response, or the 30-day period is over, the report (and any additional evidence) will be presented to the next Older Adults Accreditation Committee (AC). Please note that the committee only meets 4 times a year so the wait time for this stage does vary. The Accreditation Committee, overseen by the Chair or Vice Chair of the Combined Accreditation Committees, takes into account the criteria below and is the ultimate decision-making body with the power to accredit services.

The aim of the accreditation decision is to ensure that services are recognised for their good practice, as well as protecting the value of an accreditation award by maintaining high standards. Therefore, the criteria for making decisions are as follows:

Category 1: "accredited". The team would:

- meet 100% of type 1 standards
- meet 80% of type 2 standards
- meet 60% of type 3 standards

Category 2: "accreditation deferred". The team would:

- fail to meet one or more type 1 standards but demonstrate the capacity to meet these within a short time
- fail to meet 80% of type 2 standards but demonstrate the capacity to meet the majority within a short time.

Category 3: "not accredited". The team would:

- 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.

Services will be notified of decisions in writing within 14 days of the committee. Accreditation statuses are published on the QNOAMHS website (www.rcpsych.ac.uk/qnoamhs).

Confidentiality

It is a condition of membership that AC members agree that the accreditation report and any additional documentation submitted as part of the accreditation process are treated as confidential.

How long will accreditation last?

Services are accredited for a maximum of three years. The service will be accredited from the date of the accreditation committee at which they were accredited, until three years after the first accreditation committee at which they were considered. This means that a service will be accredited for less than three years if they are deferred.

What happens if our unit is not accredited?

If a unit is deferred

In the event that accreditation is deferred, the AC has the right to request further documentary evidence of compliance with accreditation standards and, if required, to request a targeted revisit. The AC will also stipulate the time scale required to provide additional evidence or when the revisit will need to take place. Services are only able to be deferred once and for a maximum of 12 months. Services will be required to submit an update for every accreditation committee that occurs during their deferral period.

When deferred, the host unit should only provide supporting evidence for the standards they have been deferred upon, usually this will be only the Type 1 standards.

Further documentation

The QNOAMHS project team will inform the service's project lead of the deferral, the reasons for it and advise what evidence the AC have requested in order to demonstrate that the standard is now met. Services will be provided with an 'evidence tracker' document in order to support services to track what standards are currently unmet, the accreditation committee's comments and decisions and what evidence has been submitted to evidence compliance. The evidence could include signed and dated policies, summary audit results, or photographs of environmental changes that have taken place. The project team is also able to provide template training matrixes to help services evidence their training records clearly.

When this is received, the project team compiles a report with the further supporting evidence to submit to the next AC meeting for the group to consider whether this satisfies that the standards are now met and recommend an accreditation status.

Targeted peer-review

If the nature of the issue(s) that have caused accreditation to be deferred are such that further peer-review is required to verify that problems have been remedied, this will result in a further, targeted peer-review visit. Where possible, this will be carried out by the lead-reviewer that undertook the original review. The visit must take place and the results considered within an agreed timescale. A report of the findings of the visit will be submitted to the next AC.

If a unit is not accredited

In the event that the review finds evidence that practice is unsafe or threatens the dignity, safety or rights of service users or staff, the Royal College of Psychiatrists will advise the provider organisation that it should take appropriate remedial action. If the Royal College of Psychiatrists is not satisfied that appropriate action has been taken and that there is a substantial risk to service user safety, it reserves the right to inform those with responsibility for the management of the service and/ or the relevant regulatory body.

The CCQI appeals procedure is available on request.

Interim Review and Updates

All accreditation is subject to terms and conditions, which will be sent to you as appropriate. They are also available at any time upon request. As part of your accreditation you will be asked to submit an interim review, this is due 18 months after the first Accreditation Committee at which your service was discussed.

Aims, Purpose and Outcomes

The interim review is an opportunity for your service to evaluate their performance since accreditation, including the progress on your action plan. The network team also use it to consider whether you are still meeting the required standard for accreditation. If they are satisfied that the evidence provided demonstrates continuing compliance against the standards your accreditation will be continued. Sometimes they may need to come back to you for more information in order to do this.

Details of your interim review will be sent to you nearer the time. As with evidence and data for accreditation, it is vital that information submitted for your interim review is an accurate reflection of the current performance of the service.

Updates

A condition of your membership is that you promptly alert the network team to:

- any reports from regulatory or professional bodies (for example the Care Quality Commission, Healthcare Inspectorate Wales, the Northern Ireland Regulation and Quality Improvement Authority and Healthcare Improvement Scotland) that include any mention of the service;
- any current investigations, serious untoward incidents, serious complaints or any other information that might indicate potential serious problems in the service.

These should be sent to the project team as soon as they are available, they will also be requested at your interim review.

Appendix 1: Document Checklist

This is a list of protocols, processes and documentation included in the QNOAMHS standards.

During your accreditation visit the review team will use this checklist as part of reviewing your performance against the QNOAMHS standards.

Please have these documents available, in a folder and labelled by standard number, on the day of your accreditation visit.

Please note, the review team may not ask to view all the documentation, and they may request additional evidence not listed.

Any policies should be in date. Where they are not in date, evidence must be provided that the policy is being reviewed and that there is a clear process around this. All new policies will need to have been ratified.

Standard (Type)	Documentation Required	Seen?
1.14 (1)	One month's record of resuscitation equipment checks.	
1.10 (1)	Audit of environmental risk and risk management strategy.	
2.2.4 (1)	Accessible written information given to patients on: · their rights regarding admission and consent to treatment. · their rights under the Mental Health Act; · how to access advocacy services; · how to access a second opinion; · how to view their records; · how to raise concerns, complaints and give compliments; · interpreting services.	
2.3.1 (1)	Information pack provided to patients containing: · a description of the service; · the therapeutic programme; · information about the staff team; · the unit code of conduct; · key service policies (e.g. permitted items, smoking policy); · resources to meet spiritual, cultural or gender needs.	
2.4.3 (1)	Protocol for managing situations where patients are absent without leave.	
2.5.7 (1)	Protocol for admission to general hospital.	
3.1.3 (1)	To see 5 redacted copies of a care plan	
3.2.7 (2)	Personalised 7-day therapeutic/recreational timetable of activities for patients.	
3.2.9 (1)	Written information provided about a patient's mental illness.	
3.2.10 (2)	One month's worth of minutes for a ward community meeting.	
3.2.11 (1)	Information about accessing faith-specific support.	

3.2.13 (2)	Information on how to access local organisations for SUS support and social engagement, which may include: • voluntary organisations; • community centres; • local religious/cultural groups; • peer support networks; • recovery colleges.	
3.5.8 (1)	Most recent audit data on the use of restrictive interventions, including facedown restraint. The evidence provided should have been audit data for restrictive intervention, seclusion or restraint. Other restrictions could also include food restriction, access to outside area, toilet facilities and visiting.	
3.5.9 (1)	A falls management process which includes: • falls risk assessment; • falls management plans; • audit of falls.	
3.6.4 (1)	Evidence of links to organisations which offer support with finances, benefits, debt management and housing.	
3.6.3 (1)	Evidence of access to the following referral services: • dental assessment and dental hygiene; • visual reviews; • hearing reviews; • podiatry; • wound care; • phlebotomy; • specialist infection control; • a tissue viability nurse; • specialist continence; • speech and language therapy.	
3.8.4 (2)	Accessible written information provided to carers (e.g. carer's pack), which includes: • names and contact details of key staff members and who to contact in an emergency; • other local sources of advice and support, e.g. carers' groups.	
3.8.5 (2)	Information about a carers support group.	
3.11.1 (1)	Documentation relating to consent to share information.	
4.2.1 (1)	Clear process for escalation and how it is responded to, which includes: • a method for the team to report concerns about staffing levels; • how to access to additional staff members; • an agreed contingency plan, such as the minor and temporary reduction of non-essential services.	
4.2.2 (2)	Staff rota for one month evidencing bank and agency staff use.	

4.2.3 (1)	Service Level Agreement, or similar, evidencing the duty doctor can attend the ward within 30 minutes of an emergency.	
4.3.2 (1)	Information on induction processes for new staff, including for bank and agency staff.	
4.5.4 (2)	Evidence of patient, carers and staff involvement in devising and delivering training.	
5.1 (1)	Anonymised example leave plan including all points listed.	
5.1.1 (1)	Examples of how patient and carer feedback has been used to improve the service.	
2.5.3 (2)	Anonymised example of a discharge summary.	

Appendix 2: Training and Supervision Records Checklist

This is a list of training and supervision records required to evidence specific QNOAMHS standards. During your accreditation visit the review team will request to see evidence of staff compliance with the below training and supervision.

To assist in providing this information effectively, a template is available, which will be provided to you along with this guide, please feel free to use this template to display the data.

Please note: Training matrices need to cover all staff and commentary should be provided where training hasn't been completed. Training standards need to be at 90% compliance to be deemed 'met'.

For further guidance, please contact the Project Team op@rcpsych.ac.uk.

Standard (Type)	Staff training matrix/records in relation to:	Seen?
3.3.4 (1)	Medication competency assessment training records of staff members who administer medications, completed at least three yearly.	
3.5.7 (1)	The appropriate use of physical restraint, i.e. (PMVA)	
4.3.3 (2)	Clinical Supervision. Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. Clinical and Managerial supervision should be separate sessions with evidence of dates covering 6 months.	
4.3.4 (2)	Managerial supervision. Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. Clinical and Managerial supervision should be separate sessions with evidence of dates covering 6 months.	

4.5.1a (1)	· the use of legal frameworks, such as the Mental Health Act and the Mental Capacity Act.	
4.5.1b (1) 4.5.2 (1)	· physical health assessment;	
4.5.1c (1)	· safeguarding vulnerable adults and children;	
4.5.1d (1)	· risk assessment and risk management;	
4.5.1e (1)	· recognising and communicating with patients with cognitive impairment or learning disabilities;	
4.5.1f (1)	· statutory and mandatory training, including equality and diversity, information governance, and basic life support;	
4.5.1g (2)	· carer awareness, family inclusive practice and social systems;	
4.5.1h (1)	· therapeutic observation	
4.5.2 (1)	· completion of NEWS;	
	· pressure area care;	
	· dementia awareness;	
	· falls prevention;	
	· mental capacity act and mental health act;	
	· infection prevention and control	

Appendix 3: Example of a Review Day Timetable

Time	Session	
09:30-10:00	**Introductory Meeting - All** *The review team come together and meet remotely via Teams.* *This will be an opportunity for the review team to introduce themselves and the lead reviewer to explain what to expect throughout the day.*	
10:00-10:15	**Introductory Meeting with Host Team - All** *Review Team meet with the Host Team for introductions, to explain the purpose of the day, confirm the timetable and answer any preliminary questions.*	
10:15-10:55	**Live tour and Physical Environment standards to follow up - All** *A member of the Host Team and a service user (where available) to take the Review Team on a virtual tour of the ward and answer questions about the environment and facilities available for patients, staff, and visitors.* **Reference: Workbook 'Ward/Unit Environment'** **to Lead and remaining reviewers to make notes**	
10:55-11:25	**Admission, Leave & Discharge standards to follow up on** *Review team cover 'Admission and Discharge' standards with ward managers and senior staff of the ward/unit.* **Reference: Workbook Admission, Leave & Discharge**	
11:35-12:05	***Care & Treatment standards to follow up on*** *Review team cover 'care & Treatment' standards with ward managers and senior staff of the ward/unit.*	
12:05-12:30	**Peer Review Team Writing Session** *The Review Team meets in private to consider areas of achievement and recommendations following the Ward Management and Senior Clinicians Meeting & review policies and procedures.*	
12:30- 13:00	**Lunch Break**	
13:00 – 14:00	**Staff Interviews** *Review team cover ' staffing' standards with frontline, non-managerial staff on the unit.*	**Patient Interviews** *Members of the review team meet or interview patients to gain feedback about their experiences of being on the ward.* **Reference: Service User interview guide**
14:00– 15:00	**Service Management** *Review team cover ' service management' standards with ward managers and senior staff on the unit*	**Carer Interviews** *Members of the review team meet or interview carers to gain feedback about their experiences of the ward.* **Reference: Carer interview guide**
15:00-15:45	**Review Team Writing Session** *The Review Team meets in private to consider areas of achievement and recommendations following the Ward Management and Senior Clinicians Meeting & review policies and procedures.*	
15:45 – 16:00	**Feedback Meeting with Host Service** *The Review Team and Host Team meet to discuss key areas of achievements and recommendations. The Host Team will also have the opportunity to provide feedback on how they have found the peer-review day.*	
16:00	**Close**	

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