AIMS Rehab
QUALITY NETWORK FOR MENTAL HEALTH REHABILITATION SERVICES

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Inpatient Rehabilitation Services

Accreditation Peer Review Guide

July 2020

Contents

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Introduction

Welcome to the Quality Network for Inpatient Mental Health Rehabilitation Services (AIMS Rehab).

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).

AIMS Rehab COVID-19 Update

Due to current COVID-19 restrictions, AIMS Rehab are unable to conduct peer review visits to members in person. Therefore, the AIMS Rehab Project Team have created a process to conduct remote peer review visits to members so they can continue their accreditation journey. Whilst the principles of peer review will remain the same, certain aspects of the review have been adapted to ensure that we can continue to provide a robust and comprehensive accreditation review to members.

This document has been adapted for the person(s) within your service who will take the lead in the ward's remote accreditation process. Its purpose is to inform you what to expect throughout the self-review process and the adapted accreditation visit as well as what is expected of you in your role as a project lead.

As expected, the restrictions of COVID-19 have presented various challenges for all involved with the CCQI. With the Project Team working from home to support AIMS Rehab members, adaptations and innovations have been made to ensure AIMS Rehab members benefit from their membership as far as possible.

An increase in the reliance on video technology to communicate as a College, and with our member services, has resulted in our quarterly Accreditation Committee meetings being held remotely. Therefore, whilst the evidence submission process remains unchanged for services going through the accreditation process, the impact of COVID-19 on services means there is now College guidance in place to provide support on a case-by-case basis. It is important to contact the Project Team if you feel you are affected in this way.

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Background

The Quality Network for Inpatient Mental Health Rehabilitation Services (AIMS Rehab) works with rehabilitation wards and units to assess and improve the quality of care they provide. AIMS Rehab engages staff, patients and 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. AIMS Rehab also offers accreditation for those members who can demonstrate a high level of compliance with the standards.

The AIMS Rehab 3rd edition standards are drawn from key documents and expert consensus 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.

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 AIMS Rehab 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 is completed on time

- Prepare for your accreditation visit
  - For more information, please see the Self-Review and 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 rehab reviews every year. Travel costs for attending site 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.

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AIMS Rehab 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 AIMS Rehab.

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 AIMS Rehab 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. During COVID-19

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 inpatient mental health rehabilitation 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 inpatient mental health rehabilitation 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 rehabdiscussion@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.

Shared Learning Forums and Webinars

AIMS Rehab host and produce webinars for professionals and service user and carer representatives to share good practice with the membership. Whilst COVID restricts the network's ability to visit services directly the network is also hosting Shared Learning Forums on a fortnightly basis to allow rehab professionals to remotely network and share their experiences.

General Project Lead Checklist

General Project Lead Checklist for Accreditation (Site Visit)	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).	
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.	
Submit regulator reports and information on SUIs to the project team at least 4 weeks before your review date.	
Ensure a completed workbook and all required questionnaires 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.	
Receive reviewer details from the project team and pass them on to any relevant individuals (e.g. reception).	
Ensure that there are sufficient copies of the self-review for staff members to refer to during the day.	

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Remote Accreditation Visit Checklist

For a Peer Review team to successfully conduct a Remote Accreditation Visit with your service it is important that we know how to support you to ensure you are equipped with the necessary video calling technology.

If you do not have any of the below items available, please contact the Project Team, and we will take this into consideration.

Checklist for Remote Accreditation	Complete
Laptop or desktop computer	
Webcam *Top tip: whilst a webcam is not strictly necessary to communicate, the Peer Review team will have one, and having a visual will help humanise the meetings for everyone.*	
Microphone *Top tip: a working microphone on your computer or through your personal headphones will be necessary for us to communicate. To minimise background feedback during meetings, it is helpful to mute your microphone until you would like to speak.*	
Video Conferencing Program (Preferably Microsoft Teams) *Top tip: for the best experience, it is useful to have the Microsoft Teams application installed directly onto your computer, however the program can also be easily accessed through your internet browser.* *If Microsoft Teams is not available in any capacity, we will support you with other methods.*	
A quiet room where video calling can take place uninterrupted.	
A phone with the video conferencing app installed, to mitigate for the call dropping out.	
Confirmation with your IT department that there are is no schedule maintenance which might interrupt internet connection.	
Set the dates for your accreditation review.	
Receive copy of current standards. Familiarise yourself with all COVID-19 amendments detailed in this handbook.	
Inform all staff, senior management about the visit and ensure as many as possible are involved during the day.	

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Inform all service users and carers that the Peer Review team will want to contact them for their experiences of the service.	
Once your self-review opens, provide the Project Team with the contact details of four carers and four service users who are willing to be interviewed via telephone or videocall.	
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, carers and service users (where possible). If service users are unable to access questionnaires online, arrange for them to complete a printed copy (see guidance for notes on confidentiality).	
Host group discussions and prepare a copy of the self-review workbook. Ensure that you complete all sections with concise detailed comments.	
Collate and upload all supporting evidence documents. Please see the appendix for the environment checklist, document checklist and matrix, COVID-19 evidence guidance.	
Submit regulator reports and information on SUIs to the project team at least 4 weeks before your review date.	
Ensure a completed workbook and all required questionnaires 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 workbook for staff members to refer to during the day.	
Ensure that a quiet room is available for the review meetings.	
Where possible organise for a service user or carer to be available to assist the unit during the live remote tour.	

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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 as well as a health record audit.
- 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 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.

Completing a Remote Self-Review

Services undergoing a Remote Review will be required to submit a more extensive portfolio of evidence on CARS at the point of self-review. Guidance on how to submit the relevant information is included within the 'Step-by-Step Guide to the Self-Review'.

In contrast to a face-to-face review, this evidence will be submitted in advance of the online peer-review day by the peer-review team through a pre-arranged Microsoft Teams account. The Project Team will also guide you through this setup. Submitting evidence prior to the review will enable more discussion on the peer review day.

Please refer to the following Step-by-Step Guide to Self-Review section for the additional instructions for completing a Remote Self-Review, which include:

- Additional workbook information
- Additional contextual information requirements
- Additional survey requirements
- Conducting a self-review of your ward/unit environment
- Guidance on submitting all evidence for a Remote Review

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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 may wish to use your self-review period to start collecting this evidence. Remember, you do not need to submit this evidence as part of the self-review, unless you are participating in a Remote Review.

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.

Workbook Considerations for a Remote Review

The process described above for completing a self-review workbook remains unchanged when participating in our Remote Reviews. However, we do require that services provide responses in their CARS workbook to *all standards* as far as possible. Where a standard might elicit responses related to COVID-19, we will require details of this, and these comments will be taken into consideration by the Peer Review team.

In addition to the contextual information prompts in the workbook, you will also be asked to provide the Project Team with responses to the below information, which will then be provided to the Peer Review Team prior to your review. The purpose of requesting this information is to further inform the Project Team and Peer Review team as to how they can support your service in light of the impact of COVD-19.

This further contextual information must be submitted to the Project Team via email and you will be prompted to do this when your survey targets and review dates are

arranged.

What has been the impact of COVID-19 on service users on your ward?

What has been the impact of COVID-19 on the carers of service users on your ward?

What has been the impact of COVID-19 on staff on your ward?

Are there any changes to how your service provides care in response to COVID-19 which you would like to share?

Submitting Your Regulator's Report

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 AIMS Rehab 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.

Completing 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. Around half of the records audited should be from service users who have been discharged if possible.

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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.

QuIRC

The Quality Indicator for Rehabilitative Care is an internationally recognised toolkit to enable you to measure best practice within your service and benchmark yourself against similar services. It is free to use and must be completed as part of the self-review process prior to the peer review visit/remote review. As well as providing additional information for the review team, it provides you and your team with useful information about how well your service is performing compared to other rehabilitation services

To complete the QuIRC visit http://www.quirc.eu where you will need to register. The QuIRC should be completed by a manager or senior member of the team. Once the QuIRC has been completed you will receive a report, which you can then send to your contact in the AIMS Rehab network team.

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Submitting Example Health Records

As the peer review team will not be able to view any health records in person, services participating in a Remote Review will be required to submit example health records as part of their self-review.

We will require the service to submit **five individual anonymised examples** of the following:

- Assessments completed upon admission
- Patient care plans
- Leave Plans
- Patient risk assessments
- Discharge plans

Submitting Evidence for your Remote Review

With your workbook completed on CARS, the remaining elements of your self-review evidence, including any evidence related to the environment checklist, COVID-19 evidence, and document checklist, will need to be submitted to us separately.

Therefore, in order for the Peer Review Team to allow you to do this, you will be provided access to a SharePoint group where you will be able to 'drag and drop' your evidence.

This SharePoint site will be private, accessible only to your service, the Project Team, and those involved in the Remote Review visit. The SharePoint system will contain folders labelled by standard number, and you will be required to drop any files you are preparing into the corresponding folder.

Following this, the Peer Review Team will review any evidence submitted to these folders (as well as your workbook) prior to your Remote Review.

During the arrangement of your Remote Review, the Project Team will provide you with instructions on accessing your SharePoint account.

It is important to notify the Project Team if you are experiencing any issues with submitting evidence, as we will be able to make alternative arrangements to support you where needed.

Keys to preparing for your self-review:

- 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
- 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

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.

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Accreditation Site 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 inpatient rehabilitation 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 AIMS Rehab 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.

What to expect on a Remote Accreditation Visit

Introduction Meeting

As previously mentioned, the remote accreditation visit will vary to a site visit. With further evidence previously submitted prior to the review day, the remote accreditation visit reduces the need to review any evidence on the day, thus allowing more time for discussion with the service, over a shorter period. For details of timings, please review the timetables in the appendix

Peer Review Preparation

Whilst your service is preparing your self-review materials, the Peer Review team will contact four service users and carers (with their consent) to interview them to gather their experiences of the service. These interviews will be conducted prior to your review day via , and the Project Team will prompt you via email at the beginning of your self-review to provide contact details of four service users and four carers willing to be interviewed.

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Prior to the review day, the Peer Review team will meet and spend time reviewing the evidence submitted during your self-review. This includes any evidence in relation to the ward environment, the document checklist, additional COVID-19 standards and your workbook and survey responses.

The Review Day

The review day will begin with an introductory meeting between the host service and the review team. This meeting is an opportunity for the review team to introduce themselves and the lead reviewer to explain what to expect throughout the day.

A Remote Tour of the Ward Environment

Because Remote Reviews do not include a Peer Review team visiting the host service, in order to effectively review services against the AIMS Rehab 3rd Edition Ward/Unit Environment standards, the host service will be required to conduct a live tour of the unit covering the key points of the environment standards.

Please refer to the appendix for a checklist of the Ward/Unit Environment standards the Peer Review team will consider during this stage of the review.

Privacy Notice

Please note that this should be done via a live tour of the unit. Photo or video evidence cannot be accepted unless any recordings have an accompanied signed acknowledgement that the service is compliant with their trust policies for GDPR and safeguarding. This is to ensure that the privacy of staff, patients and carers is maintained.

Ward Manager and Senior Staff Meeting

The review team will then conduct an interview with any staff qualified to comment on the Service Management standards. This interview will last for around 60 minutes.

Staff Interview

In contrast to the service user and carer interviews, we will conduct a Staff Interview on the day of the visit, using the Staffing standards. Frontline and non-managerial staff are invited to attend this.

Review Team Feedback Session

The review team will then meet separately to discuss what they have found so far, and gather feedback to be provided to the host service.

Feedback to Host Service

The host team will then re-join the videoconference so that the review team can give them feedback about the review. The next steps will also be explained

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Preparing for a Accreditation Site Visit

Preparing Evidence

In the appendix you will find a Document Checklist, this details all of the evidence that you should prepare for the day. 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 prepare a folder of clearly marked evidence for the review team on the day of the accreditation visit.

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 the appendix. 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 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.

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.

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 AIMS Rehab email discussion group for advice on planning and implementing new initiatives: rehabdiscussion@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 AIMS Rehab 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 AIMS Rehab website (www.rcpsych.ac.uk/AIMS Rehab).

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.

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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 AIMS Rehab 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.

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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.

Interim Review for Remote Reviews

In addition to the above, for services undergoing a remote review, an AIMS Rehab Peer Review team/reviewer will visit the service as part of the interim process. Further details of this will be provided by the Project Team.

Appendix 1: Remote Review Environment Checklist

Evidence of the below standards will be considered during a service's Remote Review visit. Please note it is expected that services do a live tour during the review day, however if it is not possible for a service to do this then ward/unit environment evidence will need to be submitted separately.

This list does not cover all the Ward/Unit Environment standards. Therefore, it is important that you provide written commentary on how your service is meeting these standards within the CARS Workbook.

No.	Type	Standard	Suggested Evidence
Ward/Unit Environment Checklist			
19.1	**2**	The ward/unit entrance and key clinical areas are clearly signposted.	Video recording of the ward.
19.2	**2**	Male and female patients (self-defined by the patient) have separate bedrooms, toilets and washing facilities.	Video recording of the ward.
19.3	**2**	All patients have single bedrooms.	Video or photo of a patient's bedroom (with patient's permission.)
19.4	**2**	Patients are able to personalise their bedroom spaces.	Video or photo of a patient's bedroom (with patient's permission.)
19.5	**2**	The ward/unit has at least one bathroom/shower room for every three patients.	Video recording of ward layout.
19.6	**3**	Every patient has an en-suite bathroom.	Photo of ensuite bathroom (with patient's permission.)
19.7	**2**	Laundry facilities are available to all patients.	Photo/video of laundry facilities
19.8	**1**	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room.	Photos/video of multi-faith and/or other faith facilities/resources available to patients
19.9	**2**	All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population. Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows this).	Photos/videos of resources for entertainment available to patients on the ward/unit

19.11	**1**	The environment complies with current legislation on disabled access. Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.	Photo or video evidence of compliance with legislation on disabled access.
19.19	**1**	There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded, e.g. by using mirrors.	The Ward/Unit's Floor Plan Photo or video evidence of the ward unit, with attention towards any blind spots and how they are mitigated.
19.22	**1**	There is an alarm system in place (e.g. panic buttons) and this is easily accessible.	Photo evidence of alarm system in service.
19.28	**1**	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes.	Photo of crash bag and its contents.
19.30	**2**	The ward/unit has a designated room for physical examination and minor medical procedures.	Photo of designated room.
19.31	**1**	In wards/units where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has direct access to toilet/washing facilities;	Video recording of seclusion room.
19.32	**2**	The ward/unit has at least one quiet room other than patient bedrooms.	Photo evidence of quiet room/de-escalation space.
19.33	**2**	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys, books. Guidance: The children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit.	Photo/video of visitor's room/area
19.34	**1**	There is a designated area or room (de-escalation space) that the team may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation.	Photo/video of a de-escalation room/area
19.36	**1**	The ward/unit has a designated dining area, which is reserved for dining only during allocated mealtimes.	Photo/video of dining area

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19.40	**2**	Where smoking is permitted, there is a safe allocated area for this purpose.	Photo/video of smoking area
19.41	**2**	Ward/unit-based staff members have access to a dedicated staff room.	Photo/video of staff room

Appendix 2: COVID-19 Standards Evidence Guidance

Whilst it is important to remember that the AIMS Rehab Standards have ***not*** changed, the Project Team have reviewed standards where the possibility of them being 'Met' by services could be impeded by the impact of Covid-19 on health care services.

Below is a list of the standards which have been reviewed and now contain additional guidance for services, the review team, and the Accreditation Committee to consider.

As always, it is the Peer Review team's decision to score a standard as 'Met' or 'Not Met', however the guidance provided is intended as a supplement.

If your service is struggling to provide evidence in relation to the below standards, please make this clear when completing your workbook in CARS and this will be considered.

NUMBER	TYPE	STANDARD	GUIDANCE/SUGGESTED EVIDENCE
Standards with COVID-19 Guidance/Evidence			
19.10	**3**	All patients can access a charge point for electronic devices such as mobile phones.	**Evidence:** The ward demonstrates evidence of a video calling equipment such as an iPad.
19.20	**1**	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety.	**Evidence**: whilst appropriate restrictions apply as a result of Covid-19, the ward are actively applying the least restrictions to the environment as far as possible.
19.30	**2**	The ward/unit has a designated room for physical examination and minor medical procedures.	**Evidence:** any alterations to a designated room for physical examination and minor medical procedures as a result of coronavirus are explained.
19.41	**2**	Ward/unit-based staff members have access to a dedicated staff room.	**Evidence**: if the ward/unit does not have a staff room, a temporary designated "safe space" is available to staff instead.
4.1	**2**	The patient is given an age appropriate 'welcome pack' or	**Evidence:** Guidance on social distancing is included in the information.

		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.	
4.9	**1**	Patients have a comprehensive physical health review. This is started within 4 hours of admission and is completed within 1 week, or prior to discharge.	**Evidence:** New admissions are isolated and tested for COVID-19 in accordance local guidance.
4.12	**1**	Patients have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of: • Risk to self; • Risk to others; • Risk from others.	**Evidence:** Risk assessments include Covid-19 risk and appropriate action plans are made in line with current guidance. Any pre-assessments prior to admission are conducted by phone call (or similar) prior to entering the ward.
7.1	**1**	The team develops a leave plan jointly with the patient that includes: • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Conditions of the leave;	**Evidence:** Leave plans demonstrate consideration for Covid-19-related restrictions.

		• Contact details of the ward/unit. Guidance: If there are concerns about a patient's cognition, the risk assessment includes consideration of whether the patient may be driving/using heavy machinery etc. and there is a plan in place to manage this.	
11.1	**2**	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is set within 8 weeks of admission.	**Evidence:** Discharge plans ensure patients are tested for Covid-19 prior to discharge, and the safety of the discharge placement is appropriately assessed.
11.3	**1**	A letter setting out a clear discharge plan, which the patient takes home with them, is sent to all relevant parties before or on the day of discharge. The plan includes details of: • Care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication; • Details of when, where and who will follow up with the patient.	**Evidence**: The summary evidences that patients are tested for Covid-19 prior to discharge, and that the safety of the discharge placement is appropriately assessed.
11.4	**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.	**Evidence:** The assessment considers risk of Covid-19.
6.4	**1**	There is a documented admission meeting within one week of the patient's admission. Guidance: This could take the form of a ward round meeting or a Care Programme Approach meeting (or equivalent).	**Evidence:** carers and external professionals are supported to attend these meetings through video conferencing as far as possible, or other appropriate means.
6.6	**1**	Patients and carers are able to contribute and express their views during reviews.	**Evidence:** appropriate resources are in place to allow friends and family to access all appropriate clinical meetings remotely if needed

6.9	**1**	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. *Guidance: The care plan clearly outlines:* • *agreed intervention strategies for physical and mental health;* • *measurable goals and outcomes;* • *strategies for self-management;* • *any advance directives or statements that the patient has made;* • *crisis and contingency plans;* • *review dates and discharge framework.*	**Evidence:** Care plans reflect any updated lasting power of attorney documentation and advance directives.
6.1	**1**	There is a clinical review meeting for each patient at least every four weeks, or more regularly if necessary, to which they are invited.	**Evidence:** Where it is not possible to attend in person, professionals are able to attend remotely.
8.1.6	**1**	Activities are provided 7 days a week and out of hours. Guidance: Activities which are provided during working hours, Monday- Friday, are timetabled.	**Guidance:** Activities take place as far as possible on the ward to account for reduction in off-site activities
8.1.11	**1**	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a*	**Guidance:** ward community meetings are held in consideration of the risk of Covid-19 infection.

		professional who has an understanding of group dynamics.	
8.1.12	**2**	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	**Evidence:** faith-support is provided as far as possible through technology/live streaming, and only in person where appropriate.
8.1.14	**2**	The team provides information and encouragement to patients to access local organisations for SUS support and social engagement. This is documented in the patient's care plan and may include access to: • voluntary organisations; • community centres; • local religious/cultural groups; • peer support networks; • recovery colleges	**Evidence:** access to these services are considered in light of what is appropriate during pandemic, and this is documented in the patient's care plan.
18.1	**1**	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Guidance: For carers this includes confidentiality in relation to third party information.	**Evidence:** Confidentiality and its limits in relation to remote communication is included.
19.40	**1**	Where smoking is permitted, there is a safe allocated area for this purpose.	**Guidance:** Alterations to smoking policy in light of Covid-19 leave restrictions are taken into consideration.
23.1	**2**	Patient or carer representatives are involved in interviewing potential staff members during the recruitment process.	**Evidence:** where not possible to conduct on the ward/unit, this takes place remotely.
25.1	**1**	The ward/unit actively supports staff health and wellbeing. Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed	**Evidence:** 1. Staff to be able to take annual leave or if unable, can carry it over. 2. Staff know how to access helplines (those provided by RCPsych or NHSE) 3. Appropriate PPE is available 4. Measures are put in place to ensure staff working from home have their health and wellbeing looked

			after.
26.3	**1, 2 & 3**	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.	**Evidence:** Training is provided remotely as far as possible, in consideration of postponed face-to-face training.

Appendix 3: Document Checklist

This is a list of policies/ documentation included in the AIMS Rehab Inpatient Service Standards. You should have these documents available and clearly labelled for the review team on the day of the accreditation visit.

Please note that the review team may not ask to see all the documentation and they may ask for additional evidence that is not listed.

Standard	Documentation Required	Complete
1.1	A copy of information given 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.	
1.2/ 31.1	Copy of the operational policy, service level agreement or similar (as agreed by commissioners/contractors)	
2.2	Process for exceeding bed occupancy	
4.1	Copy of the welcome pack	
4.5	Information given to detained patients	
4.6	Information given to patients 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	
7.2	Lone working policy	
7.4	Protocol for managing situations where patients are absent without leave	
8.1.6/ 8.1.7.1	Evidence of timetabled activities during working hours (Monday to Friday)	
8.1.6	Evidence of activities out of hours and at weekends	

8.1.7	Evidence of a range of personalised timetables for patients	
8.1.11	Minutes from the community meetings	
8.1.14	Information on • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	
8.2.5	PRN policy	
8.2.6/ 9.1.5/ 10.1/ 20.2/ 24.5/ 26.3A/ 26.3B/ 26.3C/ 26.3E/ 26.3F/ 26.3G	Training matrix covering: • Assessment of competency to administer medications (for all staff who administer medications) • Care of patients with a dual diagnosis • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence. • Leadership and management training (appropriate to the staff member's role and specialty) • Supervision Training (for supervisors) • The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent) • Physical health assessment • Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities • Statutory and mandatory training • Clinical outcome measures • Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality • The basic principles of rehabilitation and recovery-oriented practice	
8.2.7	Medicines management policy	
8.2.10	Most recent audit of high risk medication. This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines	
9.1.3	Protocol for the management of an acute physical health emergency	
9.1.5	Dual diagnosis policy	
9.1.6	Care pathway for women in the perinatal period	
10.3	Template for a crisis plan for when a patient is at risk of absconding	
10.4	Management of patient violence and aggression policy	

10.7	Audit of the use of restrictive practice, including face-down restraint	
10.9	Inter-agency protocols for the safeguarding of vulnerable adults and children	
11.4	Protocol to manage informal patients who discharge themselves against medical advice	
11.11	Figures on number/percentage of patients who are delayed discharges	
12.1	Joint working protocols/care pathways with: • Accident and emergency; • Social services; • Local and specialist mental health services e.g. liaison, eating disorders; • Secondary physical healthcare.	
12.2	Joint working protocols/care pathways with primary healthcare teams	
12.3	Joint working protocols/care pathways with home treatment/crisis resolution teams	
12.5	Protocol with local police	
13.4	Evidence of systems to ensure that the ward/unit takes account of any advance directives that the patient has made.	
14.1	Examples of how patient and carer feedback has been used to improve the service.	
15.4	Carers information pack	
15.6	Protocol for responding to carers when the patient does not consent to their treatment	
17.1	Examples of accessible information	
19.15	Policy on use of cameras, mobile phones and other electronic equipment	
19.16	Visiting policy	
19.17	Protocol for conducting searches of patients and their personal policy	
19.18	Audit of environmental risk and risk management strategy	
19.29	Crash bag checks	
20.1	Written documents that specify professional, organisational and line management responsibilities.	
22.1.3	Staffing paper	
22.1.1/ 22.1.2/ 22.3	Staff rota, clearly showing bank and agency staff	
22.4	Monitoring of bank and agency staff	

22.5	SLA or similar for duty doctor	
22.6	Review of staff members and skills mix	
24.2	Clinical Supervision Matrix	
24.6	Line management supervision matrix	
26.2	Evidence of competency to practice	
27.2	Review of progress against ward plan/strategy	
28.2	Clinical outcome monitoring	
29.1/ 29.3	Local and multi-centre clinical audits	
29.4	Evidence of key information generated from service evaluations and key measure summary reports	

Appendix 4: Accreditation Review Day Timetable (Not Remote)

Time	Session	
9:30 - 9:45	**Introductory Meeting – Review Team** Review Team meet for introductions, timetable review and assignment of roles **Tea and Coffee to be provided on arrival**	
9:45 - 10:15	**Morning Brief** Reviewers meet with the host team • Lead reviewer: a) introductions, b) aims of the day, c) check the programme • Host unit to give a brief description of their service and overview of actions since last review/ in last year	
10:15 -11:00	**Tour of the Unit** During the tour the reviewers will complete the environment checklist and validate standards relating to 'Physical Environment'	
11:00 - 11:45	**Senior Staff & Health Record Audit** The reviewers ask the host team about issues raised in the self-review including the self-review referrer's questionnaire and discuss standards relating to 'Admission and Discharge' **All supporting documentation specified in the documents list and case notes should be available in this session**	
11:45 - 12:45	**Senior Staff & Health Record Audit** The reviewers ask the host team about issues raised in the self-review relating to 'Care and Treatment' **Documentation as above should also be available in this session**	
12:45 - 13:00	**Review Team Writing Session** This is an opportunity for the review team to write up their findings so far	
13:00 - 13:45	**Lunch** to be provided by the host team	
13:45 - 14:30	**Frontline Staff** 1-2 reviewers will meet with non-managerial frontline staff to validate the self-review staff's questionnaire particularly in relation to the 'staffing' section	**Carers, friends and family members** 1-2 reviewers will talk to carers, friends and family members about their experience of the service
14:30 - 15:15	**Ward Managers Meeting** 1-2 reviewers will meet with the ward manager to validate standards relating to 'Service Management' **A copy of all the unit's policies should be made available**	**Service users** 1-2 reviewers will talk to service users about their experiences of using the service
15:15 - 16:00	**End of Day Discussion** Peer reviewers meet separately to summarise their findings **Tea and Coffee to be provided within this session**	
16:00 - 16:30	**Feedback to the host unit** Informal feedback will be given to the host team by the peer reviewers and clarification can be sought on any standards where further data is required	

Appendix 5: Remote Accreditation Review Day Timetable

Time	Session	Participants	Method
	Peer Review Preparation		
Two weeks prior to review day	***Patient & Carer Interviews*** A member of the AIMS Rehab project team (and possibly a service user/carer rep) conducts phone interviews with service users and carers two weeks prior to the review day to gather their feedback. This would allow carers and service users to choose a date/time suitable.	AIMS Rehab Project Team Members Service user/ Carer reps?	Phone Calls
Day before prep meeting 3:00 hrs	Peer review team review submitted evidence and workbook. Review team validate: • Environment standards (whole team reviews this) • Document checklist - allocated reviewer(s) • Additional COVID-19 standards - allocated reviewer(s) • Health records - allocated reviewer(s) Review team will highlight areas in the workbook to focus on during the review day and allocate roles for the review day.	Whole review team	Microsoft Teams
	Day 1		
10:00 – 10:30	**Introductory Meeting** 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. Half an hour should also give enough time to iron out any potential technical difficulties.	Whole review team	Microsoft Teams
10:30-12:00	**Live Ward/Unit Environment Tour** Review team focus on standards in relation to the ward/unit environment and review the service's evidence of their physical environment. This could be done by the lead reviewer sharing their screen and going through each standard and the evidence submitted. Whilst host service and team discuss.	Selected Members of the peer review team Host Service	Microsoft Teams
12:00 – 13:00	**Ward manager & Senior Staff meeting** Review team cover "service management" standards with ward managers and senior staff of the ward/unit.	Relevant members of the review team	Microsoft Teams

		Senior staff/management	
13:00 – 13:45	**Break/Lunch**		
13:45 – 14:45	**Staff Interviews** Review team cover "Staffing" standards with front-line, non-managerial staff on the ward/unit.	Relevant members of the review team	Microsoft Teams
14:45 – 15:15	**Review Team Feedback Session** The review team discuss what they have found so far and create a list of pieces of evidence or questions that the review team need for any remaining standards.	Whole review team	Microsoft Teams
15:15 – 15:45	**Feedback to Host Service** Review team go through any standards which require more clarification or evidence with the host service and inform them of the timetable for the next day.	Whole review team Host Service	Microsoft Teams
Day 2			
10:00 – 10:15	**Introduction Meeting** As with the first day the review team come together and prepare for the day.	Peer Review Team	Microsoft Teams
10:15 – 11:30	**Mop up session with host service** Review team and host service go through any areas that were not sufficiently covered on day 1 (this would have been discussed with the service during the feedback session previously).	Whole review team Host Service	Microsoft Teams
11:30- 12:00	**Review Team Feedback Session** Review team discuss their findings so far and come up with a final list of areas of achievement and improvement.	Whole review team	Microsoft Teams
12:00 – 12:30	**Final feedback to service** Review team provide feedback to service and explain next steps e.g. accreditation committees, when to expect report etc.	Whole review team Host Service	Microsoft Teams

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