COLLEGE CENTRE FOR QUALITY IMPROVEMENT

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# Standards for Serious Incident Reviews – Second Edition

*Serious Incident Review Accreditation Network*

**Editors:** Elena Baker-Glenn, Rob Poole, Jemini Jethwa and Hannah Lucas-Motley
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# Contents

# Introduction

These standards have been developed from recommendations in key literature, research and in consultation with a range of stakeholders. Care has been taken to ensure that the development of these standards has taken into consideration a wide range of sources, along with the perspectives of researchers, policy makers, professionals, people who receive care from services and their loved ones.

These standards have been developed for the purpose of review as part of the Serious Incident Review Accreditation Network (SIRAN); however, they can also be used as a guide for anyone undertaking serious incident reviews. Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

## Who are these standards for?

These standards are for service providers and commissioners of mental health services to help them ensure they carry out high quality serious incident reviews.

## Categorisation of standards

Each standard has been categorised as follows:

**Type 1:** failure to meet these standards could indicate that reviews are not conducted in a way that captures learning from serious incidents, potentially risking similar incidents occurring again and hence posing a threat to service user safety, rights or dignity and/or the potential for there to be a breach of the law. These standards also include the fundamental principles of conducting serious incident reviews that are effective, transparent and inclusive.

**Type 2:** standards that an organisation would be expected to meet;

The full set of standards is aspirational and it is unlikely that any service would meet them all. To achieve accreditation, an organisation must meet 100% of type 1 standards, at least 80% of type 2 standards. The Network facilitates quality improvement and will support teams to achieve accreditation.

## Terminology

This document refers to Serious Incident Reviews. Devolved nations have different terms for these reviews: in England and Wales, the process is referred to as Serious Incident Investigations, Scotland refer to Adverse Event Reviews, and Northern Ireland refer to Adverse Incident Reviews. All of these processes refer to the response organisations have to adverse events and the processes that they have in place to help to identify learning from that event where family and carers and staff are able to contribute to the review process.

Throughout this document, “family” refers to persons in a close and long-term relationship with the patient, including close friends. “Children” refers to minors.

# Standards for Serious Incident Reviews

## Section 1: Organisational Processes

| Std No | Type | Standard |
|---|---|---|
| 1 | 1 | There is a written process in place for reporting incidents.<br>*Guidance: This is set out clearly and made available to staff.* |
| 2 | 1 | There is a written process in place for deciding which serious incidents require further review. |
| 3 | 1 | There is evidence that this process is followed. |
| 4 | 1 | The Board receive a report related to serious incident reviews. |
| 5 | 2 | There are clear processes to ensure action plans and/or improvement plans have been implemented in at least 80% of the examined reports.<br>*Guidance: This may require evidence from previous investigations.* |
| 6 | 1 | Information governance agreements are in place to ensure information sharing between partner agencies where appropriate. |
| 7 | 2 | There is a mechanism of accountability of the reviewers set out in the local policy.<br>*Guidance: This includes accountability in the instance of external reviews.* |

## Section 2: Incident Review Processes

| Std No | Type | Standard |
|---|---|---|
| 8 | 1 | The organisation attempts to contact the patient and/or family within three working days of the incident being reported in order to provide support in line with the Statutory Duty of Candour. |
| 9 | 1 | Reviews are led by someone who is independent of the treating team. |
| 10 | 1 | The review is led by someone who has relevant experience, expertise, or training in reviews. |
| 11 | 1 | At least one reviewer has service specific expertise relevant to the review or, if not, specialist advice is sought. |
| 12 | 2 | The locally agreed timescale for the individual reviews is adhered to.<br>*Guidance: Any agreed extensions are clearly documented.* |
| 13 | 1 | Terms of reference are agreed by senior managers. |
| 14 | 2 | There is evidence that the review team accessed to specialist advice in a timely manner, where indicated. |

## Section 3: Reports

| Std No | Type | Standard |
|---|---|---|
| 15 | 1 | Reports state the name and professional role of each reviewer. |
| 16 | 1 | There are clear terms of reference specific to the case. |
| 17 | 1 | Appropriate legal framework concerning openness and candour is considered and applied. |
| 18 | 2 | The report states whether there are, or have been, other reviews related to this incident. |
| 19 | 1 | Reports are succinct and written in plain English. |
| 20 | 1 | All specialist vocabulary, acronyms and jargon are explained in the report. |
| 21 | 2 | There is a glossary to explain abbreviations used. |
| 22 | 1 | The rationale for the conclusions is clear from evidence set out in the body of the report. |
| 23 | 1 | The rationale for recommendations is clear from evidence set out in the body of the report. |
| 24 | 2 | Reports evaluate clinical decision-making processes relevant to the incident. |
| 25 | 1 | There is a clear improvement and/or action plan where required. |
| 26 | 1 | It is clear how the improvement and/or action plans are derived. |
| 27 | 1 | Improvement and/or action plans are implementable.<br>*Guidance: This includes using the SMART framework.* |
| 28 | 1 | The improvement and/or action plan are monitorable.<br>*Guidance: This includes using the SMART framework.* |
| 29 | 1 | There is a specific individual, named in the report, that is accountable for delivering the action plan within a specified timescale. |
| 30 | 2 | Reports refer to existing organisational policies or relevant guidance. |
| 31 | 2 | Recommendations refer to the organisation's existing action plans and quality priorities. |
| 32 | 1 | There is a recognition of potential learning evident in the report. |
| 33 | 1 | Significant incidental findings lying outside of terms of reference are noted and acted upon. |
| 34 | 1 | Where case notes and staff are inaccessible to the reviewing team, reports acknowledge any limitations. |

## Section 4: Involvement of Clinical Staff

| Std No | Type | Standard |
|---|---|---|
| 35 | 1 | Staff and professional stakeholders involved in the care of the patient are formally contacted at the outset of the review process. |
| 36 | 1 | Terms of reference are made available to staff and professional stakeholders involved in the patient's care. |
| 37 | 1 | Staff and professional stakeholders involved in the patient's care are informed who is conducting a review at the outset. |
| 38 | 1 | Staff and professional stakeholders involved in the patient's care are informed of a realistic timeline for a review. |
| 39 | 1 | Staff and professional stakeholders involved in the patient's care are informed about any delays in a timely fashion and provided with the reasons for those delays. |
| 40 | 1 | Staff and professional stakeholders involved in the patient's care are invited to contribute to the review. |
| 41 | 1 | Staff are able to review their contribution to the report. |
| 42 | 1 | Staff and professional stakeholders involved in the patient's care are invited to check for factual accuracy prior to publication of the report. |
| 43 | 1 | Staff and professional stakeholders involved in the patient's care are informed of the outcome of the review and are invited to comment on the findings of the report. |
| 44 | 1 | Staff within the organisation are made aware of how to access support. |
| 45 | 2 | Staff are able to meet with the review team and reflect on the quality of care provided. |
| 46 | 2 | Staff are treated respectfully and sensitively during the review process. |
| 47 | 2 | Learning is recognised in the review process where appropriate. |

## Section 5: Involvement of Patients and Families

| Std No | Type | Standard |
|---|---|---|
| 48 | 1 | Patient and/or families are contacted at the outset of the review process. |
| 49 | 1 | Patient and/or families are informed who is conducting investigations at the outset. |
| 50 | 1 | Patient and/or family views are considered when formulating the scope of the review. |

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|---|---|---|
| 51 | 1 | Patient and/or families are informed of a realistic timeline for reviews. |
| 52 | 1 | Patient and/or families are informed of delays in a timely fashion and provided with the reasons for them. |
| 53 | 1 | Patient and/or families are invited to contribute to reviews. |
| 54 | 1 | Patient and/or families are invited to check for factual accuracy prior to the publication of reports. |
| 55 | 1 | Patient and/or families are informed of the outcome of the review and invited to comment on the findings of reports. |
| 56 | 2 | There is a process whereby patients and/or families involved can give feedback about the review process if they wish to. |

## References

Principles for investigating serious incidents involving patients, 2018

Principles for investigating serious incidents| Royal College of Psychiatrists (rcpsych.ac.uk)

Standards for Community-Based Mental Health Services, 3rd Ed, 2019
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/ccqi-resources/rcpsych_standards_com_2019_lr.pdf?sfvrsn=321ed2a3_2

Serious Incident Framework, NHS England, 2015

https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

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## Contact Details

Jemini Jethwa
Serious Incident Review Accreditation Network
Royal College of Psychiatrists' Centre for Quality Improvement
21 Prescot Street
London E1 8BB

**Tel:** 0208 618 4061
**Email:** SIRAN@rcpsych.ac.uk

Royal College of Psychiatrists Centre for Quality Improvement
21 Prescot Street · London · E1 8BB



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