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SIRAN
SAFETY INCIDENT RESPONSE ACCREDITATION NETWORK

Safety Incident Response Accreditation Network

Standards

Third Edition

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Artwork displayed on the front cover of this report was created by Tim A Shaw, Norfolk and Suffolk NHS Foundation Trust, Courtesy of Hospital Rooms.

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 Safety Incident Response Accreditation Network (previously named Serious Incident Review Accreditation Network); 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 safety incident responses and 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.

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 Safety Incident Responses

Section 1: Organisational Processes

Std No	Type	Standard
1	1	There is a written process in place for reporting and managing incidents. *Guidance: This is set out clearly and made available to staff.*
2	1	There is a written process in place for deciding which patient safety incidents require further review *Guidance: This should consider different methodologies or types of reviews.*
3	1	There is evidence that the decision-making process is followed for patient safety reviews.
4	1	The Board receives a report covering learning response activity in relation to patient safety. *Guidance: This includes a summary of the learning or the key improvements that have taken place*.
5	2	There is evidence of timely implementation of improvements and a process of oversight from the learning identified from the patient safety incident reviews.
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. *Guidance: This includes accountability in the instance of external reviews.*

Section 2: Incident Review Processes

Std No	Type	Standard
8	1	The organisation compassionately engages with those affected by the incident as soon as reasonably practicable to ensure their needs are met.
9	1	The organisations fulfils the Statutory Duty of Candour. *Guidance: Where this does not apply, for example, in Northern Ireland, appropriate principles of candour and openness are followed.*
10	1	Reviews are led by someone who is independent of the treating team.
11	1	The review is led by someone who has relevant experience, expertise, or training in reviews.

12	1	At least one reviewer has service specific expertise relevant to the review or, if not, specialist advice is sought. *Guidance: Where specialist advice is obtained, this is clearly described in the report*.
13	2	The locally agreed timescale for the individual reviews is adhered to. *Guidance: Any agreed extensions are clearly documented*.
14	1	Terms of reference are agreed by senior managers.
15	2	Where there are multiple organisations involved in the patients care, there is evidence of multi-agency learning and sharing of information.

Section 3: Reports

Std No	Type	Standard
16	1	Reports state the name and professional role of each reviewer.
17	1	There are clear terms of reference specific to the case.
18	2	Reports refer to existing organisational policies or relevant guidance.
19	1	Reports are succinct, written in plain English and avoid unnecessary jargon.
20	1	All specialist vocabulary, acronyms and jargon are explained in the report.
21	1	All abbreviations should appear in full the first time they appear in the report.
22	2	There is a glossary to explain abbreviations and specialist terms.
23	1	The rationale for the conclusions is clear from the analysis contained in the report.
24	1	The rationale for recommendations and areas for improvement is clear from the analysis contained in the report.
25	2	Reports evaluate clinical decision-making processes relevant to the issues being investigated.
26	1	There is a clear improvement/action plan where required.
27	1	It is clear how the improvement/action plans are derived.
28	1	Improvement and/or action plans clearly describe actions that are appropriate for the recommendation and areas for improvement. *Guidance: This may include using the SMART framework*.
29	1	Where there is an improvement and/or action plan, there is a specific individual, named in the report, that is accountable for delivering those actions within a specified timescale.
30	2	Recommendations refer to the organisation's existing action plans and quality priorities.

31	1	There is evidence of a quality improvement (QI) or audit programme in place which focuses on learning for improvement.
32	1	Significant findings lying outside of terms of reference are noted and also acted upon.
33	1	Reports acknowledge any limitations, including where case notes and staff are inaccessible.

Section 4: Involvement of Clinical Staff

Std No	Type	Standard
34	1	Staff and professional stakeholders involved in the care of the patient are formally contacted at the outset of the review process.
35	1	Terms of reference are made available to staff and professional stakeholders involved in the patient's care.
36	1	Staff and professional stakeholders involved in the patient's care are informed who is conducting a review at the outset.
37	1	Staff and professional stakeholders involved in the patient's care are informed of a realistic timeline for a review.
38	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.
39	1	Staff and professional stakeholders involved in the patient's care are invited to contribute to the review.
40	1	Staff and professional stakeholders involved in the patient's care are invited to check for factual accuracy prior to publication of the report.
41	1	Staff and professional stakeholders involved in the patient's care are invited to comment on the findings of the report prior to the publication of the report.
42	1	Staff members are made aware of how to access post-incident reflection and support.
43	2	Staff are invited to meet with the review team and reflect on the quality of care provided.
44	1	There is a process whereby staff can give feedback about the review process if they wish to.
45	2	Staff are treated respectfully and sensitively during the review process.
46	2	Learning is recognised in the review process where appropriate.

Section 5: Involvement of Patients and Families

Std No	Type	Standard
47	1	Patient and/or families are contacted at the outset of the review process.
48	1	Patient and/or families are informed who is conducting a review at the outset.
49	1	Patient and/or family views are considered when formulating the scope of the review and/or terms of reference.
50	1	Patient and/or families are informed of a realistic timeline for reviews.
51	1	Patient and/or families are informed of delays in a timely fashion and provided with the reasons for them.
52	1	Patient and/or families are invited to contribute to reviews.
53	2	Where patients and/or families have asked particular questions, these should be clearly answered in a separate section of reports.
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	The organisation provides patients and/or family members with appropriate support needs e.g. an interpreter.
57	1	There is a process whereby patients and/or families involved can give feedback about the review process if they wish to.
58	1	The organisation provides patients and/or family members with contact details of the review team.
59	2	There is a designated individual responsible for liaising with and supporting family members. *Guidance: A Family Liaison Officer (FLO) could fulfil this role where available.*

References

Principles for investigating serious incidents involving patients, 2018

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

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Patient Safety Incident Response Framework, NHS England, 2022

NHS England » Patient Safety Incident Response Framework and supporting guidance

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