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SAFETY INCIDENT RESPONSE ACCREDITATION NETWORK

Safety Incident Response Accreditation Network

Standards

Fourth Edition

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Contents

Artwork displayed on the front cover of this report was created by a patient named Philiph.M from Secure Inpatient Services at Ridgeway, Rosebery Park Hospital.

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. However, they can also be used as a guide for anyone undertaking serious incident reviews. Please contact us 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.

Key changes from the 3rd edition of standards

To indicate any revisions since the last edition of standards, we have used the following key:
(m) = standards modified since the last edition
(n) = new standard since the last edition

Terminology

This document refers to patient safety incident responses and 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.

Standards for Safety Incident Responses

Section 1: Governance of safety systems

Std No	Type	Standard
1 (m)	1	There is a written process in place for reporting and managing patient safety incidents. *Guidance: This is set out clearly and made available to all 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 (m)	1	The board receives a report covering patient safety learning response activity. *Guidance: This includes a summary of the learning and/or the key improvements that have taken place.*
5 (n)	1	Members of the board follow up on important areas of learning and improvements, which may include asking about these during service visits or engaging in discussion with relevant staff.
6 (n)	1	There is a process of oversight from the learning identified from the patient safety incident reviews. *Guidance: This includes oversight of dissemination of learning and improvement activity*
7 (n)	1	There is evidence of implementation of improvements within timeframes set out from the review.
8	2	Information governance agreements are in place to ensure information sharing between partner agencies where appropriate.
9 (m)	2	There is robust governance of reviews processes, both internal and external, to enable clear accountability of those undertaking this work. This includes a mechanism to receive feedback on reviewers.

Section 2: Quality of safety incident reviews

Std No	Type	Standard
10 (m)	1	The organisation engages compassionately and meaningfully with those affected by the incident as soon as reasonably practicable to understand and respond to their needs.
11 (m)	1	Where appropriate, the organisation fulfils the principles of Duty of Candour.

		Guidance: Where this does not apply, for example, in Northern Ireland, appropriate principles of candour and openness are followed.
12 (m)	1	Investigations are led by someone independent of the treating team. *Guidance: This can include Patient Safety Incident Investigation's (PSII's), Serious Adverse Incident's (SAI's) and Serious Adverse Event Review's (SAER's).*
13 (m)	1	The review is led by someone who has relevant experience, expertise, or training in reviews. *Guidance: Training should be relevant for the type of review being carried out.*
14	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.*
15	2	The locally agreed timescale for the individual reviews is adhered to. *Guidance: Any agreed extensions are clearly documented.*
16	1	Terms of reference are agreed by senior managers.
17 (m)	2	Where there are multiple organisations involved in the patients care, there is evidence of multi-agency engagement, learning and sharing of information.

Section 3: Learning responses

Std No	Type	Standard
18 (n)	2	There is evidence of a commitment to learning which is embedded in all levels of the organisations. This can be evidenced through a QI project or shared learning events for a specific learning response in relation to patient safety.
19 (m)	1	Reports state the name and job title of each reviewer.
20 (m)	1	There are clear terms of reference specific to the case and/or the scope of review is well defined.
21 (m)	2	Reports refer to existing organisational policies, national guidance or other relevant documents.
22 (m)	1	All written documents are succinct, written in plain English and avoid unnecessary jargon.
23	1	All specialist vocabulary and jargon are explained in full in the report and acronyms are avoided. *Guidance: A summary list of acronyms can be included.*
24 (m)	1	All abbreviations should appear in full the first time they appear in all written documents.

25	1	The rationale for the conclusions is clear from the analysis contained in the report.
26	1	The rationale for recommendations and areas for improvement is clear from the analysis contained in the report.
27	1	There is a clear improvement/action plan where required.
28	1	It is clear how the improvement/action plans are derived.
29	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.*
30 (m)	1	Where there is an improvement and/or action plan, this is allocated to a specific job role that is accountable for delivering those actions within a specified timescale.
31 (m)	2	Recommendations refer to the organisation's existing action plans and quality priorities where appropriate.
32	1	There is evidence of a quality improvement (QI) or audit programme in place which focuses on learning for improvement.
33 (m)	1	Significant findings lying outside of terms of reference are recorded, monitored and acted upon.
34	1	Reports acknowledge any limitations, including where case notes and staff are inaccessible.

Section 4: Engagement and involvement of clinical staff

Std No	Type	Standard
35 (m)	1	Staff and professional stakeholders involved in the care of the patient are contacted at the outset of the review process.
36 (m)	1	Terms of reference are shared with staff and professional stakeholders involved in the patient's care.
37 (m)	1	Staff and professional stakeholders are involved in contributing to the review, including the Terms of Reference.
38	1	Staff and professional stakeholders involved in the patient's care are informed who is conducting a review at the outset.
39	1	Staff and professional stakeholders involved in the patient's care are informed of a realistic timeline for a review.
40	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.
41 (m)	1	Staff and professional stakeholders involved in the patient's care are invited to check for factual accuracy and comment on written outputs on learning responses prior to publication.
42 (m)	1	Staff members are made aware of how to access post-incident support.

43 (m)	2	Staff are invited to meet with the review team and reflect on the care provided.
44 (m)	1	There is a process whereby staff can give feedback about the review process if they wish to. *Guidance: Staff are encouraged to provide feedback and consideration is given around how this will take place.*
45 (n)	1	The organisation addresses safety culture using staff feedback to drive improvements. Guidance: This can include reviewing findings from national or Trust-wide staff surveys and focusing on the themes relating to patient safety.
46 (m)	1	Staff are treated respectfully and sensitively during the review process.
47 (n)	2	Staff are able to feedback and describe changes made as a result of patient safety learning responses and the impact.

Section 5: Engagement and involvement of patients and families

Std No	Type	Standard
48 (m)	1	Patient and/or families are contacted at the outset of the review process. *Guidance: There is clear guidance for staff around how the appropriate person is identified for contact.*
49	1	Patient and/or families are informed who is conducting a review at the outset.
50	1	Patient and/or family views are considered when formulating the scope of the review and/or terms of reference.
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 (m)	1	Patient and/or families are invited to contribute to the patient safety incident response.
54	2	Where patients and/or families have asked particular questions, these should be clearly answered in a separate section of reports.
55 (m)	1	Patient and/or families are invited to review draft reports, including checking for factual accuracy and making amendments as necessary.
56	2	Patient and/or families are informed of the outcome of the review and invited to comment on the findings of reports.
57 (n)	2	A needs assessment is completed with the patient and/or family to understand their needs and support for involvement through the review process.

58 (n)	2	The organisation provides patients and/or family members with appropriate support needs.
59	1	There is a process whereby patients and/or families involved can give feedback about the review process if they wish to.
60 (n)	1	The organisation provides patients and/or family members with contact details of the member of the review team who is responsible for leading on family engagement.
61 (n)	1	Patients and/or families are clear on who to contact and when, at the outset of the review process
62 (m)	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

Patient Safety Incident Response Framework, NHS England, 2022

NHS England » Patient Safety Incident Response Framework and supporting guidance

Principles for investigating serious incidents involving patients, 2018

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

CCQI Core Standards for Community Mental Health Services, Fourth Edition (2022).

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