PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Inpatient Perinatal Mental Health Services

Sixth Edition

Date: March 2018

Contents

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

1. Access & Admission

No.	Type	Standard
1.1		**Provision and procedures ensure that inpatient care is available to those who need it**
1.1.1	1	The unit admits women with serious mental illness from 32 weeks of pregnancy.
1.1.2	1	The unit admits women at risk of recurrence of serious mental illness in the early days after delivery.
1.1.3	1	The unit can admit women directly to the mother and baby unit without prior admission to an acute adult ward. Guidance: Admission should take place within 24 hours of acceptance. The unit should provide details of the source of all admissions (e.g. a maternity hospital or general adult psychiatric ward).
1.1.4	1	The unit can accept admissions at all times (including out of hours emergencies and those detained under the Mental Health Act).
1.1.5	1	The unit is able to manage patients without them having to be transferred to a general adult psychiatric ward due to the severity of behavioural disturbance, unless there are exceptional circumstances. Guidance: The unit should provide numbers of patients out of the total number of admissions transferred out of the mother and baby unit to other inpatient services (including PICU).
1.1.6	1	All decisions to admit to the unit are made by a senior clinical staff member. Guidance: Senior clinical staff members include the ward/unit manager or nurse in charge. Additionally, a record of refusals and reasons why must be kept.
1.1.7	2	Admissions for the purpose of mother and baby parenting assessments are only undertaken in the known or suspected presence of significant/complex mental illness.
1.1.8		If a mother under the age of 18 is admitted to a mother and baby unit then:
1.1.8a	1	The local authority (or local equivalent) is informed of the admission.
1.1.8b	1	The Care Quality Commission, or local equivalent, is informed (if the patient is detained).
1.1.8c	1	There is a named CAMHS clinician who is available for consultation and advice.
1.2		**Referrers and other related professionals have ready access to information about the unit**
1.2.1	1	Referrers can speak to a senior member of the unit team to discuss potential admissions and the care of women who are at risk of being admitted.
1.2.2	1	The unit has clear, written criteria for admission.

No.	Type	Standard
1.2.3	2	The unit maintains a list of other mother and baby units with contact details to provide to referrers if the patient would have been accepted, but the unit is full.
1.2.4	1	Information is available (in hard copy and electronically) for referrers and other related professionals e.g. an information booklet etc.
1.2.5	1	Systems are in place to record, audit and evaluate transfers, refusals, waiting lists and the length of prior admission to an adult psychiatric ward. Guidance: The unit should include the numbers of transfers to other inpatient units, the numbers admitted after a period of 24 hours from acceptance, the numbers separated from their baby for longer than 24 hours and the lengths of any prior admission to an inpatient unit.
1.3		**There is equity of access to units in relation to ethnic origin, social status, disability, physical health and location of residence.**
1.3.1	1	Staff work in a way that respects the individual needs of patients from different ethnic, cultural or religious backgrounds.
1.3.2	1	The environment complies with current legislation on disabled access. Guidance: Relevant assistive technology equipment, such as hoists, handrails and accessible access e.g. lifts or ramps are provided to meet individual needs and to maximise independence.
1.3.3	2	The unit works to minimise barriers to access for patients and family members from remote areas. Guidance: For example, by providing information about local resources and accommodation.
1.3.4	1	The unit has access to interpreters and relatives are only used in exceptional circumstances.
1.4		**Units are family-friendly**
1.4.1	2	The unit information leaflet clearly states that the participation of partners/siblings/family members is encouraged.
1.5		**Patients are made familiar with the unit as soon as possible after admission**

No.	Type	Standard
1.5.1	1	Patients are introduced to a member of staff who will act as their point of contact for the first few hours of admission. Patients are shown around the ward within an hour of their admission, or as soon as they are well enough. Guidance: Within the first 4 hours of admission to the ward/unit, patients feel welcomed by staff members. Staff members show patients around and introduce themselves and other patients, offer patients refreshments, and address patients using the name and title they prefer. If a patient is not well enough within the first 4 hours, this takes place as soon as they are well enough.
1.5.2	1	Staff members wear their Trust ID when working on the ward and this is easily visible.
1.5.3	1	Staff members explain the purpose of the admission to the patient as soon as is practically possible.
1.6		**All patients are assessed for their health and social care needs**
1.6.1		Patients have an assessment of their needs and of the needs of their child which is regularly reviewed. This includes:
1.6.1a	1	Risk to themselves, the baby and others.
1.6.1b	1	Support and supervision required in caring for themselves and their baby.
1.6.1c	1	Mode of infant feeding (breast, bottle, weaning etc.).
1.6.1d	1	Care of baby which should include physical care, emotional care, developmental care and the ability to ensure safety.
1.6.2		The immediate risk assessment of the patient includes:
1.6.2a	1	Risk of self-harm and suicide.
1.6.2b	1	Level of substance use.
1.6.2c	1	Absconding risk.
1.6.2d	1	Sexual vulnerability.
1.6.2e	1	Domestic violence.
1.6.2f	1	Patients have a full physical history and examination including blood pressure, pulse, temperature, respiration rate and urinalysis (dipstick) which are recorded in patient notes within 4 hours of admission.
1.6.2g	1	Weight and height, liver function, renal function – electrolytes, creatine and GFR, thyroid function and antibodies, Hb, ESR and film, drug and alcohol screening investigations are undertaken within 1 working day (no more than 72 hours of admission) and recorded in patient records.
1.6.2.h	1	Women admitted within 5 days of delivery have twice daily temperature/pulse, respiration and daily blood pressure and must be seen by a midwife within 2 days of admission and this must be recorded in patient records. Guidance: This should continue for as long as clinically indicated.

No.	Type	Standard
1.6.3	1	Risk assessments and management plans are updated weekly or more frequently if there is a change in the mental state of the mother or the needs of the infant, or if the mother is acutely ill.
1.6.4	1	Patients are reviewed by a perinatal consultant or senior doctor (e.g. specialist registrar or staff grade) within one working day of admission.
1.6.5	1	Case notes show evidence of assessment of social care needs and involvement with other agencies.
1.6.6	1	The unit liaises with local safeguarding children/vulnerable adult services if there are any concerns (or out of area if applicable).
1.6.7	1	Patients have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.
1.6.8	1	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear details on and management plans for the following (this is also discussed with the patient): • Arrangements for other children • The security of the patient's home
1.6.9	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).

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

2. Environment & Facilities

No.	Type	Standard
2.1		**The unit is well designed and has the necessary facilities and resources**
2.1.1	2	Patients can access safe outdoor space which is available every day.
2.1.2	1	The unit has a communal lounge area.
2.1.3	1	The unit has a dedicated nursery which can be accessed 24 hours a day.
2.1.4	1	There is a selection of age appropriate toys.
2.1.5	1	There are laundry facilities for the exclusive use of patients on the unit.
2.1.6	1	The unit has a designated area for the separate preparation and storage of baby food. Guidance: This can be within the same room as adult food if the areas are clearly defined.
2.1.7	1	The unit has a dedicated office for use by clinical staff.
2.1.8	2	There should be at least one additional office for individual clinical assessments and interventions.
2.1.9	1	The ward/unit has a designated dining area, which is reserved for dining during allocated mealtimes.
2.1.10	2	The unit has access to private space for meetings with partners, relatives and other professionals.
2.1.11	2	Staff members and patients can control heating, ventilation and light.
2.1.12	1	The temperature in the nursery and bedrooms is appropriate for sleeping babies. Guidance: This should be between 16-20°C.
2.1.13	2	There are sufficient IT resources (e.g. computer terminals) to provide practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.
2.1.14	2	The ward/unit entrance and key clinical areas are clearly signposted.
2.1.15	3	All patients can access plug sockets to charge electronic devices such as mobile phones.
2.1.16d	2	There are facilities for patients to make their own hot and cold drinks and snacks.
2.1.16e	3	Patients are consulted about changes to the ward/unit environment.
2.1.17		**The unit is equipped with medical items for examining mothers including:**
2.1.17a	1	Weighing scales

No.	Type	Standard
2.1.17b	1	Ophthalmoscope
2.1.17c	1	Thermometer
2.1.17d	1	Stethoscope
2.1.17e	1	Blood glucose monitoring kit
2.1.17f	1	Blood pressure monitoring machine
2.1.18		**The unit is equipped with medical items for examining babies including:**
2.1.18a	1	Weighing scales
2.1.18b	1	Thermometer
2.1.18c	1	Stethoscope
2.1.19	1	Resuscitation equipment, including a crash bag and infant face mask and pump, must be available immediately in an emergency. Equipment is maintained and checked weekly and after use.
2.1.20	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery. Guidance: Reviewers should check whether doors to kitchens/bathrooms/nursery are not routinely locked or separated and whether mothers have access to all the facilities on ward that they need. Mothers and their babies should not be routinely separated e.g. for a period after admission.
2.1.21	2	Ward/unit-based staff members have a dedicated staff room.
2.1.22	2	All staff have a locker or locked area to store personal belongings.
2.1.23	2	All patients have available a range of current culturally appropriate 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).
2.1.24	2	The unit provides internet access for all patients.
2.1.25	1	Staff members respect the patient’s personal space, e.g. by knocking and waiting before entering their bedroom.

No.	Type	Standard
2.1.26	1	People use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy. Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached. Patients must be advised not to take photographs of other patients and their babies.
2.2		**Mother and baby units are separate from adult units**
2.2.1	1	The unit has a separate entrance with restricted access equivalent to that on maternity/neonatal units.
2.3		**Premises are designed and managed so that mother's rights, privacy and dignity are respected**
2.3.1	1	Each patient has their own bedroom with a wash basin.
2.3.2	1	All bedrooms are equipped so that babies can be roomed with their mothers.
2.3.3	1	The ward/unit has at least one bathroom/shower room for every three patients.
2.3.4	3	Every patient has an en-suite bathroom.
2.3.5	2	The ward/unit has a designated room for physical examination and minor medical procedures.
2.3.6	2	The ward/unit has at least one quiet room other than patient bedrooms.
2.3.7	2	There are sufficient areas to allow for visitors which should be appropriate for children with appropriate facilities such as toys and books, in addition to the mother's bedroom or communal areas.
2.3.9	2	All patients have access to lockable storage which may be within their own individual rooms, or access to a safe on the ward.
2.3.10	1	There is access to the day room at night for patients who cannot sleep.
2.3.11	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 and access to a multi-faith room.
2.3.12	1	Staff members follow an agreed protocol when conducting searches of patients and their personal property.
2.4		**The unit provides a safe environment for staff and patients**
2.4.1	1	There are clear lines of sight to enable staff to observe mothers and their babies. Guidance: This should include mirrors for any blind spots.

No.	Type	Standard
2.4.2	1	The team keeps medication in a secure place, in line with the organisation's medicine management policy.
2.5		**There is equipment and procedures for dealing with emergencies in the unit**
2.5.1	1	There are alarm systems in place (e.g. panic buttons/call buttons/personal alarms) and these are easily accessible and are available to patients and visitors (instructions are given for their use). Alarm systems/call buttons/personal alarms are available to patients and visitors, and instructions are given for their use.
2.5.2	1	A collective response to alarm calls and fire drills is agreed by the team before incidents occur. This is rehearsed at least annually.
2.5.3	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed. Guidance: This includes an audit of ligature points and potential hazards to babies.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

3. Staffing

No.	Type	Standard
3.1		**The number of nursing staff on the unit is sufficient to safely meet the needs of patients and babies at all times**
3.1.1a	1	A typical unit with six beds includes at least two qualified nurses per day shift.
3.1.1b	1	A typical unit with six beds includes at least two nurses at night (one of which is qualified).
3.1.1c	2	A typical unit with six beds includes at least three qualified nurses per day shift and two qualified nurses at night.
3.1.2	1	The ward/unit has a mechanism for responding to low staffing levels, including: • A method for the team to report concerns about staffing levels • Access to additional staff members • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.
3.1.3	1	In an emergency, extra nursing cover is available from nearby wards. Guidance: For example, there is access to additional on-call staff or staff from a nearby unit.
3.1.4	1	If used, bank and agency staff work alongside core staff members and are familiar with the unit, and unfamiliar bank and agency staff are only used in exceptional circumstances.
3.1.5	1	Staff carrying out physical examinations are either of the same sex, or there is a same-sex chaperone present.
3.1.6	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans. Guidance: This should be a minimum of 30 minutes.
3.2		**There are nurses with a specialist qualification in the unit at all times**
3.2.1	1	A typical unit with six beds includes at least one nurse holding the RMN qualification on duty at all times.
3.2.2	2	There is at least one specialist nursery nurse to cover day duty (including early and late shifts).
3.2.3	2	There is at least one specialist nursery nurse covering the unit 24 hours a day.
3.2.4	1	The ward manager is supernumerary for a proportion of their time to allow for managerial responsibilities.
3.3		**The unit comprises a core multi-professional team with specialist skills and knowledge**

No.	Type	Standard
3.3.1	1	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can: • Attend the ward/unit within 30 minutes in the event of a psychiatric emergency. • Attend the ward/unit within 1 hour during normal working hours. • Attend the ward/unit within 4 hours when out of hours.
3.3.2	1	A typical unit with six beds includes at least 0.5 WTE consultant psychiatrist. Guidance: This may be provided by two clinicians in a split post. Cover from a specialist consultant must be provided at all times during the working week.
3.3.3	1	A typical unit with six beds includes at least 0.5 WTE junior doctor or equivalent.
3.3.4	1	A typical unit with six beds includes at least 0.5 WTE clinical psychologist or there should be clear evidence of formal representations to achieve this by Oct 2020. Guidance: This should be in place by October 2020 and annual evidenced progress reports will be required to maintain accreditation.
3.3.5	1	A typical unit with six beds includes at least 0.5 WTE occupational therapist or there should be clear evidence of formal representations to achieve this by Oct 2020. Guidance: This should be in place by October 2020 and annual evidenced progress reports will be required to maintain accreditation.
3.3.6	2	A typical unit with six beds includes at least 0.5 WTE social work input.
3.3.7	1	All patients have a designated health visitor.
3.3.8	2	Units should have a designated health visitor who visits at least once a week to advise mothers and clinical staff on childcare issues and liaise with the mother's usual health visitor.
3.3.9	1	All patients have visits and advice from a midwife when clinically appropriate.
3.3.10	2	Core staff are not required to do duties on other units during their designated working hours that would impact on the safe running of the unit; other than reasonable contributions to duty rotas.
3.3.11	3	When the occupancy levels on the mother and baby unit are low, staff are used to provide care in the community where possible.
3.3.12	2	A typical unit with six beds includes at least 0.5 WTE administrative support.

No.	Type	Standard
3.3.13	2	At least two members of the team are trained and supervised to deliver psychological and/or psychosocial interventions that facilitate mother-infant care, interaction and enjoyment.
3.3.14	2	Units should have a designated pharmacist who is available to discuss medication with mothers and clinical staff.
3.3.15	1	There are written documents that specify professional, organisational and line management responsibilities.
3.3.16	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit.
3.4		**There is provision for training relating to perinatal mental health**
3.4.1	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.
3.4.2	1	There are arrangements to allow staff to attend mandatory education and training events.
3.4.3	2	There are arrangements to allow staff to attend at least 1 day of non-mandatory training each year. Staff members have access to study facilities (including books and journals on site or online) and protected time to support relevant research and academic activity.
3.4.4	2	The unit has a budget for staff training and development.
3.4.5	1	All newly qualified nursing staff members are allocated a preceptor to oversee their transition onto the ward/unit. Guidance: This should be offered to recently graduated students, those returning to practice, those entering a new specialism and overseas-prepared practitioners who have satisfied the requirements of, and are registered with, their regulatory body. For more practical advice, see http://www.rcn.org.uk/__data/assets/pdf_file/0010/307756/Preceptorship_framework.pdf
3.4.6	2	All new staff members are allocated a mentor to oversee their transition onto the ward/unit.
3.4.7	1	Practitioners only perform in line within their professional qualification and if still in training are practising under the supervision of a senior qualified clinician.
3.5		**Training has been provided in the following:**

No.	Type	Standard
3.5.1	1	Pharmacological interventions for medical and qualified nursing staff (this is completed annually).
3.5.2	1	Resuscitation (child and adult) (this is completed annually).
3.5.3	1	Risk assessment and risk management. Guidance: This could include: Assessing and managing suicide risk and self-harm; Prevention and management of aggression and violence; Prevent training; Recognising and responding to the signs of abuse, exploitation or neglect; safeguarding vulnerable adults and children (Level 3 for trained staff).
3.5.4	1	Culturally-sensitive practice, disability awareness, and other equality issues.
3.5.5	1	Staff who undertake assessment and care planning have received appropriate training (e.g. CPA or local equivalent) Guidance: This should include training on discharge planning.
3.5.6	1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. Guidance: This training could include: A range of therapeutic interventions for staff to use with patients, for example, cognitive and behavioural techniques, brief psychotherapy techniques, family interventions and counselling.
3.5.7	2	Relevant mental health awareness training (for all non-clinical staff working on the unit). Guidance: This may be covered at induction.
3.5.8	1	Common physical disorders in pregnancy and the early postnatal period (for all clinical staff facilitated by an appropriate specialist).
3.5.9	1	Common physical disorders in infancy (for all clinical staff facilitated by an appropriate specialist).
3.5.10	1	Basic infant development including the main development milestones (for all clinical staff).
3.5.11	1	Staff who undertake assessment and care planning have received training in risk management and risk assessment for both mother and baby.
3.5.12	1	Clinical staff have training in understanding and facilitating mother-baby interaction.
3.5.13	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).
3.5.14	2	Staff members can access leadership and management training appropriate to their role and specialty.

No.	Type	Standard
3.5.15	1	All staff members who administer medications have been assessed as competent to do so. Assessment is repeated on a yearly basis using a competency-based tool.
3.5.16	2	Significant other/family member awareness, family inclusive practice and social systems, including significant other/family members' rights in relation to confidentiality.
3.5.17	2	Patients, significant other/family members and staff members are involved in devising and delivering all forms of training.
3.5.18	3	Shared in-house multi-disciplinary team training, education and practice development activities occur on the ward/unit at least every 3 months.
3.6		**All staff receive regular supervision and can access appropriate support**
3.6.1	1	All clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body. Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.
3.6.2	1	All staff members receive monthly line management supervision.
3.6.3	1	Staff members in training and newly qualified staff members are offered weekly supervision.
3.6.4	1	All staff members receive an annual appraisal and personal development planning (or equivalent). Guidance: This contains clear objectives and identifies development needs.
3.6.5	1	All staff are able to contact a senior colleague as necessary 24 hours a day. Guidance: This will include the on-call system.
3.6.6	1	Staff members, patients and carers who are affected by a serious incident are offered a debrief and post incident support.
3.6.7	2	The team has protected time for team-building and discussing service development at least once a year.
3.6.8	2	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.

No.	Type	Standard
3.6.9	1	The ward/unit actively supports staff health and well-being. Guidance: For example, providing access to support services, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.
3.6.10	2	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.
3.6.11	2	Staff members have access to reflective practice groups.
3.6.12	2	Staff members work well together as an MDT, acknowledging and appreciating each other's efforts and contributions.
3.7		**There is a recruitment policy to ensure vacant posts are filled quickly with well qualified and checked candidates**
3.7.1	3	When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for temporary staff cover.
3.7.2	3	Patient or significant other/family member representatives are involved in interviewing potential staff members during the recruitment process.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

4. Care & Treatment

No.	Type	Standard
		Physical care
4.1		**All mothers receive appropriate maternity care and support**
4.1.1	1	Mothers admitted within 10 days postpartum are seen by a midwife as required in line with standard care needs.
4.2		**The unit team has good access to a range of services, as appropriate to the needs of the patients. These include the following:**
4.2.1	1	Patients are supported by staff members to access care from other mental and physical health services to meet their needs where necessary. This includes ready access to: • Accident and emergency • Social services • Local and specialist mental health services e.g. liaison, eating disorders, rehabilitation • Secondary physical healthcare • Neonatal and general paediatric services • Obstetrics and gynaecology services • Community GP • Domestic and sexual violence agencies
4.2.5	1	The team gives targeted lifestyle advice and provides health promotion activities for patients. This includes: • Smoking cessation advice • Healthy eating advice • Physical exercise advice and opportunities to exercise
4.2.6	1	Patients who are prescribed mood-stabilising medication must be treated in accordance with NICE guidelines on antenatal and postnatal mental health with particular regard to the need for informed consent, suitability of use in breastfeeding and the possible adverse effects on pregnancy. Sodium valproate should not be used in women of reproductive potential and in pregnancy. Guidance: Reasons for the use of mood stabilisers including anti-epileptic drugs must be documented with signed consent and evidence of the patient's understanding of the risks and benefits.
4.2.7	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. Guidance: This includes guidance about when to call 999 and when to contact the duty doctor.
		Psychiatric care
4.3		**All patients have a written care plan as part of the Care Programme Approach (or equivalent)**

No.	Type	Standard
4.3.1	1	Every patient has a written care plan, reflecting their individual needs. Guidance: This clearly outlines: • Agreed intervention strategies for physical and mental health • Measurable goals and outcomes • Strategies for self-management • Any advance directives or stated wishes that the patient has made • Crisis and contingency plans • Review dates and discharge framework • Physical healthcare
4.3.2	1	The practitioner develops the care plan collaboratively with the patient and their significant other/family member (with patient consent). They are also offered a copy of the care plan and the opportunity to review this.
4.3.3	1	The team reviews and updates care plans according to clinical need or at a minimum weekly.
4.3.4	1	Patients are supported by staff members, before (to prepare), during (to understand) and after (to feedback outcomes) any formal review of their care.
4.3.5	1	A full multi-disciplinary ward round/review occurs at least one a week which the patient has the opportunity to attend.
4.3.6	1	Patients and significant other/family members contribute and express their views during reviews.
4.4		**All units have access to a range of therapeutic interventions focusing on mother, baby and family**
4.4.1	1	Patients are offered pharmacological and psychological interventions in accordance with the evidence base and good practice.
4.4.2	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.
4.4.3	2	Patients are offered art/creative therapies.
4.4.4	1	Patients are offered occupational therapy. Guidance: This should include an assessment of need by an OT and ensuring that the facilities used have been risk assessed as a safe environment for a mother and infant. The OT should be part of the MDT.
4.4.5	1	Mothers are offered the opportunity to engage in mother and baby interventions. Guidance: This could include baby massage, play sessions and/or video feedback.

No.	Type	Standard
4.4.6	3	Patients have access to complementary therapies, in accordance with local policy and procedures (and the safety of the baby).
4.4.7	1	Patients are offered the opportunity to engage in family and couples' interventions (where appropriate).
4.5		**There is a programme of care and treatment**
4.5.1	1	Activities are planned in consultation with patients and provided 7 days a week and out of hours. Guidance: Activities which are provided during working hours (Monday to Friday) are timetabled.
4.5.2	2	There is a weekly minuted community meeting that is attended by patients and staff members. Guidance: This is an opportunity for patients to share experiences, to highlight issues on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.
4.5.3	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of perinatal mental health issues.
4.5.4	3	The team provides information and encouragement to patients to access local organisations for support and social engagement. This is documented in the patient's care plan.
4.6		**Patients can meet easily with members of staff, and their key workers**
4.6.1	1	Patients have the opportunity to meet their consultant or senior doctor on a weekly basis outside of the ward review.
4.6.2	1	Each patient receives a pre-arranged session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.
4.7		**During admission, good communication is maintained with the patient's family and local services**
4.7.1	1	The patient's chosen contacts are identified and contact details recorded.
4.7.2	1	Carers are advised on how to access a statutory carer's assessment, provided by an appropriate agency.
4.7.3	1	Partners and designated family members are involved in decisions about the care of the baby (with the patient's consent).
4.7.4	2	Partners are offered individual time with staff members, within 48 hours of the patient's admission to discuss concerns, family history and their own needs.

No.	Type	Standard
4.7.5	2	Carers have access to a carer support network or group. This could be provided by the ward/unit or the team could signpost carers to an existing network. Guidance: This could be a group/network which meets face-to-face or communicates electronically.
4.7.6	1	All partners and significant others are seen within 1 week of admission by a senior clinician to discuss the mother's condition (with the patient's consent).
4.7.7	1	Partners and significant others are offered the opportunity to attend ward reviews and significant meetings (with the patient's consent).
4.7.8	2	Partners and significant others are offered at least one of the following which is documented in a care plan: partner support sessions, family sessions, couple sessions.
4.7.9	2	Partners and significant others are offered at least one of the following: parent-infant activities, practical parenting advice/support with the nursery nurse/health visitor etc.
4.7.10	2	Partners and significant others are offered access to at least one of the following: written/video narratives of experience and recovery of perinatal patients, meeting patient representatives (e.g. service/family days, charities).
4.8		**Drugs are administered according to the relevant guidelines**
4.8.1	1	Drug charts clearly state whether the patient is breastfeeding or not.
4.8.2	1	Staff give information to patients about the use of medication in pregnancy and breastfeeding and risks are discussed.
4.8.3	1	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.
4.8.4	1	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime. Guidance: Side effect monitoring tools can be used to support reviews.
4.8.4i	1	Patients (and their partners, with patient consent and where possible) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.

No.	Type	Standard
4.8.5	1	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.
4.8.6	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.
4.8.7	2	Outcome data is used as part of service management and development, staff supervision and caseload feedback. Guidance: This should be undertaken every 6 months as a minimum.
		Care of baby
4.9		**All babies receive appropriate care and support**
4.9.1	1	Health visitors are informed of all new babies arriving on the unit within 48 hours of admission.
4.9.2	1	There is a care plan for the baby which is developed with the mother wherever possible.
4.9.3	1	Care planning for the baby takes into consideration national guidelines on infant care.
4.9.4	1	Babies are roomed with their mothers whenever possible. If this is not possible, the baby is moved into the nursery for the minimum period required and the reasons for this are documented.
4.9.5	1	If the separation of the mother and baby is prolonged, partners/family members are given the opportunity to provide interim care for the baby, where appropriate.
4.9.6	1	If the risk is too great for the mother to remain primary caregiver to the baby on the MBU, consideration would be given to significant others to provide interim care for the baby.
4.9.7	1	When mothers are unable to consent, breastfed babies are only given formula milk if clinically necessary. Where appropriate, the baby's father is consulted in making this decision.
4.9.8	1	Appropriate food is provided for weaning babies when patients are unable to provide it themselves.
4.9.9	2	All babies are weighed and body mapped on admission to the unit.
4.9.10	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 • Contact details of the ward/unit • Driving/DVLA guidance

No.	Type	Standard
4.9.11	1	Staff members follow a lone working policy and feel safe when escorting patients on leave.
4.9.12	1	Patients are sent on leave only after consultation with significant other/family members.
4.9.12	1	The health visitor and GP are informed of all periods of overnight leave.
4.9.13	1	The team follows a protocol for managing situations where patients are absent without leave.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

5. Information, Confidentiality & Consent

No.	Type	Standard
5.1		**Patients and families have good access to information**
5.1.1	2	A full range of leaflets and posters relevant to the services offered are on clear display and are readily available to patients.
5.1.2	1	Information, which is accessible and easy to understand, is provided to patients and partners. Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is appropriate.
5.1.3	2	The patient is given a 'welcome pack' or 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
5.1.4	2	Staff members explain the main points of the welcome pack to the patient and ask if they need further information on anything explained. This discussion is documented in patient notes.
5.1.5	2	The team provides significant others and family members with appropriate information. Guidance: This includes the names and contact details of key staff members on the unit. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.
5.1.6	1	Patients are told about the level of observation that they are under, how it is instigated, the review process and how their own patient perspectives are taken into account.
5.1.7	1	Patients and significant other/family members are offered written and verbal information about the patient's mental illness. Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group.
5.2		**Patients and families can find out about the unit before admission**

No.	Type	Standard
5.2.1	2	Patients can visit the unit before agreeing to admission (with the exception of emergency admissions). Guidance: Patients and families are able to see the unit's website and/or see a virtual tour of the unit.
5.3		**Personal information about patients is kept confidential, unless this is detrimental to their care**
5.3.1	1	Confidentiality and its limits are explained to the patient and significant other/family member on admission, both verbally and in writing. Guidance: For significant other/family members, this includes confidentiality in relation to third party information.
5.3.2	1	The patient's consent to the sharing of clinical information outside the clinical team is recorded. If this is not obtained the reasons for this are recorded.
5.3.3	1	All patient information is kept in accordance with current legislation. Guidance: Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.
5.3.4	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation and documented in the patients' notes. When patients don't have capacity to consent to interventions, best interest processes involving professionals and family (where appropriate) are followed (or local equivalent). Guidance: These assessments should be undertaken: • On admission • At regular intervals as required by the relevant legal requirement • If the patient's capacity changes; • If the treatment plan changes; • If the patient, family or professionals request it • Capacity assessments are performed in accordance with current legislation
5.3.5	1	The team follows a protocol for responding to significant other/family members when the patient does not consent to their involvement.
5.3.6	1	There are systems in place to ensure that the ward/unit takes account of any advance directives that the patient has made.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

6. Rights & Safeguarding

No.	Type	Standard
6.1		**All examination and treatment is conducted with the appropriate consent**
6.1.1	1	There is documentation to demonstrate that the risks and benefits of specific treatments have been discussed with the patient.
6.1.2	1	Audio and/or video recording facilities and one-way screens are only used with the written consent of patients.
6.2		**The unit is patient-centered and patients have their rights respected**
6.2.1	1	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs and are appropriate for women in late pregnancy or breastfeeding.
6.2.2	2	Staff members ask patients for feedback about the food and this is acted upon.
6.2.3	1	Patients are given verbal and written information 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
6.2.4	1	Detained patients are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes. This should include their rights to access a mental health tribunal and/or managers hearing.
6.2.5	1	Patients can make and receive telephone calls in private, where clinically appropriate.
6.2.6	1	Patients feel that they are treated with compassion, dignity and respect. Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.
6.2.7	1	Patients feel listened to and understood in consultations with staff members.
6.2.8	1	Staff members are knowledgeable about, and sensitive to, the mental health needs of patients from minority or hard-to-reach groups. This may include: Black, Asian and minority ethnic groups; Asylum seekers or refugees; Lesbian, gay, bisexual or transgender people; Travellers.
6.2.9	3	The ward has a designated equalities champion.

No.	Type	Standard
6.3		**Patients can complain or ask questions if they are unhappy with their care and treatment**
6.3.1	2	All patients have access to an advocacy service.
6.3.2	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment.
6.4		**The unit operates within the appropriate legal framework in relation to the use of physical restraint**
6.4.1	1	After any episode of control, seclusion, restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the patient reflecting on why this was necessary. The patient's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.
6.4.2	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other patients on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.
6.4.3	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
6.4.4	1	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their significant other/family, in line with the Duty of Candour agreement.
6.4.5	1	The team effectively manages patient violence and aggression. Guidance: 1) Staff members do not restrain patients in a way that affects their airway, breathing or circulation 2) Restrictive intervention always represents the least restrictive option to meet the immediate need 3) Individualised support plans, incorporating behaviour support plans, are implemented for all patients who are known to be at risk of being exposed to restrictive interventions 4) The team works to reduce the amount of restrictive practice used 5) Providers report on the use of restrictive interventions to service commissioners, who monitor and act in the event of concerns
6.5		**Staff are aware of the legal status of those admitted**
6.5.1	1	The Mental Health Act status of patients (including those who are not detained) is known to all staff and visible on notes.
6.6		**The unit complies with local LSCB procedures and with guidance contained in "What to do if you're worried a child is being abused" (2003) or local equivalent**

No.	Type	Standard
6.6.1	1	The child protection status and responsible social worker is recorded in notes with contact details. Guidance: The absence of child protection status should also be recorded.
6.6.2	1	The unit has policies and procedures on how to deal with allegations of abuse and child protection concerns during and out of working hours. This should include allegations involving babies, patients, visitors or staff.
6.6.3	1	The health record includes a note of who has parental rights and responsibility.
6.6.4	3	There is a policy for defining the status of the baby and the implications of this are defined. Guidance: For example: as patient, guest, visitor, dependent child.
6.6.5	1	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward. Guidance: Staff must consider whether sexual incidents that are said to be consensual have been the result of coercion or exploitation or where a person's capacity to consent may have been affected by her mental health. Where there is any doubt the incident must be investigated. Links must be established with the police in serious untoward incidents and to child protection and vulnerable adult policies.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

7. Audit & Policy

No.	Type	Standard
7.1		**The unit evaluates annually:**
7.1.1	2	Patients and their partners/significant others are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service. Guidance: This might include patient and significant other/family member surveys or focus groups.
7.1.2	2	Feedback from referrers.
7.1.3	2	Feedback from unit staff.
7.1.4	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.
7.1.5	2	Analysis of complaints.
7.1.6	2	The findings of audits.
7.1.7	2	Key performance data (e.g. bed occupancy and outcome measurement data).
7.1.8	2	Action plans are developed based on the service evaluation and resulting quality improvement is monitored.
7.2		**Unit staff are involved in clinical audit**
7.2.1	3	There are dedicated resources to support clinical audit within the directorate or specialist areas e.g. staff time, dedicated budget and training in clinical audit for appropriate staff.
7.2.2	3	The team, patients and carers are involved in identifying priority audit topics in line with national and local priorities and patient feedback.
7.2.3	1	The safe use of high risk medication is audited, at least annually and at a service level. Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination.
7.2.4	2	When staff members undertake audits they: • Agree and implement action plans in response to audit reports • Disseminate information (audit findings, action plan) • Complete the audit cycle
7.2.5	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.
7.3		**The unit has a comprehensive range of policies and procedures which consider the special needs of women, babies and families**

No.	Type	Standard
7.3.1	2	Clinical staff are consulted in the development of unit specific policies, procedures and guidelines that relate to their practice.
7.3.3	1	There are written admission and discharge procedures.
7.3.4	1	There are policies and procedures regarding patients' self-harm.
7.3.5	1	There are policies relating to the safety of the environment and baby safety e.g. detailed fire procedures.
7.3.6	1	There is a locked door and deprivation-of-liberty policy.
7.3.7	1	There is a visiting policy which includes procedures to follow for specific groups including: • Children • Unwanted visitors (i.e. those who pose a threat to patients, or to staff members)
7.3.8	1	There are policies, procedures and guidance for infection control practice including childhood ailments.
7.3.9	1	There is a policy on the use of drugs and alcohol, and on the management of those who may be abusing drugs and alcohol.
7.3.10	1	There is a restraint policy which includes procedures for the review of each incident of restraint.
7.3.11	1	The team follows a policy when prescribing PRN (i.e. as required) medication.
7.3.12	1	The ward/unit has a policy for the care of patients with dual diagnosis.
7.3.13	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.
7.3.14	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
7.3.15	3	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as patient and significant other/family member representatives.
7.3.16	2	Patient representatives attend and contribute to local and service level meetings and committees.
7.3.17	3	Commissioners and service managers meet at least 6 monthly.

No.	Type	Standard
7.3.18	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.

PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

8. Discharge

No.	Type	Standard
8.1		**Before discharge, decisions are made about meeting any continuing needs**
8.1.1	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is discussed.
8.1.2	1	Pre-discharge planning involves all services involved in patient care.
8.1.3	1	Patients and their carer (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.
8.1.4	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
8.1.5	1	The inpatient team invites a community team representative to attend and contribute to ward rounds and discharge planning.
8.1.6	1	Community professionals are informed of all periods of leave.
8.1.7	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
8.1.8	1	Patients and their families have 24-hour access to telephone advice from the mother and baby unit for at least four weeks after discharge from inpatient care.
8.1.9	1	The team makes sure that patients who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk. Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.
8.1.10	1	When patients are transferred between wards/units there is a handover which ensures that the new team have an up to date care plan and risk assessment.
8.1.12		**Prior to discharge from the unit, patients are given advice and information on:**
8.1.12a	1	Contraception.

No.	Type	Standard
8.1.12b	1	The risk of recurrence of problems with subsequent pregnancies.
8.1.12c	1	Medication, its side effects and its impact on driving.
8.1.13	2	The unit works to ensure that all patients have a named local community consultant and named nurse as soon as possible to ensure discharge planning begins.

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

www.rcpsych.ac.uk

COLLEGE CENTRE FOR QUALITY IMPROVEMENT