



Quality Network for Perinatal Mental Health Services

Standards for Mother and Baby Inpatient units

Edited by Leanne Shinkwin and Peter Thompson

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**The Royal College of Psychiatrists'
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A manual of standards written primarily for:

Perinatal inpatient mental health services

Also of interest to:

Patients

Commissioners

Policy makers

Researchers

Edition January 2008

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A full copy of this document is available on our website at:

www.rcpsych.ac.uk/perinatal-network

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Introduction

Background

Following the inquiry into the deaths of Daksha and Freya Emson in October 2003 and the publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004, the Royal College of Psychiatrists made a commitment to promote perinatal mental health.

Initial funding was provided for the College Centre for Quality Improvement (CCQI) to complete a national survey of Specialist Perinatal Mental Health Services and to set up a network.

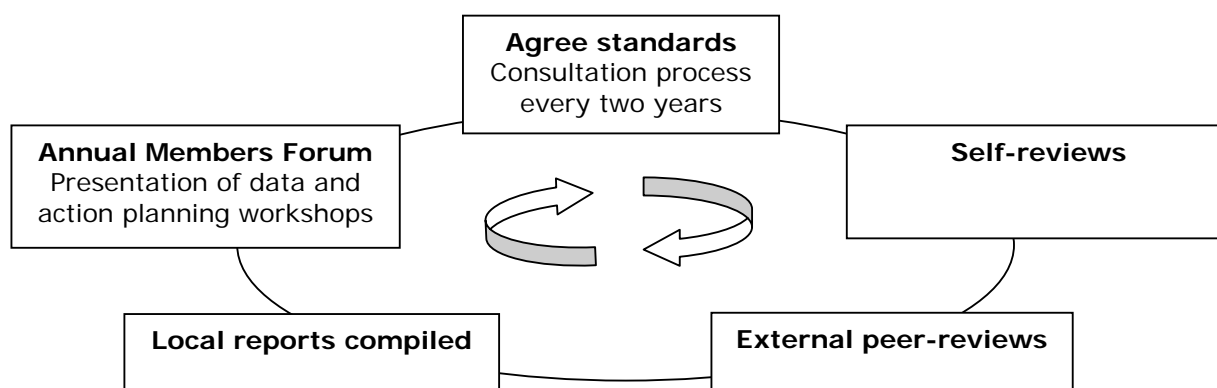
The Quality Network for Perinatal Mental Health Services was launched in June 2007, as part of this commitment, to develop and maintain standards for mother and baby units. The network engages with frontline staff and applies a clinical audit method within a peer-support network.

The Review Process

The standards represent just one part of the cycle: the real benefit for mother and baby units is in taking part in the process of reviews. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see figure below).

If you are interested in joining the network please contact Peter Thompson on 020 7977 6693 or pthompson@cru.rcpsych.ac.uk.

The annual cycle of reviews



The Standards

A draft set of standards was written as the result of an extensive literature review. On 21 May 2007, a wide range of disciplines from mother and baby units were invited to a one-day workshop to discuss and review the standards. The group was divided into two and each group discussed four sections of standards each; groups were asked to 'brainstorm' items and consider what is critical to the quality of care provided. They then worked through each standard and criterion, noting comments and amendments.

A consultation document was sent out to all mother and baby units in England, Wales and Scotland for their comments.

All criteria have been allocated a rating of either 'E' for essential/legal requirement or 'D' for desirable.

Important Note

Data collection tools adapted from these standards will be provided with guidance notes to members before reviews take place. This document is provided for reference and not for data collection.

These are best practice statements and consequently we would not expect services to meet every standard. While there are some statements that are based upon legal requirements, this document is not intended to act as a legal guide in any way. This is not intended to be a guide to any reviews conducted by regulatory bodies.

If you have any questions about these standards please contact Peter Thompson on 020 7977 6693 or email pthompson@cru.rcpsych.ac.uk.

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1	Access and Admission	
1.1	Provision and procedures ensure that inpatient care is available to all those who would need it	
1.1.1	There are sufficient beds to match need, i.e. all women with a child under the age of 12 months who require a psychiatric admission will be admitted to the mother and baby unit, unless there are contra-indications	E
1.1.2	The unit has the capacity to admit women with current or enduring serious mental illness within the last weeks of pregnancy (based on individual need)	E
1.1.3	The unit has the capacity to admit women at risk of recurrence of mental illness in the early days after delivery	E
1.1.4	The unit has the capacity to manage women who are acutely psychotic on admission, i.e. patients are not admitted to a general adult psychiatric ward because they are too disturbed	E
1.1.5	The unit has written referral pathways	E
1.1.6	The unit has a designated catchment area	E
1.1.7	There are local perinatal outreach teams related to the unit, so that mothers are not admitted to inpatient units inappropriately, early discharge is promoted and there is good aftercare	E
1.1.8	Patients who are at risk of serious mental illness following delivery are encouraged to receive their psychiatric and maternity care in the same locality	D
1.1.9	All admissions to the unit only take place after discussion with a senior member of the team	E
1.1.10	Patients' psychiatric care notes are available on admission	E
1.1.11	Maternity notes are available for women admitted within 28 days of delivery	E
1.2	Referrers and other related professionals have ready access to information about the unit	
1.2.1	Referrers can access a senior member of the unit team during working hours to discuss potential admissions and the care of women who are at risk of being admitted	E
1.2.2	The unit has clear, written criteria for admission.	E
1.2.3	A referral to an alternative mother and baby unit that is closest to the patient is made if the unit is full	D
1.2.4	Mothers and their babies are admitted if appropriate. If it is not appropriate, the referrer is given the reasons and alternatives	D
1.2.5	Information is available (in hard copy and electronically) for referrers and other related professionals, e.g. service directory, information booklet	D
1.2.6	Systems are in place to record and audit refusals and waiting lists	E
1.3	Treatment is offered without unacceptable delay	
1.3.1	Patients do not experience delay in treatment that leads to care being offered in inappropriate settings, e.g. in general psychiatric units or community based services	E
1.3.2	Mothers at severe risk can be admitted as emergencies (i.e. within 24 hours), including out-of-hours	E

1.4	There is equity of access to units in relation to ethnic origin, social status, disability, physical health and location of residence	
1.4.1	The special needs of patients from different ethnic, cultural or religious backgrounds are reflected in the unit's policies, e.g. there are special dietary arrangements when needed	E
1.4.2	Advocacy services are easily available	E
1.4.3	The environment meets the needs of people with physical disabilities, and complies with current legislation on disabled access	E
1.4.4	Patients' location of residence does not affect their access to services, e.g. patients from remote areas have access to services, and where necessary special arrangements are made for families who need to stay overnight	D
1.4.5	Minimum levels of access to interpreters is agreed. Relatives are not be routinely used as interpreters.	E
1.5	Units are family-friendly	
1.5.1	The families of out-of-area admissions receive assistance to facilitate the family relationship, e.g. overnight stay/travel	D
1.5.2	The unit information leaflet clearly states that the participation of partners/family members is encouraged	D
1.5.3	The unit provides support to partners in adjusting to their new role and responsibilities and to help develop their parenting skills, if needed	E
1.6	All mothers on the unit have a significant mental illness	
1.6.1	Admissions for the purpose of mother and infant parenting assessments are only undertaken in the known or suspected presence of significant mental illness	E
1.7	Each patient has a key worker	
1.7.1	Referrals must have a named local RMO and care co-ordinator/key worker on admission	E
1.7.2	On the day of admission or as soon as they are well enough, the patient is told the name of their key worker and how to arrange a meeting with them	E
1.7.3	The patient's views are taken into account if they are not satisfied with their key worker, and there is a process in place to deal with this	E
1.8	All mothers are assessed for their health and social care needs	
1.8.1	Patients have an assessment of their needs, which is regularly reviewed. This includes: <ul style="list-style-type: none"> • potential risk to themselves and the infant • risk of self-harm • level of substance use • ethnicity • risk of absconding • spiritual needs • support required in caring for themselves and their baby • mode of feeding (breast, bottle, weaning etc.) • care of baby (routine etc.) • consent or refusal of consent to treatment 	E

1.8.2	Patients have an initial assessment (including risk assessment) of their mental state within two hours of admission	E
1.8.3	Patients are seen by a doctor within four hours of admission	E
1.8.4	The unit establishes a level of nursing observation for each new admission as part of the risk assessment	E
1.8.5	Case notes show evidence of assessment of social care needs, including establishing if the patients are involved with or have access to other agencies	E
1.8.6	If there are any child protection concerns, the local social services department is consulted on admission	E
1.8.7	A second opinion can be accessed	E

2	Environment and Facilities	
2.1	The unit is well designed and has the necessary facilities and resources	
2.1.1	The unit is comfortable and has a warm, welcoming atmosphere	E
2.1.2	The unit has sufficient outdoor space for exercise and access to fresh air	E
2.1.3	The unit has a range of shared spaces to facilitate social interaction	D
2.1.4	There is a nursery	E
2.1.5	There is a selection of age appropriate toys	E
2.1.6	There are laundry facilities dedicated to the unit	D
2.1.7	The unit has designated areas for the separate preparation of infant and adult food	E
2.1.8	The unit has a separate fridge specifically for baby food and milk	E
2.1.9	The unit has a dedicated office for use by clinical staff	E
2.1.10	There is a designated dining area	E
2.1.11	The unit contains large and small rooms for individual and family interviews	E
2.1.12	All confidential case materials, e.g. notes, are kept in locked cabinets or locked offices	E
2.1.13	Drugs are kept in a secure place with the dispensary book	D
2.1.14	Key clinical areas are clearly signposted	D
2.1.15	There is sufficient car parking space for staff and visitors	E
2.1.16	Heating and ventilation in the unit is adequately regulated	E
2.1.17	The unit has sufficient access to maintenance staff to ensure environmental difficulties are resolved quickly	D
2.1.18	There are sufficient IT resources to support high quality care and the monitoring and evaluation of the service	D
2.1.19	Mother and baby units are on the same site as paediatric and maternity services	E
2.1.20	Patients on high obs do not have access to a private bathroom, e.g. en suite bathrooms can be locked from the outside	E
2.1.21	The unit is equipped with medical items that reflect the requirements of maternity, paediatric and psychiatric care	E
2.1.22	The unit is equipped with basic infant resuscitation equipment	E
2.1.23	The unit has clearly signposted access to adult resuscitation equipment	E
2.2	Mother and baby units are separate from adult units	
2.2.1	The unit has a separate entrance with restricted access and visiting, equivalent to that on maternity/neonatal units	E
2.3	Premises are designed and managed so that mother's rights, privacy and dignity are respected	
2.3.1	All bedrooms are single with a wash basin	D
2.3.2	All bedrooms are equipped with facilities for babies	E
2.3.3	There are facilities for clinical examinations of mothers and their infants	E
2.3.4	There are suitably located quiet room(s) available within the unit, other than bedrooms	D
2.3.5	There are sufficient areas in addition to the mother's bedroom or communal areas, to allow for visitors	D

2.4	The unit provides a safe environment for staff and patients	
2.4.1	There are areas with clear lines of sight to enable staff to monitor those who need closer observation	E
2.4.2	There is appropriate security within the unit, e.g. certain doors may be locked if needed	E
2.4.3	Entrances and exits are designed to enable staff to see who is entering or leaving	D
2.4.4	There are arrangements for the safe-keeping of patients' property	D
2.5	Mothers are consulted about the unit environment and have choice when this is appropriate	
2.5.1	Mothers are consulted when decisions are made about changes to the unit's environment and have a choice, when this is appropriate	D
2.5.2	Mothers are encouraged to have personal items in their bedrooms	D
2.6	There is equipment and there are procedures for dealing with emergencies in the unit	
2.6.1	There is a procedure for evacuation in case of fire, which is rehearsed at regular intervals	E
2.6.2	The procedure for resuscitation (infant and adult) is clearly documented, resuscitation equipment is available and its location is clearly identified	E
2.6.3	There is an alarm/communication system in place, e.g. there are panic buttons or walkie-talkies for the staff	E
2.6.4	There is a way for mothers to raise an alarm in an emergency	D
2.6.5	A collective response to alarm calls is agreed before incidents occur and consistently rehearsed and applied	E
2.6.6	Alarm systems/call buttons are checked and serviced regularly	E
2.6.7	The unit complies with appropriate local and statutory health and safety legislation	E
2.6.8	An audit of environmental risk has been conducted with regard to both adults and infants, e.g. hazardous small objects, unguarded radiators	E

3	Staffing (Please note that the following criteria are based on staffing recommendations for a typical six-bed unit)	
3.1	The number of nursing staff on the unit is sufficient to safely meet the needs of women and babies at all times	
3.1.1	There are sufficient nursing staff to maintain appropriate observation, care and safety of mothers and babies	E
3.1.2	There are sufficient nursing staff to maintain a therapeutic environment	E
3.1.3	Extra nursing cover is available when needed, e.g. there is access to additional on-call staff or staff from a nearby unit in an emergency	E
3.1.4	The unit is staffed by permanent staff and agency staff are used only in exceptional circumstances	D
3.1.5	If used, bank and agency staff initially work alongside core staff members and are familiar with the unit	E
3.2	There are nurses with a specialist qualification in the unit at all times	
3.2.1	There is at least one nurse holding the RMN qualification on duty at all times and one specialist nursery nurse during an extended day period	E
3.3	The unit comprises a core multi-professional team with specialist skills and knowledge	
3.3.1	There is an identified duty doctor available at all times to attend the unit	E
3.3.2	A typical unit with six beds includes at least 0.5 WTE consultant psychiatrist	E
3.3.3	A typical unit with six beds includes at least 0.5 WTE junior doctor or equivalent	E
3.3.4	A typical unit with six beds includes at least 0.5 WTE clinical psychologist	E
3.3.5	A typical unit with six beds includes at least 0.5 WTE social work input	E
3.3.6	Arrangements are in place for a designated link health visitor to visit the unit regularly	E
3.3.7	Arrangements are in place for a specialist link midwife to visit the unit regularly	E
3.4	Unit staff work effectively as a multi-disciplinary team	
3.4.1	There is a line management structure with clear lines of accountability within the unit	E
3.4.2	There are regular multi-disciplinary team meetings for clinical matters and administration, and the team is consulted on relevant management decisions such as developing and reviewing operational policy	E
3.4.3	Good staff morale is recognised as important and efforts to improve morale are made when necessary	E
3.4.4	The roles and responsibilities of unit staff are clearly defined, e.g. in up-to-date job descriptions and in operational policy	E
3.4.5	There is time scheduled in staff rotas to allow handover sessions between shifts	E

3.4.6	Core staff are not required to do duties on other units during their designated working hours	E
3.4.7	There are sufficient administrative and secretarial staff to support the effective running of the unit	D
3.4.8	The unit has a designated clinical risk management lead	D
3.5	There is provision for training relating to perinatal mental health	
3.5.1	Members of the nursing team, including all newly appointed senior nurse managers, have undertaken further training in perinatal mental health	E
3.5.2	Induction training is provided for temporary and permanent staff	E
3.5.3	All staff have a comprehensive specialist induction which covers key aspects of care	E
3.5.4	All staff participate in continuing professional development	E
3.5.5	Whenever appropriate staff training and induction is multi-disciplinary and multi-agency	D
3.5.6	Staff have access to books, journals, video tapes and access to the internet, e.g. from a unit library	D
3.5.7	There are arrangements for staff cover to allow staff to attend education and training events	D
3.5.8	All staff are provided with study facilities and time	D
3.6	The training needs of unit staff have been formally assessed	
3.6.1	All healthcare professionals who care for mothers and babies work within the relevant competencies developed by skills for health (www.skillsforhealth.org.uk) and in line with the relevant colleges and professional bodies	E
3.6.2	Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year	E
3.6.3	The Trust has supplied appraisal training and the relevant documentation to managers	E
3.7	Training has been provided in the following:	
3.7.1	Aetiology, symptoms and assessment of the range of relevant conditions	E
3.7.2	Pharmacological interventions for medical and qualified nursing staff	E
3.7.3	A range of therapeutic interventions for staff to use with mothers, including cognitive and behavioural techniques, brief psychotherapy techniques, family interventions, counselling	E
3.7.4	Resuscitation (child and adult)	E
3.7.5	Management of imminent and actual violence, breakaway techniques and restraint measures	E
3.7.6	Recognising the risks, signs and symptoms of child abuse, and who to contact for advice and management	E
3.7.7	Recognising the risks, signs and symptoms of domestic abuse, and who to contact for advice and management	E
3.7.8	Legal frameworks such as the Children Act 1989, Mental Health Act 1983 and the revised Code of Practice	E
3.7.9	Culturally-sensitive practice, disability awareness, and other equality issues	E
3.7.10	Relevant health and safety issues	E
3.7.11	Confidentiality	E
3.7.12	Clinical governance	D

3.7.13	Audit and research skills	D
3.7.14	Policy and procedures, e.g. referral procedures	E
3.7.15	The use of support or supervision networks	E
3.7.16	The role of other services and the range of local services and activities	E
3.7.17	Management and team leadership (for Unit Managers who are nursing staff)	D
3.7.18	Relevant mental health awareness training (for non-clinical staff)	D
3.7.19	Common disorders in pregnancy and the early post-natal period	D
3.7.20	Common disorders in infancy	D
3.7.21	Basic infant development	D
3.7.22	Infant feeding, encouraging and maintaining breastfeeding	E
3.7.23	Contraception, including emergency contraception	E
3.7.24	Normal emotional changes in pregnancy and the postpartum period	D
3.7.25	Cultural differences in infant feeding/care/interaction, marital and family relationships	D
3.8 All staff receive regular supervision		
3.8.1	All staff receive regular supervision totalling at least one hour per month from a person with appropriate experience	E
3.8.2	All staff who have been working for less than six months have at least one hour per week of group and/or individual supervision.	E
3.8.3	Junior staff have regular supervision totalling at least one hour per week and are able to contact a senior colleague as necessary	D
3.8.4	All staff receive annual appraisals and personal development planning	D
3.8.5	Managers and practitioners have agreed clear and realistic clinical performance targets	D
3.8.6	Staff are provided with opportunities for de-briefing	E
3.9 There is a recruitment policy to ensure vacant posts are filled quickly with well qualified and checked candidates		
3.9.1	All unit staff are police-checked before their appointment	E
3.9.2	Staff with a professional regulatory body (e.g. Nursing and Midwifery Council, Royal College of Psychiatrists, Council for Professions Supplementary to Medicine or the General Medical Council) are checked for appropriate registration on recruitment and again at renewal date	D
3.9.3	When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for temporary staff cover	D
3.9.4	Reasons for staff leaving are established, e.g. exit questionnaires or interviews are used	D
3.9.5	Staff vacancies are advertised as widely as possible	E

4	Care and Treatment	
	Physical care	
4.1	All mothers receive appropriate maternity care and support	
4.1.1	Mothers admitted 0 - 10 days postpartum have a daily visit from a midwife in line with standard care	E
4.1.2	Mothers admitted between 11 - 28 days postpartum are seen by a midwife as required in line with standard care	E
4.1.3	Supervision and support is provided for the mother to help care for her baby based on individual need	E
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	Neonatal and general paediatric services	D
4.2.2	Substance and alcohol misuse services	D
4.2.3	Learning disability services	D
4.2.4	Accident and emergency facilities	D
4.2.5	Obstetrics and gynaecology	E
4.2.6	Fetomaternal services	E
	Psychiatric care	
4.3	All patients have a written care plan as part of the Care Programme Approach (or equivalent)	
4.3.1	There is a written management or care plan for every patient, reflecting their individual needs	E
4.3.2	There is a written management or care plan for the infant	E
4.3.3	Patients are actively involved in the development of their management or care plan	E
4.3.4	The views of patients are noted in the management or care plan	D
4.3.5	The plan is signed by the patient when competent	D
4.3.6	Patients are given a copy of the management or care plan or have ready access to it	E
4.3.7	The management or care plan is reviewed at defined and agreed intervals during admission (e.g. a weekly ward round and three monthly CPA (or equivalent) review)	E
4.3.8	The unit holds regular CPA (or equivalent) reviews for every patient to ensure that continuing needs are met, regardless of Mental Health Act status	E
4.3.9	The CPA (or equivalent) and associated documentation reflects the perinatal context (e.g. different professionals involved)	D
4.4	All units have access to a range of therapeutic interventions focusing on mother and baby	
4.4.1	Drug therapy	E
4.4.2	Cognitive behavioural therapy	E
4.4.3	Behavioural therapy	E

4.4.4	Family therapy and family work	E
4.4.5	Parenting skills training	D
4.4.6	Creative therapies	D
4.4.7	Dietetic advice	D
4.4.8	Physiotherapy – post-natal exercise	D
4.4.9	Occupational therapy	D
4.4.10	Infant development training	D
4.4.11	Baby massage	D
4.4.12	Play therapy	D
4.4.13	Video feedback	D
4.4.14	Physical exercise	E
4.5	There is a programme of care and treatment	
4.5.1	A therapeutic programme of activities is available	E
4.5.2	There is opportunity for socialisation, recreation and exercise	E
4.6	Wherever possible the treatment provided is evidence-based	
4.6.1	Treatments are selected according to the evidence of their effectiveness or according to nationally agreed best practice or guidance	E
4.7	Patients can meet easily with members of staff, and particularly the key worker	
4.7.1	Patients have access to the consultant when needed, for example, outside planned meetings	E
4.7.2	Patients can arrange appointments with other staff as needed	E
4.8	During admission good communication is maintained with the patient's family and local services	
4.8.1	At admission partners and family members are involved in meetings to explain care etc, with the mother's consent	E
4.8.2	Partners and family members are actively encouraged to attend ward rounds and meetings unless there are specific reasons for not doing so	E
4.8.3	Staff ask partners and family members for their views about the mother and baby's progress and recovery, with the mother's consent	E
4.9	Drugs are administered according to the relevant guidelines	
4.9.1	Medication is prescribed in accordance with the NICE guideline 45 Antenatal and Postnatal Mental Health. Reasons for deviation from the NICE guidelines are clearly documented	E
4.9.2	Drug charts clearly state whether the mother is breastfeeding	E
4.9.3	There are written guidelines for the use of rapid tranquillisation (appropriate to pregnancy and early postpartum period)	E
4.10	Outcome measurement is undertaken routinely using validated outcome tools	
4.10.1	Outcome is evaluated from the perspective of staff, patients and carers at a minimum	E
4.10.2	Staff have been trained in the use of appropriate clinical outcome measures	E

4.10.3	Information from outcome measurement is fed back to the whole staff team, users and commissioners	D
	Care of infant	
4.11	All babies receive appropriate care and support	
4.11.1	All babies are seen by the health visitor between 14 and 28 days, and follow-up visits occur where appropriate	E
4.11.2	There is an identified doctor to provide primary medical services to the infant	E
4.11.3	New born infants receive the same level of paediatric care as on maternity wards	E
4.11.4	Whenever possible, infants are roomed in with their mothers. If this is not possible, the baby is moved into the nursery for the minimum period required and the reasons for this documented	E
4.11.5	If the separation of the mother and infant is prolonged, partners/family members are given the opportunity to provide interim care for the baby if they wish to do so, unless there are specific reasons for not doing so	E
4.11.6	The same level of hygiene is maintained on the unit as that on maternity wards appropriate to the age of the infant	E
4.11.7	Formula milk is not given to breastfed babies unless clinically indicated, with the mother's consent	E
4.11.8	Appropriate food is provided for weaning infants	E

5	Information and Confidentiality	
5.1	Patients and families have good access to information	
5.1.1	A full range of appropriate leaflets and posters relevant to the services offered are on clear display and are readily available	D
5.1.2	Information when necessary is accessible and in languages other than English and in forms which people with sight, learning and other disabilities can use	E
5.1.3	A 'welcome pack' or introductory booklet is provided when people first use the service, including unit rules and procedures	E
5.2	Patients and families can find out about the unit before the admission	
5.2.1	Patients can visit the unit and find out about the services offered before agreeing to admission (with the exception of emergency admissions)	D
5.2.2	There is a pre-admission meeting to discuss the aims of the admission (with the exception of emergency admissions where aims are discussed upon admission)	E
5.3	Patients and partners are involved in decisions about their treatment	
5.3.1	There is a process for actively asking what information patients and families need, e.g. about the service, their care and treatment	E
5.3.2	Patients are given a clear explanation of their diagnosis or the assessment programme if diagnosis has not been determined on admission	E
5.3.3	Patients' views are explicitly sought about their condition to help treatment compliance	E
5.4	Patients have access to their health records	
5.4.1	Patients are informed of their rights to see their health records and the limitations on those rights	E
5.5	Personal information about patients is kept confidential, unless this is detrimental to their care	
5.5.1	Confidentiality and its limits are explained to the patient, e.g. it is made clear that this is extended beyond the clinical team only if the quality of their care and/or the safety of another depends on this, and then only to those who need to know	E
5.5.2	Consent to the sharing of information outside the clinical team is recorded, and if this is not obtained then reasons for this are recorded	E

6	Rights and Consent	
6.1	All examination and treatment is conducted with the appropriate consent	
6.1.1	There is documentation to demonstrate that the risks and benefits of specific treatments have been discussed with the patient, partner and any other significant person	E
6.1.2	Audio and/or video recording facilities and one-way screens are not used without the written consent of patients	E
6.1.3	Consent is obtained in writing whenever appropriate	E
6.2	The unit is patient-centred and patients have their rights respected	
6.2.1	There is a choice of well-prepared food that suits all nutritional, personal, cultural and clinical dietary needs appropriate to women in late pregnancy and breastfeeding	E
6.2.2	There are facilities for patients to make their own hot and cold drinks and snacks, which are safe for visitors and toddlers	D
6.2.3	Patients are informed of arrangements for seeing staff of a particular gender where this is important to them	E
6.2.4	Patients feel respected by staff and find staff friendly and approachable	E
6.2.5	Patients' rights and what they can expect are explained, e.g. they are given a copy of the Patient's Charter or a similar document	E
6.3	Patients can complain or ask questions if they are unhappy with their care and treatment	
6.3.1	Patients are given clear information on how to raise concerns and complaints	E
6.3.2	There is information available on how to get independent help and advocacy	E
6.4	The unit operates within the appropriate legal framework in relation to the use of physical restraint	
6.4.1	After restraint the patient is counselled on why it was necessary and their views are sought and included in de-briefing about the incident	E
6.4.2	The senior nurse discusses the incident within the same day or shift and staff meetings include a formal analysis of the event	D
6.5	Staff are aware of the legal status of those admitted	
6.5.1	The Mental Health Act status of patients is known to all staff and visible on notes	E
6.6	The unit complies with local LSCB procedures and with the guidance contained in "What to do if you're worried a child is being abused" (2003)	
6.6.1	The child protection status and responsible social worker is recorded in the notes with contact details	E
6.6.2	The unit has policies and procedures on how to deal with allegations of abuse and child protection concerns during and out of working hours	E

6.6.3	Local LSCB guidelines, Working Together under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses are available and accessible to all staff members	E
6.7	The unit has a policy on dealing with allegations of abuse against staff, patients or visitors, including contact visits by relatives or friends	
6.7.1	The Trust informs the Home Office or the National Assembly for Wales if there is reason to believe that an offence has been committed against a patient or baby by a member of staff	E
6.7.2	The health record includes a note on who has parental rights and responsibility	E
6.7.3	There is a policy for defining the legal status of the baby, e.g. as patient, guest, visitor, dependent child and the implications of this are defined	D
6.7.4	There is a policy for dealing with allegations of abuse involving babies, patients, visitors or staff	E

7	Audit and Policy	
7.1	All available information is used to evaluate the performance of the unit	
7.1.1	Information from patients is used to evaluate the unit through a number of means, e.g. suggestion boxes, surveys and user groups	D
7.1.2	The views of referrers are used in the service evaluation	D
7.1.3	The service evaluation includes the views of all unit staff	D
7.1.4	The service evaluation includes accident and incident records, key performance data (e.g. waiting times, number of rejected referrals, bed occupancy, non attendance, adverse occurrences) and the findings of key audits	D
7.2	Unit staff are involved in clinical audit	
7.2.1	A range of local and multi-centre clinical audits is conducted	E
7.2.2	There are dedicated resources to support clinical audit within the directorate or specialist areas e.g. staff time and dedicated budget	E
7.2.3	Practitioners are involved in identifying priority audit topics in line with national and local priorities	D
7.2.4	The results of surveys, audits, incident reviews, clinical outcomes and activity are fed back to the clinical team, and action plans and resulting quality improvement is monitored	D
7.3	The unit has a comprehensive range of policies and procedures which take into account the special needs of women, babies and families	
7.3.1	There are written referral criteria	E
7.3.2	There is a written procedure for emergency referrals	E
7.3.3	There are written admission and discharge procedures	E
7.3.4	There is a policy on clinical risk assessment specific to the perinatal context	E
7.3.5	There are policies and procedures regarding patients' self-harm	E
7.3.6	There are policies and procedures regarding the involvement of the police if offences are committed in the unit	E
7.3.7	There is a contingency plan and procedures to cover accidents and emergencies and disasters such as suicide	E
7.3.8	There are policies relating to the safety of the environment and baby safety, e.g. detailed fire procedures	E
7.3.9	There is a locked door and restriction-of-liberty policy	E
7.3.10	There are policies on visiting, and contact between patients and their family and friends is encouraged	E
7.3.11	There are policies and procedures in place for the management of unwanted visitors (i.e. those who pose a threat)	E
7.3.12	There are policies, procedures and guidance for infection control practice specific to childhood ailments	D
7.3.13	There are policies and procedures regarding searches of patients' rooms and of visitors	D
7.3.14	Policies, procedures and guidelines are formatted, disseminated and stored in ways front-line staff find accessible and easy to use	E
7.3.15	There is a policy on the day-to-day care of the infant, e.g. baby feeding, hygiene, use of milk kitchen	E
7.3.16	There is a policy on the use of drugs and alcohol, and on the management of those who may be abusing drugs and alcohol	E
7.3.17	There are clear policies and procedures for managing complaints.	E

7.3.18	There is evidence of action and feedback from complaints	E
7.3.19	Unit policies and procedures are reviewed at regular intervals and audits of their use are undertaken where appropriate	E

8	Discharge	
8.1	Before discharge, decisions are made about meeting any continuing needs	
8.1.1	Discharge planning begins as soon as possible after admission or after the initial assessment has been completed	E
8.1.2	Pre-discharge planning involves the health visitor, midwife, GP and (if involved) social services, as well as the care co-ordinator, patient and key family members	E
8.1.3	All periods of leave are co-ordinated with community professionals	D
8.1.4	All key professionals receive copies of the discharge plan including details of when they will next be seen, who by and emergency contact details	E
8.1.5	Following discharge, women are seen by a mental health professional within one week	E
8.1.6	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	D
8.1.7	Prior to discharge from the unit, patients are given advice and information on contraception, the risk of recurrence of problems with subsequent pregnancies and medication	D
8.1.8	Before discharge patients are advised about medication and their side effects, e.g. driving	E

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Standards Order Form

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