



The Perinatal Quality Network: Standards for Perinatal Inpatient Services

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Editor: Ruby Lucas

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Perinatal Quality Network (PQN)
**Royal College of Psychiatrists' Centre for Quality
Improvement**

21 Prescott Street

London

E1 8BB

www.rcsych.ac.uk/perinatal-network

Perinatal-CHAT@rcpsych.ac.uk

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Authors: Ruby Lucas, Arun Das, Niamh Payne

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Name	Profession	Service/Organisation
Bronwen Ashton	Patient Representative	PQN
Roch Cantwell	Consultant Psychiatrist / Professional Advisor	Perinatal and Early Years Mental Health Scottish Government
Harriet Clarke	Head of Quality and Accreditation	CCQI
Arun Das	Programme Manager	CCQI
Kavita Davis	Ward Manager	Birmingham and Solihull Mental Health NHS Foundation Trust
Joanne Field	Matron	Norfolk and Suffolk NHS Foundation Trust
Skye-Blue Ford	Ward Manager	Dorset Healthcare University NHS Foundation Trust
Dora Goode	PQN Project Officer	PQN - CCQI
Georgina Hadfield	Ward Manager	Derbyshire Healthcare Foundation Trust
Rebecca Horton	General Manager, Perinatal Services	South London and Maudsley NHS Foundation Trust

June Judd	Ward Manager	South London and Maudsley NHS Foundation Trust
Bina Kennedy	Ward Manager	Avon and Wiltshire Mental Health Partnership
Lisa Knight	Quality Lead	Midlands Partnership NHS Foundation Trust
Harriet Lambah-Heap	Perinatal Inpatient Team Leader	Midlands Partnership University NHS Foundation Trust
Ruby Lucas	Deputy Programme Manager	PQN - CCQI
Joli Overton	Specialities Lead Nurse for MBU and Outreach Team	Birmingham and Solihull Mental Health NHS Foundation Trust
Mary Pappin	Senior Programme Manager	NHS England
Niamh Payne	PQN Project Officer	PQN - CCQI
Janice Rigby	Consultant Clinical Psychologist	South London and Maudsley NHS Foundation Trust
Deborah Sells	Ward Manager	Nottingham Healthcare NHS Trust
Jenny Shaieb	Occupational Therapist	South London and Maudsley NHS Foundation Trust
Natalie Tasker	Patient Representative	PQN
Peter Thompson	Director of CCQI	CCQI
Verity Westgate	Patient Representative	PQN
Rebecca Wilshaw	Operational Manager	Greater Manchester Mental Health NHS Foundation Trust

Chair's Foreword

Welcome to the Ninth Edition of the Perinatal Quality Network standards. The Perinatal Quality Network was launched in 2007 and over the last 17 years there have been huge changes, however the premise of the inpatient branch of the network remains the same, in the words of Margaret Oates, "to develop and uphold standards for mother and baby units".

The first edition of the inpatient standards were published in 2007 and over the past 17 years there has been a huge increase in the number of MBUs nationally, to 22, with the development of further units on the cards. This brings us closer to the gold standard that all mothers, wherever they live, have equitable access to high quality perinatal mental health inpatient care.

The standards are regularly reviewed to reflect the ever-changing aspirations and challenges of services, policy and the NHS. Throughout this revision there has been liaison, feedback and consultation with professionals, patient representatives and services alike to ensure the development of the standards are fair and clear to all. It is hoped that the revision will make the standards more user-friendly and achievable whilst maintaining best practice.

The standards continue to follow patients' experience from admission to discharge, highlighting areas of environment and facilities, staffing, care and treatment, information, consent and confidentiality, rights and safeguarding and audit and policy. Notable changes of the standards within this revision include clarifying staffing expectations, ensuring partners/chosen others are considered and adding guidance to some of the standards that have previously been deemed difficult to evidence or interpret.

Working on the Margaret Oates Mother and Baby Unit, it is impossible to not mention her. She was founding chair of the Advisory Group and the Network, being instrumental in the development of the standards from their first publication. Margaret Oates opened her first perinatal bed 50 years ago this year with the ambition to provide high quality perinatal mental health care to all mothers suffering from a serious mental illness, in a timely manner, whilst remaining with their babies.

These standards, and their regular revisions, support Mother and Baby Units to maintain and improve care and treatment in being the very best they can, striving for the gold standard, allowing patients and their families to receive the best experience possible.

We would like to thank everyone involved in the network for all your hard work and commitment.

Deborah Sells,

Ward Manager & PQN Accreditation Committee Chair

Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patients & carers, and email forums with professional groups involved in the provision of inpatient mental health services for mothers. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to mother and baby units (MBUs).

Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

Who are these standards for?

These standards are designed to be applicable to inpatient perinatal services (Mother and Baby Units) and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

CCQI core standards

The core standards are used by the quality networks and accreditation programmes within the College Centre for Quality Improvement (CCQI). Each project adopts the relevant core standards which will be used alongside the specialist standards that relate to the service type being reviewed. The core standard reference number can be viewed on the right-hand column throughout the document. Those that are not marked with a core number are specialist standards relating to inpatient mental health services that are not included in the core set.

Criteria

All criteria are rated as Type 1, 2 or 3.

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: Expected standards that most services should meet.

Type 3: Desirable standards that high performing services should meet.

Sustainability Principles

The fourth edition of the QED quality standards for inpatient eating disorder services has been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

(www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx)



The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).
2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.
3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.
4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of

face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamworking facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.




Sustainability standards are marked throughout the document with the leaf icon.

Section 1: Access and Admission

Standard Number	Standard Type	Standard Criteria	CCQI Core 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 moderate to severe mental illness from 32 weeks of pregnancy, or earlier in pregnancy if clinically indicated.	
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 admits women directly to the mother and baby unit without prior admission to an acute adult ward unless there are exceptional and documented circumstances. <i>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).</i>	
1.1.4	1	The unit is open to admissions 24 hours a day, seven days a week.	
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 and documented circumstances.	
1.1.6	2	Where units are offering formal parenting assessments, admissions for the purpose of parenting assessments are only undertaken in the known or suspected presence of significant/complex mental illness.	
1.1.7	1	If a mother under the age of 18 is admitted to a mother and baby unit then: <ul style="list-style-type: none"> - There is a named CAMHS clinician who is available for consultation and advice; - The local authority or local equivalent is informed of the admission; - The CQC, or local equivalent, is informed if the patient is detained - A single room is used. 	1.2

1.1.8	1	<p>The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment.</p> <p><i>Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.</i></p>	1.3
1.2		Referrers and other related professionals have ready access to information about the unit	
1.2.1	1	The service provides information to referrers about how to make a referral.	1.1
1.2.2	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.	
1.2.3	1	<p>Systems are in place to record and evaluate transfers, declined referrals, waiting lists and the length of prior admission to an adult psychiatric ward.</p> <p><i>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.</i></p>	
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	<p>Staff members work in a way that respects the individual needs of patients from different ethnic, cultural or religious backgrounds.</p> <p><i>Guidance: There is equity of access to units in relation to ethnic origin, social status, sexual orientation, disability, physical health and neurodiversity.</i></p>	
1.3.2	1	<p>The environment complies with current legislation on disabled access.</p> <p><i>Guidance: Relevant assistive technology equipment, such as hoists, handrails, accessible access (e.g. lifts or ramps) are provided to meet individual needs and to maximise independence. Access for patients with visual or hearing impairments is also considered.</i></p>	17.10



1.3.3	2	The unit works to minimise barriers to access for patients and partners/chosen others from remote areas. <i>Guidance: For example, by providing information about local resources and accommodation.</i>	
1.3.4	1	The unit works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances. <i>Guidance: This also includes sign language interpreters.</i>	15.1
1.4		Patients are made familiar with the unit as soon as possible after admission	
1.4.1	2	Patients can visit the unit or access a video tour before agreeing to admission (with the exception of emergency admissions). <i>Guidance: Patients and partners/chosen others are able to see the unit's website and/or see a virtual tour of the unit.</i>	
1.4.2	1	On admission to the unit, patients feel welcomed by staff members who explain why they are in hospital. <i>Guidance: Staff members:</i> - Show patients around and introduce themselves and other patients; - Offer patients refreshments; - Address patients using their preferred name and correct pronouns; - should enquire as relevant how patients would like to be supported in regard to their gender.	2.1
1.4.3	1	The patient's partner/chosen other is contacted as soon as possible by a staff member (with patient consent) to notify them of the admission and to give them the unit contact details.	2.2
1.5		All patients are assessed for their health and social care needs	

1.5.1	1	<p>Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's:</p> <ul style="list-style-type: none"> - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development. <p>Sustainability Principle: Improving Value</p>	<p>2.4</p> 
1.5.2	2	An occupational therapist conducts an activity of daily living assessment as soon as is practically possible.	
1.5.3	1	<p>Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, then the reason is recorded, and repeated attempts are made.</p> <p>Sustainability Principle: Prioritise Prevention</p>	<p>2.5</p> 
1.5.4		Patients have an assessment of their needs and of the needs of their child which is regularly reviewed. This includes:	
1.5.4a	1	Support and supervision required in caring for themselves and their baby.	
1.5.4b	1	Mode of infant feeding (breast, bottle, weaning etc.).	
1.5.4c	1	Care of baby which should include physical care, emotional care, developmental care and the ability to ensure safety.	
1.5.5	1	<p>Patients have a risk assessment and management plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers:</p> <p>Sustainability Principle: Prioritise Prevention</p>	<p>2.6</p> 
1.5.5a	1	Risk of self-harm and suicide.	
1.5.5b	1	Risk to the baby.	
1.5.5c	1	Risk to others (e.g. patients, babies, staff).	
1.5.5d	1	Level of substance use.	
1.5.5e	1	Absconding risk.	
1.5.5f	1	Sexual vulnerability.	
1.5.5g	1	Domestic violence.	
1.5.6	1	Physical health assessments of the patient are undertaken whereby:	


1.5.6a	1	<p>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 four hours of admission.</p> <p><i>Guidance: When this cannot be done, reasons for this are documented.</i></p>	
1.5.6b	1	<p>Standard laboratory screening investigations should be undertaken within one working day (no more than 72 hours of admission) and recorded in patient records.</p> <p><i>Guidance: These may include weight and height, liver function, renal function, electrolytes, creatine and eGFR, glucose and antibodies, Hb, ESR, drug and alcohol screening. When this cannot be done, reasons for this are documented.</i></p>	
1.5.6c	1	<p>Women admitted within five days of delivery have their temperature/pulse and respiration measured twice daily, and blood pressure measured daily. They must be seen by a midwife within two days of admission and this must be recorded in patient records.</p> <p><i>Guidance: This should continue for as long as clinically indicated.</i></p>	
1.5.7	1	<p>All babies are weighed and body mapped on admission to the unit.</p>	
1.5.8	1	<p>Patients are reviewed by a perinatal consultant or senior doctor (e.g. specialist registrar or staff grade) within one working day of admission.</p>	
1.5.9	1	<p>Case notes show evidence of assessment of social care needs and involvement with other agencies.</p> <p><i>Guidance: This should be part of the standard admission protocols carried out by ward staff.</i></p>	
1.5.10	1	<p>The unit liaises with local safeguarding children/vulnerable adult services if there are any concerns (or out of area if applicable).</p>	
1.5.11	1	<p>On admission the following is given consideration:</p> <ul style="list-style-type: none"> - Arrangements for dependants (children, people they are caring for); - The security of the patient's home; - Arrangements for pets. 	2.7

1.5.12	1	There is a documented formalised review of care or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.	4.2
1.5.13	1	Patients admitted to a mother and baby unit outside the area in which they live have a review of the appropriateness of the placement setting (at least monthly). This is reviewed jointly with the patient during ward meetings.	2.8

Section 2: Environment and Facilities

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
2.1		The unit is well designed and has the necessary facilities and resources	
2.1.1	1	<p>Patients have access to safe outdoor space every day.</p> <p>Sustainability Principle: Consider Carbon</p>	6.1.11 
2.1.2	2	<p>Patients, according to risk assessment, have access to regular 'green' walking sessions.</p> <p><i>Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear.</i></p> <p>Sustainability Principle: Consider Carbon</p>	6.1.12 
2.1.3	3	<p>Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation should accommodate a spectrum of gender and patient gender self-identification should be supported wherever possible.</p> <p><i>Guidance: Self-identification as male or female should be accepted, and allocation to a gendered room done with patients' agreement. Where this allocation could present risks to the patient or to vulnerable others, this is risk assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care.</i></p>	17.1
2.1.4	3	<p>Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment</p>	17.3
2.1.5	1	<p>The unit has a communal lounge area.</p>	
2.1.6	1	<p>There is a separable gender-specific space which can be used as required.</p> <p><i>Guidance: When there is a need, a space can be made available, for example, when there are male visitors on the unit.</i></p>	17.22

2.1.7	1	The unit has a nursery which can be accessed 24 hours a day.	
2.1.8	1	There is a selection of age-appropriate toys and baby equipment.	
2.1.9	2	All patients can access a range of current culturally-appropriate resources for entertainment, which reflect the ward/unit's population. <i>Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.</i>	17.8
2.1.10	1	The unit has a designated area for the sterilisation of baby items and storage of baby milk. <i>Guidance: This can be within the same room as adult food if the areas are clearly defined.</i>	
2.1.11	1	The unit has a designated dining area, which is reserved for dining during allocated mealtimes.	
2.1.12	2	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. <i>Guidance: Hot drinks may be available on a risk-assessed basis.</i>	17.23
2.1.13	3	There is a kitchen on the unit for the sole use of MBU patients, and their partners/chosen others. This can be used both for OT assessments and for mothers to cook their own and infants' foods when clinically appropriate.	
2.1.14	2	Staff members and patients can control heating, ventilation and light on the unit. <i>Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.</i>	17.17
2.1.15	1	The temperature in the nursery and bedrooms is appropriate for sleeping babies. Temperatures are monitored and recorded continuously throughout the year. <i>Guidance: Between 16-20°C, based on safer sleep guidance. When temperatures exceed 20 degrees, the team mitigates the risk with trust-approved methods to reduce temperature. There is a mitigation plan which includes a strategy to ensure</i>	


		<i>more permanent solutions (such as installing air conditioning) where temperatures consistently exceed safe levels.</i>	
2.1.16	1	The unit has a dedicated office for use by staff members.	
2.1.17	2	There are at least two rooms in addition to the nursing office for individual clinical assessments and interventions.	
2.1.18	2	There are rooms of various sizes that accommodate group and individual interventions.	
2.1.19	2	There are sufficient IT resources on the unit to provide staff members with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.	
2.1.20	2	Unit-based staff members have access to a dedicated staff room. Sustainability Principle: Empowering Staff	17.25 
2.1.21	1	Patients use mobile phones and/or 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. <i>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.</i>	17.13
2.1.22	3	All patients can access a charge point for electronic devices such as mobile phones.	17.9
2.2		Patients are consulted about the unit environment and have choice when this is appropriate	
2.2.1	2	Patients are consulted about changes to the unit environment.	17.26
2.2.2	2	Patients are able to personalise their bedroom spaces. <i>Guidance: For example, by putting up photos and pictures.</i>	17.4
2.3		The unit is equipped with appropriate medical equipment and this is well-maintained	

2.3.1	1	The unit is equipped with medical items for examining patients including:	
2.3.1a	1	Weighing scales	
2.3.1b	1	Ophthalmoscope	
2.3.1c	1	Thermometer	
2.3.1d	1	Stethoscope	
2.3.1e	1	Blood glucose monitoring kit	
2.3.1f	1	Blood pressure monitoring machine	
2.3.1g	1	Pulse oximeter	
2.3.2	1	The unit is equipped with medical items for examining babies including:	
2.3.2a	1	Weighing scales	
2.3.2b	1	Thermometer	
2.3.2c	1	Stethoscope	
2.3.2d	1	Pulse oximeter	
2.3.3	1	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	17.18
2.4		Premises are designed and managed so that mothers' rights, privacy and dignity are respected	
2.4.1	2	All patients have single bedrooms	17.2
2.4.2	1	All bedrooms are equipped so that babies can be roomed with their mothers.	
2.4.3	1	The unit has at least one bathroom/shower room for every three patients.	17.5
2.4.4	3	Every patient has an en-suite bathroom.	17.6
2.4.5	2	All patients have access to lockable storage which may be within their own individual rooms, or access to a safe on the ward.	
2.4.6	2	The unit has a designated room for physical examination and minor medical procedures.	17.19
2.4.7	2	The unit has at least one quiet room or de-escalation space other than patient bedrooms.	17.21
2.4.8	1	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom.	17.11

2.4.9	2	The unit has access to private space for meetings with partners/chosen others, relatives and other professionals.	
2.4.10	1	Patients are involved (wherever possible) in decisions about the level of observation by staff. <i>Guidance: Patients are also supported to understand how the level can be reduced.</i>	8.2
2.4.11	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 patient's bedroom or communal areas.	
2.4.12	1	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	17.12
2.4.13	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.	17.7
2.5		The unit provides a safe environment for staff and patients	
2.5.1	1	There are clear lines of sight to enable staff to observe patients and their babies. <i>Guidance: This should include mirrors for any blind spots and ensuring cots in bedrooms are visible through the bedroom door.</i>	
2.5.2	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. <i>Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis e.g. access to milk room, laundry facilities, other.</i>	17.15
2.5.3	1	Patients and staff members feel safe on the ward.	21.2
2.6		There is equipment and procedures for dealing with emergencies in the unit	
2.6.1	1	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms. There is an agreed response when an alarm is raised.	17.16
2.6.2	1	A collective response to alarm calls and fire drills is agreed by the unit. This is rehearsed at least annually.	

2.6.3	1	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	17.14
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Section 3: Staffing


Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
3.1		The number of nursing staff on the unit is sufficient to meet the needs of patients and babies at all times	
3.1.1	1	<p>For all units, there are at least two registered mental health nurses (RMNs) on a unit per day shift.</p> <p>For units with eight beds or more, staffing would be expected to routinely include at least three nursing staff (additional staffing could be from disciplines including RMNs, Nursing Associates, Nursing Assistants, Support Workers, HCAs, RGNs).</p> <p><i>Guidance: There should be evidence to show that the nursing staffing complement continues to provide safe and effective care for patients and their infants. Staffing should be proportionately increased to meet nursing requirements, based on unit size, occupancy and acuity.</i></p>	
3.1.2	1	<p>For all units, there are at least two nurses (at least one RMN, alongside additional nursing staff, which could include additional RMNs, Nursing Associates, Nursing Assistants, Support Workers, HCAs, RGNs) on a unit per night shift.</p> <p>For units with eight beds or more, staffing would be expected to routinely include at least one RMN and two additional nursing staff (as defined above).</p> <p><i>Guidance: There should be evidence to show that the nursing staffing complement continues to provide safe and effective care for patients and their infants. Staffing should be proportionately increased to meet nursing requirements, based on unit size, occupancy and acuity.</i></p>	
3.1.3	1	The ward manager is rostered as supernumerary and only used in a clinical role if necessary.	
3.1.4	1	There is at least one specialist nursery nurse covering the unit 24 hours a day.	
3.1.5	1	<p>The unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:</p> <ul style="list-style-type: none"> • A method for staff members to report concerns about staffing levels • Access to additional staff members 	19.1 


		<ul style="list-style-type: none"> An agreed contingency plan, such as the minor and temporary reduction of non-essential services. <p>Sustainability Principle: Empowering Staff</p>	
3.1.6	2	The unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need or short-term absence of permanent staff.	19.2
3.2		The unit comprises a core multi-professional team with specialist skills and knowledge	
3.2.1	1	<p>A unit with 6 beds includes at least 0.5 WTE consultant psychiatrist.</p> <p><i>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. There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	
3.2.2	1	<p>A unit with 6 beds includes at least 0.5 WTE non-consultant medic, or equivalent.</p> <p><i>Guidance: There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	
3.2.3	1	There is an identified duty doctor available at all times to attend the unit, including out of hours. The doctor can attend the unit within 30 minutes in the event of an emergency.	19.3
3.2.4	1	<p>A unit with 6 beds includes at least 0.5 WTE clinical psychologist. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.</p> <p><i>Guidance: The clinical psychologist should have experience in working with patients with moderate to severe presentations of mental illness, ideally including inpatient and/or perinatal settings. It would be desirable for the clinical psychologist to have experience in working with parent-infant attachment relationship difficulties. Trainee psychologists should not be included in these numbers.</i></p>	6.1.2

		<i>There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i>	
3.2.5	3	<p>A unit with 6 beds includes at least 0.5 WTE consultant clinical psychologist.</p> <p><i>Guidance: This is in addition to the qualified clinical psychologist post. The consultant clinical psychologist post should be held by an experienced senior clinician with substantial knowledge and skills in providing leadership and consultation to multi-disciplinary colleagues. There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	
3.2.6	3	Trainee clinical psychologists are offered placements on the unit.	
3.2.7	1	<p>A unit with 6 beds includes at least 0.5 WTE occupational therapist. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions.</p> <p><i>Guidance: There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	6.1.3
3.2.8	2	<p>A unit with 6 beds includes at least 0.5 WTE social work input.</p> <p><i>Guidance: There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	
3.2.9	1	<p>A unit with 6-8 beds includes at least 0.5 WTE administrative support.</p> <p><i>Guidance: There should be evidence to show that the specialist staffing complement continues to provide safe and effective care for patients and their infants. We would expect staffing numbers in larger units to increase to the nearest 0.5 WTE to ensure patients are safely and effectively cared for.</i></p>	

3.2.10	2	Patients and partners/chosen others and prescribers are able to meet with a pharmacist to discuss medications.	6.2.5
3.2.11	3	There is dedicated sessional input from arts or creative therapists.	6.1.4
3.2.12	2	The unit has formalised and regular input from peer support workers.	
3.2.13	1	Units have access to health visitors to advise patients and clinical staff on childcare issues. <i>Guidance: There is a protocol in place with local primary care/health visitation services to ensure all mothers and babies have access to health visitation when required, supporting discussions about childcare and liaison around discharge. This includes women who are admitted out of area.</i>	
3.2.14	2	Units have a designated health visitor who visits at least once a week to advise patients and clinical staff on childcare issues and liaise with the mother's usual health visitor.	
3.2.15	1	All patients have visits and advice from a midwife when clinically appropriate.	
3.2.16	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 unit.	
3.3		New staff members receive a comprehensive induction	
3.3.1	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. The induction should include: - arrangements for shadowing colleagues; - jointly working with a more experienced colleague; - being observed and receiving enhanced supervision until core competencies have been assessed as met. <i>Guidance: The unit should refer to the NHS HEE Competency Framework for Professionals working with Women who have Mental Health Problems in the Perinatal Period. (Or equivalent, e.g. NES Perinatal Curricular Framework)</i>	20.2
3.4		Staff are provided with a thorough training programme	
3.4.1	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. For accreditation, training should be recorded in the PQN training matrix. This training includes:	


3.4.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
3.4.1b	2	The Children Act.	
3.4.1c	1	Physical health assessment. <i>Guidance: This should include training in understanding physical health problems, undertaking physical observations and when to refer the patient for specialist input.</i>	22.1b
3.4.1d	1	Safeguarding vulnerable adults and children. <i>Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.</i> Sustainability Principle: Prioritise Prevention	22.1c 
3.4.1e	1	Risk assessment and risk management. <i>Guidance: This should cover risk for both the patient and baby. For the patient, this should include: assessing and managing suicide risk and self-harm; prevention and management of aggression and violence.</i> Sustainability Principle: Prioritise Prevention	22.1d 
3.4.1f	1	Recognising and communicating with patients with cognitive impairment and learning disabilities.	22.1e
3.4.1g	1	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	22.1f
3.4.1h	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	22.1g
3.4.1i	1	Pharmacological interventions. <i>Guidance: This should be completed annually by medical and qualified nursing staff.</i>	
3.4.1j	1	Common physical disorders in pregnancy and the early postnatal period. <i>Guidance: This should be completed by all clinical staff and facilitated by an appropriate specialist. This training should be repeated at a minimum of every three years.</i>	


3.4.1k	1	Common physical disorders in infancy. <i>Guidance: This should be completed by all clinical staff and facilitated by an appropriate specialist. This training should be repeated at a minimum of every three years.</i>	
3.4.1l	1	Basic infant development including the main development milestones. <i>Guidance: This should be completed by all clinical staff. This training should be repeated at a minimum of every three years.</i>	
3.4.1m	1	Understanding and facilitating mother-baby interaction. <i>Guidance: This should be completed by all clinical staff. This training should be repeated at a minimum of every three years.</i>	
3.4.1n	3	Trauma-informed care.	
3.4.1o	3	Working with peer support workers. <i>Guidance: This standard applies to units where peer support workers have been recruited to work. For accreditation, training should be recorded in the PQN training matrix.</i>	
3.4.2	1	All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool. <i>Guidance: For accreditation, training should be recorded in the PQN training matrix.</i>	6.2.4
3.4.3	1	All staff undergo specific training in therapeutic observation when they are inducted into a trust or changing wards. This includes: - principles around positive engagement with patients, - when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this; - actions to take if the patient absconds <i>Guidance: For accreditation, training should be recorded in the PQN training matrix.</i>	22.1h
3.4.4	1	All staff members who deliver therapies and activities are appropriately trained and supervised. Sustainability Principle: Staff Empowerment	6.1.14 

3.4.5	3	Shared in-house multi-disciplinary training, education and practice development activities occur on the unit at least every 3 months.	
3.4.6	2	Patient and/or carer representatives are involved in delivering and developing staff training.	22.2
3.4.7	2	Peer support workers are provided with appropriate training, handovers, and supervision. <i>Guidance: This standard applies to units where peer support workers have been recruited to work. This should be delivered in units where peer support workers are recruited.</i>	
3.5		All staff receive regular supervision and can access appropriate support	
3.5.1	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. <i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. For accreditation, this should be evidenced through a supervision matrix which clearly outlines the numbers of eligible staff.</i>	20.3
3.5.2	1	All staff members receive line management supervision at least monthly. <i>Guidance: For accreditation, this should be evidenced through a supervision matrix which clearly outlines the numbers of eligible staff.</i>	20.4
3.5.3	1	All staff members receive an annual appraisal and personal development planning (or equivalent). <i>Guidance: This contains clear objectives and identifies development needs.</i>	
3.5.4	1	All staff members are able to contact a senior colleague as necessary 24 hours a day. <i>Guidance: This will include the on-call system.</i>	
3.5.5	1	Patients, partners/chosen others, and staff members who are affected by a serious incident, including control and restraint and rapid tranquilisation, are offered post incident support. <i>Guidance: This includes attention to physical and emotional wellbeing of the people involved and post incident reflection.</i> Sustainability Principle: Empowering Individuals	21.4 
3.5.6	2	The unit has protected time for team-building and discussing service development at least once a year.	




3.5.7	1	<p>The unit actively supports staff health and well-being.</p> <p><i>Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i></p> <p>Sustainability Principle: Empowering Staff</p>	21.1 
3.5.8	1	<p>Staff members are able to take breaks during their shift that comply with the European Working Time Directive.</p> <p><i>Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours in a shift. Adequate cover is provided to ensure staff members can take their breaks.</i></p>	21.3
3.5.9	3	<p>Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.</p> <p>Sustainability Principle: Empowering Staff</p>	18.1 
3.5.10	1	<p>Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.</p> <p>Sustainability Principle: Empowering Staff</p>	18.2 
3.5.11	1	<p>Staff members know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.</p>	8.1
3.5.12	1	<p>When staff members meet for handover, adequate time is allocated to discuss patients' needs, risks and management plans.</p>	18.3
3.6		There is a recruitment policy to ensure vacant posts are filled quickly with well qualified and checked candidates	
3.6.1	3	<p>When posts are vacant or in the event of long-term sickness or maternity leave, prompt arrangements are made for temporary staff cover.</p>	
3.6.2	2	<p>Patient or partner/chosen other representatives are given the opportunity to be involved in the interview process for recruiting new staff members.</p> <p><i>Guidance: The representatives should have experience of the relevant service.</i></p> <p>Sustainability Principle: Empowering Individuals</p>	20.1 

Section 4: Care and Treatment

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
4.1		The unit has good access to a range of services, as appropriate to the needs of the patients. These include the following:	
4.1.1	1	<p>Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission.</p> <p><i>Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.</i></p>	7.1
4.1.2	1	<p>Patients are offered personalised healthy lifestyle interventions such as advice on:</p> <ul style="list-style-type: none"> • healthy eating • physical activity • access to smoking cessation services. <p>This is documented in the patient's care plan.</p> <p>Sustainability Principle: Consider Carbon</p>	7.2 
4.1.3	1	<p>Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon.</p>	7.4
4.1.4	1	<p>Patients who are prescribed mood-stabilising medication must be treated in accordance with MHRA and NICE guidelines on antenatal and postnatal mental health with particular regards 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.</p>	

		<i>Guidance: Reasons for the use of anti-epileptic drugs used as mood stabilisers and lithium must be documented with signed consent and evidence of the patient's understanding of the risks and benefits.</i>	
4.1.5	1	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. Sustainability Principle: Prioritise Prevention	7.3 
4.1.6	3	The team supports patients to attend an appointment with their community GP if they need whilst an inpatient, if they are admitted in the local area.	10.1
4.2		All patients have a written care plan as part of the Care Programme Approach (or equivalent)	
4.2.1	1	Every patient has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with patients and their partner/chosen other (with patient consent) when developing the care plan, and they are offered a copy. <i>Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.</i>	4.3
4.2.2	1	Care plans are reviewed and updated according to clinical need or at a minimum weekly.	
4.2.3	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		There is a broad programme of care and treatment appropriate for the needs of patients and their babies	
4.3.1	1	Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. <i>Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.</i>	6.1.6
4.3.2	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	
4.3.3	2	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. <i>Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.</i>	6.1.9

4.3.4	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of perinatal mental health issues.	6.1.10
4.3.5	2	The unit provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: - Voluntary organisations; - Community centres; - Local religious/cultural groups; - Peer support networks; - Recovery colleges.	6.1.13
4.3.6	1	The team supports patients to access support with finances, benefits, debt management and housing needs.	10.2
4.3.7	1	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	6.1.1
4.3.8	1	Patients are encouraged to engage in activities which promote mother infant attachment and enjoyment. <i>Guidance: This could include OT-led activities, baby massage, play sessions, and video feedback.</i>	
4.3.9	3	Patients have access to complementary therapies, in accordance with local policy and procedures (and the safety of the baby).	
4.3.10	2	Patients receive information about/psychoeducation on emotional regulation, stress management, coping skills, and parent-infant interaction and attachment, and baby development if clinically needed.	6.1.5
4.3.11	1	Staff can recognise, adapt care and make reasonable adjustments for neurodivergent patients specific to the perinatal period.	
4.4		Drugs are administered according to the relevant guidelines	
4.4.1	1	Drug charts clearly state whether the patient is breastfeeding or not.	
4.4.2	1	Staff members give information to patients about the use of medication in pregnancy and breastfeeding and risks are discussed.	
4.4.3	1	When medication is prescribed, specific treatment goals are agreed with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	6.2.1

4.4.4	1	<p>Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime.</p> <p><i>Guidance: Side effect monitoring tools can be used to support reviews.</i></p> <p>Sustainability Principle: Consider Carbon</p>	<p>6.2.2</p> 
4.4.5	1	<p>Every patient's PRN medication is reviewed weekly, with consideration of the frequency, dose and indication.</p>	6.2.3
4.4.6	1	<p>Clinical outcome measurement data is collected at two time points (admission and discharge).</p> <p><i>Guidance: This includes patient-reported outcome measurements where possible.</i></p>	23.1
4.4.7	2	<p>Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.</p>	23.2
4.5		Patients can meet easily with members of staff and their key workers	
4.5.1	1	<p>Patients know who the key people are in their team and how to contact them if they have any questions.</p>	4.1
4.5.2	1	<p>Patients have the opportunity to meet their consultant or senior doctor on a weekly basis outside of the ward review/ward round.</p>	
4.5.3	1	<p>Each patient receives a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.</p>	6.1.7
4.6		During admission, good communication is maintained with the patient's family and local services	
4.6.1	2	<p>Partners/chosen others are offered individual time with staff members within 48 hours of the patient's admission to discuss concerns, family history and their own needs.</p> <p>Sustainability Principle: Empowering Individuals</p>	<p>13.3</p> 
4.6.2	1	<p>Partners/chosen others (with patient consent) are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents.</p> <p>Sustainability Principle: Empowering Individuals</p>	<p>13.1</p> 

4.6.3	1	Partners/chosen others are involved in decisions about the care of the baby (with the patient's consent).	
4.6.4	1	Partners/chosen others are supported to access a statutory carer's assessment, provided by an appropriate agency.	13.2
4.6.5	2	Partners/chosen others have access to a carer support network or group. This could be provided by the unit or staff members should signpost carers to an existing network. <i>Guidance: This could be a group/network which meets face-to-face or virtually.</i>	
4.6.6	2	Partners/chosen others are offered support, e.g. through partner support sessions, family sessions, or couple sessions.	
4.6.7	2	Partners/chosen others are encouraged to be involved in the following: parent-infant activities, practical parenting advice/support with the nursery nurse or health visitor etc.	
4.6.8	2	Partners/chosen others feel supported by ward staff members.	13.5
4.7		All babies receive appropriate care and support	
4.7.1	1	Health visitors are informed of all new babies arriving on the unit within 48 hours of admission.	
4.7.2	1	There is a care plan for the baby which is developed with the patient wherever possible, and takes into consideration national guidelines on infant care.	
4.7.3	1	Babies are roomed 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 are documented.	
4.7.4	1	If the separation of the patient and baby is prolonged, partners/chosen others are given the opportunity to provide interim care for the baby, where appropriate.	
4.7.5	1	When patients are unable to consent, breastfed babies are only given formula milk if clinically necessary.	
4.7.6	1	Appropriate food is provided for weaning babies when patients are unable to provide it themselves.	
4.8		Leave is planned in collaboration with the patient and their partner/chosen other	
4.8.1	1	The team and the patient jointly develop a leave plan, which is shared 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;	5.1

		<ul style="list-style-type: none"> - Contact details of the ward/unit and crisis numbers and ability to access bed on return; - Contact details of other relevant professionals; - Information on how the patient can get help for the infant if needed (including breastfeeding support). 	
4.8.2	1	Staff agree leave plans with the patient's partner/chosen other where appropriate, allowing them sufficient time to prepare.	5.2
4.8.3	1	<p>When patients are absent without leave, the team (in accordance with local policy):</p> <ul style="list-style-type: none"> - Activates a risk management plan; - Makes efforts to locate the patient; - Alerts partner/chosen other, people at risk and the relevant authorities; - Escalates as appropriate. 	5.3

Section 5: Information, Consent and Confidentiality

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
5.1		Patients and partners/chosen others have good access to information	
5.1.1	1	Information, which is accessible and easy to understand, is provided to patients and partners/chosen others. <i>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. Any written information to be given to patients and partners/chosen others should be co-authored and regularly annually.</i>	
5.1.2	2	The patient is given an information pack on admission that contains the following: <ul style="list-style-type: none"> - A description of the service; - The therapeutic programme; - Information about the staff team; - The unit code of conduct; - Key service policies (e.g. permitted items, smoking policy); - Resources to meet spiritual, cultural or gender needs. 	3.1
5.1.3	2	The team provides each partner/chosen other with accessible carer information. <i>Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.</i>	13.4
5.1.4	1	Patients (and partners/chosen others, with patient consent) are offered written and verbal information about the patient's mental illness and treatment.	6.1.8
5.1.5	2	Information given to patients and significant others is developed collaboratively and regularly reviewed.	
5.2		Personal information about patients is kept confidential, unless this is detrimental to their care	

5.2.1	1	Confidentiality and its limits are explained to the patient and their partner/chosen other on admission, both verbally and in writing. Patient's preferences for sharing information with the third parties are respected and reviewed regularly.	16.1
5.2.2	1	<p>All patient information is kept in accordance with current legislation.</p> <p><i>Guidance: This includes transfer of patient identifiable information by electronic means. 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.</i></p>	16.3
5.2.3	1	<p>The team knows how to respond to partner/chosen other when the patient does not consent to their involvement.</p> <p><i>Guidance: The ward may receive information from the carer in confidence.</i></p>	16.2


Section 6: Rights and Safeguarding

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
6.1		All examination and treatment is conducted with the appropriate consent	
6.1.1	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.	11.1
6.1.2	1	Audio and/or video recording facilities and one-way screens are only used with the written consent of patients.	
6.1.3	1	The Mental Health Act status of patients (including those who are not detained) is known to all staff and visible on notes.	
6.2		The unit is patient-centred and patients have their rights respected	
6.2.1	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: <ul style="list-style-type: none"> - Their rights regarding admission and consent to treatment; - Their rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - How to access interpreting services; - How to view their health records; - How to raise concerns, complaints and compliments. 	2.3
6.2.2	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 late pregnancy or breastfeeding.	17.24
6.2.3	2	Staff members respond to patient feedback about the food served at the unit.	
6.2.4	1	Patients feel listened to and understood by staff members.	14.2

6.2.5	1	All patients have access to an advocacy service including IMHAs (Independent Mental Health Advocates).	10.4
6.2.6	2	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	8.4
6.2.7	1	Staff members treat all patients and partners/chosen others with compassion, dignity and respect.	14.1
6.3		The unit monitors and actively works to reduce restrictive practice	
6.3.1	1	Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, are observed to be breathing, have their vital signs monitored by staff members and any deterioration is responded to.	8.9
6.3.2	1	When restraint is used staff members restrain in adherence with accredited restraint techniques.	8.3
6.3.3	3	Staff members should ensure that during episodes of restraint, patients are treated with dignity and respect, and are emotionally supported.	
6.3.4	1	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long-term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018.	8.5
6.3.5	1	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions.	8.6
6.3.6	1	The team uses seclusion only as a last resort and for brief periods only. <i>Guidance: Where seclusion is not used, please score this standard as not applicable.</i>	8.7
6.3.7	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	24.1
6.3.8	1	When mistakes are made in care this is discussed with the patient themselves and their partner/chosen other, in line with the Duty of Candour agreement.	24.2
6.3.9	1	The multi-disciplinary team collects audit data on the use of restrictive interventions, including the ethnicity of the patients,	8.10


		and actively works to reduce its use year on year through use of audit and/or quality improvement methodology.	
6.4		The status of the baby is clearly documented and child protection procedures are in place	
6.4.1	1	The health record includes a note of who has parental rights and responsibility.	
6.4.2	1	The child protection status and responsible social worker is recorded in notes with contact details. <i>Guidance: The absence of child protection status should also be recorded.</i>	
6.4.3	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, family members, patients, visitors or staff. <i>Guidance: This should be specific to an MBU setting.</i>	

Section 7: Audit and Policy

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
7.1		All available information is used to evaluate the performance of the unit	
7.1.1	1	<p>Patients and their partners/chosen others are given the opportunity to feed back about their experiences of the unit, and their feedback is used to improve the service.</p> <p><i>Guidance: This might include patient and partner/chosen other surveys or focus groups.</i></p> <p>Sustainability Principle: Empowering Individuals</p>	<p>12.1</p> 
7.1.2	2	Key clinical/service measures and reports are shared between the unit and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.	
7.1.3	2	Feedback received from patients and partners/chosen others is analysed and explored to identify any differences of experiences by protected characteristics.	12.2
7.1.4	2	Services are developed in partnership with appropriately experienced patients and partners/chosen others who have an active role in decision making.	12.3
7.1.5	3	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team	18.4
7.2		Unit staff are involved in clinical audit	
7.2.1	1	<p>There are dedicated resources, including protected staff time, to support clinical audit within the directorate or specialist areas. When staff members undertake audits they should do the following:</p> <ul style="list-style-type: none"> - Agree and implement action plans in response to audit reports - Disseminate information including audit findings and action plan - Complete the audit cycle. 	

7.2.2	3	Patients, partners/chosen others, and staff members are involved in identifying priority audit topics in line with national and local priorities and patient feedback.	
7.3		The unit has a comprehensive range of policies and procedures which consider the special needs of patients, babies and families	
7.3.1	2	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.	
7.3.2	2	Staff members are consulted in the development of MBU-specific policies, procedures and guidelines that relate to their practice.	
7.3.3	1	There is a locked door policy which allows patients to be cared for in the least restrictive environment possible.	
7.3.4	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). <i>Guidance: This should be specific to an MBU setting.</i>	
7.3.5	1	The unit has a policy for the care of patients with mental illness and substance misuse.	
7.3.6	1	There is a policy for responding to serious incidents requiring investigation.	
7.3.7	1	The unit follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	
7.4		The unit is actively involved in quality improvement	
7.4.1	1	Lessons learned from untoward incidents are shared with unit staff and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	24.3
7.4.2	2	The team use quality improvement methods to implement service improvements.	24.4
7.4.3	3	The team actively encourages patients and partners/chosen others to be involved in QI initiatives.	24.5
7.4.4	3	The team actively encourages patients and partners/chosen others to be involved in audits and research.	

Section 8: Discharge

Standard Number	Standard Type	Standard Criteria	CCQI Core 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.	
8.1.2	1	Pre-discharge planning involves all services involved in patient care. <i>Guidance: For example, representatives from community teams should be invited to reviews and discharge meetings.</i>	
8.1.3	1	Patients and their partner/chosen other (with patient consent) are invited to a discharge meeting and are involved in decisions about discharge plans.	
8.1.4	1	The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. <i>Guidance: The plan includes details of:</i> <ul style="list-style-type: none"> - Care in the community/ aftercare arrangements; - An update about the infant's health for the patient's health visitor; - Crisis and contingency arrangements including details of who to contact; - Medication including monitoring arrangements; - Details of when, where and who will follow up with the patient. <p>Sustainability Principle: Prioritise Prevention</p>	9.2 
8.1.5	1	A discharge summary is sent, within a week, to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted and how their condition has changed, and their diagnosis, medication and formulation.	9.3
8.1.6	1	The team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge.	9.4

8.1.7	1	Mental health practitioners carry out a thorough assessment of the patient's personal, social, safety and practical needs to reduce the risk of suicide on discharge. Guidance: Where possible, this should be completed in partnership with partners/chosen others.	9.1
8.1.8	1	When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible.	9.6
8.1.9	1	Patients and their partners/chosen others have 24-hour access to telephone advice from the mother and baby unit for at least four weeks after discharge from inpatient care.	
8.1.10		Prior to discharge from the unit, patients are given advice and information on:	
8.1.10a	1	Contraception.	
8.1.10b	1	The risk of recurrence of mental health problems in future perinatal periods, and at other times, and any appropriate preventative interventions. <i>Guidance: This should include how to seek pre-conception/ pre-birth advice.</i>	
8.1.10c	1	Medication, including its potential side effects including impact on sleep, driving and the ability to carry out day to day tasks.	
8.1.11	2	All patients have a named local community perinatal mental professional.	