

Eliminating mixed sex accommodation in hospital to improve patient experience

A London trust is working to eliminate mixed sex accommodation by changing culture and adapting buildings to maximise privacy and dignity

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ABSTRACT Maxwell S, Sigsworth J (2009) Eliminating mixed sex accommodation in hospital to improve patient experience. *Nursing Times*; 105: 44, 12-14.

This article outlines the work undertaken by Imperial College Healthcare Trust to eliminate mixed sex accommodation in its hospitals. It gives background information on the issue, and details the trust's policy to tackle it, including monitoring and evaluation.

INTRODUCTION

The health service has set out its commitment to privacy and dignity – and to eliminating mixed sex accommodation as part of this – in a number of key policy initiatives.

In 2007, a report by chief nursing officer for England Dame Christine Beasley highlighted shortcomings in the provision of single sex accommodation (Department of Health, 2007).

Dame Christine said single sex accommodation was a “visible affirmation of the NHS’ commitment” to privacy and dignity. Lord Darzi’s NHS next stage review also discussed the need to organise care around the individual, “not just clinically but in terms of dignity and respect” (DH, 2008).

In early 2009, then health secretary Alan Johnson announced that, from 2010, hospitals that treat patients in mixed sex accommodation will not be paid for their care (DH, 2009a). A package of measures to encourage trusts to address the issue included a £100m ringfenced privacy and dignity fund to help them make quick adjustments to accommodation, as well as a system of financial penalties for hospitals that do not comply, unless it can be clinically justified.

However, the DH (2009b) recently reported that while 99% of trusts say they are providing same sex sleeping accommodation and 97% same sex toilets and bathrooms, nearly one-quarter of patients still report being in a mixed sex sleeping area when first admitted to hospital. It stressed: “There is clearly work to be done both to provide more same sex accommodation and to improve patient perceptions” (DH, 2009b).

To help avoid, reduce and manage the mixing of sexes in acute and mental health trusts, the NHS Institute for Innovation and Improvement (2007) published a good practice guide and two self-assessment checklists (see Guidance in brief, page 15).

BACKGROUND Strategic objectives

Imperial College Healthcare Trust was formed in October 2007 following a merger of two large London trusts. Its board structure ensures that decision making is clinically driven at all levels and our aim is to bring together research, education and the service provided to impact positively on patient care and outcomes.

The trust has a proven track record in delivering high quality care, demonstrated by its consistent position in the top three UK trusts for hospital standardised mortality rates. It has ambitious strategic objectives, which set the background to our proactive approach to eliminate mixed sex accommodation.

Maintaining patients’ privacy and dignity is key to delivering these objectives and is also a top priority for the trust, reflected in its nursing and midwifery strategy *Our Vision, Our Promise*. The strategy has four key objectives, which all link to improving the experience of both patients and staff:

- To provide safe, effective and compassionate care;
- To integrate service, education and research for patient benefit;
- To recruit and retain the most talented people who share our vision, values and ambitions;
- To strengthen nursing and midwifery leadership and innovation.

Each objective is underpinned by sub-projects, which will ensure delivery, and

PRACTICE POINTS

- A change in organisational culture is needed to achieve zero tolerance towards mixed sex accommodation.
- It is vital that staff feel ownership of initiatives to promote privacy and dignity.
- Solutions to achieve single sex accommodation are complex and require both innovative ideas and building work.

combine to make up the nursing and midwifery work plan for the next three years. Top of our list is the elimination of mixed sex accommodation as we believe this will have a significant impact on patients' experience of care and is fundamental to our ambitions.

Physical design

The trust has hospital buildings on five sites, a total of 80 inpatient areas with approximately 1,165 beds and delivered 163,000 inpatient spells of care in 2008-09.

Each hospital site has specialty specific wards, ensuring that patients are cared for by highly skilled nurses and midwives in the field of their condition. However, this increases the number of mixed sex wards. To compound the issue, many wards have an integrated critical care bay, again giving patients access to specialist staff but this consequently led to mixed sex areas.

The estate is of variable design and condition, which can often make it challenging to achieve single sex accommodation. We faced a major task, particularly since at the end of March 2009 we had declared non-compliance against the Care Quality Commission's standard 20b on privacy and dignity.

First we identified the challenges, which were different across the sites.

Charing Cross Hospital has 393 beds in variable ward configurations:

- Adequate partitioning;
- Needed more single sex washing facilities;
- Admission wards not always single sex;
- Side rooms not always en suite.

St Mary's Hospital, with 414 beds, had not undergone any major refurbishment outside the critical care areas for many years.

The inpatient facilities comprise a mixture of buildings, including Nightingale style wards in Victorian buildings and open plan wards built in the 1980s:

- Open plan bays with no partitioning;
- Needed more single sex shower and toilet facilities;
- Critical care facilities provided in four specialty wards;
- Admission wards open plan.

Hammersmith Hospital has 358 beds and a mixture of new build modern facilities and old fashioned wards in Victorian buildings, with the design further complicated by specialty wards with collocated critical care facilities in certain areas such as cardiac and renal:

- Admission wards with Nightingale layout;
- Cardiac unit layout poor;

- Variable partition quality;
- Required improvements to bathroom and toilet facilities.

A FOCUS ON SINGLE SEX ACCOMMODATION

In October 2008 it was agreed that although the ward teams were trying to achieve maximum privacy and dignity for patients, a significant improvement in estates and a strong focus on the operational delivery of single sex accommodation was needed. The trust board approved this new approach, which was and still is nurse-led.

A complete culture change was needed to eliminate mixed sex accommodation at the trust, underpinned by a new policy clearly setting out the roles, responsibilities and expectations of all staff. The policy ensures that organisational arrangements are in place to make certain that patients are nursed in a bay with those of the same sex and have easy access to single sex bathroom and toilet facilities.

The overall aim is to promote a culture that does not accept mixed sex accommodation, by encouraging local ownership of the issue and empowering staff to take action to reduce/eliminate mixing of patients, and helping them to escalate matters as needed. We want to create the absolute best environments for care which maximise privacy and dignity, as well as encourage zero tolerance to any patients being placed in mixed sex accommodation. We recognised the issues would not be solved by estates work alone.

The policy was developed using the NHS London definition of single sex accommodation as our baseline and then applying this to the patient pathway and challenges at the trust (Box 1).

BOX 1. DEFINITION OF SINGLE SEX ACCOMMODATION

NHS London defines single sex accommodation as follows: "Men and women are cared for in separate bays or rooms and have their own toilet facilities... In practice, good segregation can be achieved if men and women have separate sleeping areas (for example, single sex bays) and separate toilets and bathrooms that can be reached without having to pass through (or close to) opposite sex areas. Ward layouts should minimise any risk of overlooking or overhearing from members of the opposite sex."

Source: NHS London

THE TRUST'S DEFINITION

To provide a consistent and robust approach for single sex facilities, the NHS London definition has been refined to ensure the standard can be applied trust-wide and can be communicated to patients via patient literature, the hospital handbook and a poster campaign.

Standards for sleeping accommodation

All accommodation in the trust will conform to the following principles to maximise privacy and dignity:

- Nightingale (open wards) will be segregated to ensure patients cannot observe others of the opposite sex;
- Bay areas will have a standard level of partitioning to prevent patients being observed from:
 - Adjacent bays or side-rooms;
 - Corridors or thoroughfares through the ward;
 - Entrances to the ward.

Toilets and bathing facilities

All accommodation in the trust will conform to the following principles to maximise privacy and dignity:

- Best practice means that side-rooms should have en suite facilities with an entrance contained within the room and that these en suite facilities are only used by the patient occupying the room;
- Each bay or segregated area should have access to a toilet and bathroom that is for the sole use of patients within that bay or segregated area.

The policy was produced by the nursing team and developed with extensive consultation across the trust. It was vital to engage ward staff and those responsible for managing the operational service to ensure our plans were feasible and would be achieved.

We are considering the options of applying the criteria to make single sex wards and single sex theatre lists. We have stipulated that all new building work must comply fully.

We were well supported by nursing colleagues at NHS London and the DH, who came in and helped to review every inpatient bed, bathroom and toilet against a set of definitions. This involved a small team of senior nurses walking round the wards, talking with ward sisters, staff nurses and patients to understand what the issues were.

An estates solution was considered for

practice changing practice

every issue and in the very challenging areas the whole multidisciplinary team was involved in elements of building design and operational plans. We put a great deal of time and energy into this project to deliver the high standard we wanted. Each estate modification was incorporated into a detailed building project plan which includes the number of bed closures needed weekly to allow progress.

The trust board has ratified the policy and its effect is being monitored by collecting and analysing data on breaches of the policy in real time. Ward staff complete a breach record when mixing occurs for clinical needs. Consent is taken and documented from all patients in the bay. The breach numbers are monitored daily and collated on a weekly basis and submitted by the head of nursing. Ward staff are fully engaged throughout this process and are leading improvements for patients. Every effort is made to move patients as quickly as possible if the need to mix them occurs.

Funding

The policy is supported by a £10m trust-wide capital redevelopment programme, which started in April 2009 across 250 clinical areas. The programme will ensure the physical environment is changed to improve privacy and dignity, while the policy ensures the culture change. The solution is complex and required innovative ideas and precise management of the building work. This includes:

- Fifty-eight partitions or screens being erected;
- Provision or conversion of 160 bathrooms, toilets and washrooms;
- Complete redevelopment of the admission wards at St Mary's Hospital.

Real time monitoring of the building work is needed in order to ensure that capacity is managed while beds are closed. This is achieved by partnership working across disciplines and clinical programme groups and is coordinated by the site management team.

Weekly conference calls have been in place throughout the programme, led by the heads of nursing. This ensures that work is only authorised to start when capacity allows. This has been increasingly challenging with the added pressure of a flu pandemic, although work remains on track to deliver.

Progress with the building programme and the impact on patients' experience is

reported to our 'eliminating mixed sex accommodation' (EMSA) board, formed in April 2009. It is chaired by the chief executive and meets every two weeks to ensure momentum is maintained.

Clinical programme groups are held to account for their performance. Each has an action plan to address areas where compliance is a particular issue, including critical care areas. The standard is that all patients will be moved to a single sex area within 24 hours of admission and that the senior nursing team will be informed of all breaches to ensure this occurs.

Patients' perceptions are changing as a result of the concentrated effort and improving clinical leadership through visibility and support for the whole patient experience.

AREAS OF CONCERN Critical care facilities

Critical care is provided on three hospital sites and specialty level 2 facilities continue to create issues for the single sex accommodation agenda. While the same principles are being applied to these areas, clinical need takes precedent.

Plans are in place to increase monitored bed capacity to allow single sex facilities where required and the new cardiac critical care facility will comply fully when it opens in November 2009. The bedspaces in critical care areas are large and the risk associated with moving patients needs to be assessed before applying the principles. However, work is under way to ensure that, where possible, mixing does not happen. We have visited other trusts in central London facing the same issues in their level 2 and 3 facilities.

Live kidney donors

The North West London renal unit at Hammersmith runs the biggest live donor transplant service in Europe, performing 80-95 live donor transplants each year. Research shows the psychological benefit of nursing patients in this group together. Many donors are recipients' partners or parents and therefore may be the opposite gender. Therefore, it may be difficult to achieve single sex compliance in the critical care facility.

Patient views are being sought to help the trust prove the clinical need for exclusion for this group. At a recent pre-transplant seminar, out of the 67 patients surveyed 54 (81%) said they would definitely want to be nursed together. The 6% who reported

they were not sure said their opinion would depend on their donor's view. The Charing Cross Kidney Patient Association is helping the trust with this work which will be published in the near future.

Tensions therefore remain between providing outstanding clinical care, shown by the trust's excellent hospital standardised mortality rates, and providing a positive emotional and psychological experience for patients.

CONCLUSION

Lord Darzi published a review of progress against his visionary NHS next stage review in June 2009 (DH, 2009c; 2008). This reiterated the commitment to eradicating mixed sex accommodation in NHS hospitals by 2010, with the help of the £100m fund (DH, 2009c).

Imperial College Healthcare Trust is in a prime position to ensure we comply. Our building schemes are on target and are halfway to completion, our policy is in place and the nursing and midwifery strategy was launched at the beginning of November 2009. Our weekly breach analysis will be incorporated into clinical programme group performance scorecards and is already being reported to the EMSA and trust boards.

The whole organisation is buzzing with the positive impact the work is having on facilities for patients and the culture of acceptance of mixed accommodation is also changing, shown by our results. ●

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