Promoting single sex acute units

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An audit revealed single sex accommodation in an acute medicine unit greatly improves patient satisfaction

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This article discusses an audit to explore patients’ experiences of being nursed in mixed sex accommodation on an acute medicine unit. It outlines achievements resulting from the audit, which include staff awareness of the effect of mixed sex areas on patients and changing the culture in the unit to embrace single sex bays.

This article discusses an audit to explore patients’ experiences of mixed sex accommodation on an acute medicine unit. It describes how they felt and indicates why they should be in single sex bays.

The baseline audit highlighted major concerns. The follow-up audit showed that the issues were resolved when segregated bays were introduced or maintained.

The main achievements were:
- Staff awareness was raised of the effect of being admitted to mixed sex accommodation on patients;
- Staff learnt about the single sex standard (Department of Health, 2009b);
- The culture within the AMU changed to embrace single sex accommodation. This work has changed nurses’ perceptions that single sex accommodation cannot be achieved in an AMU.

In conducting this audit, we built on evidence from corporate and quality improvement work (Hunt et al, 2010; Maxwell and Sigsworth, 2009), by developing a local AMU standard, guidelines and a bespoke survey designed to extrapolate patient-centred concerns. The lessons learned can be transferred to all hospital admission and assessment areas, such as clinical decision units, surgical assessment units and day case units.

Background The Heart of England Foundation Trust is gradually eliminating mixed sex accommodation to improve patient dignity and privacy (DH, 2009b; NfIS Institute for Innovation and Improvement, 2007). This includes building work to improve bathrooms, provide more toilets and erect partitions.

We felt it was also important to understand patients’ experiences of acute medical admissions so we could bring about patient-centred improvements. AMUs are specialist areas in acute hospitals with two parts – assessment and short-stay admission beds (Royal College of Physicians, 2007). They differ considerably from traditional wards in staffing, skills and organisational processes, and have a large patient throughput – at our trust, this is 1,500 patients a month.

Since AMUs do not have a fixed number of male and female beds, they need a flexible approach to designating beds and bays so they can manage the volume or sex of patients referred during any shift. For this reason, AMUs are always labelled as mixed sex units, with designated male and female single sex bays to separate sleeping areas.

Delivering single sex accommodation in AMUs requires expert coordination of patients referred for assessment, admission, transfer to other areas of the hospital and discharge.

It is crucial that staff across the whole emergency pathway work as a team; otherwise, single sex sleeping bays cannot be accommodated in an AMU.

Important considerations Nurses in areas with a high patient volume should consider individual patients’ anticipated journey before they are transferred – it is preferable to place them in the right place first time (RCP, 2007).

Moving patients from ward to ward to locate single sex bays is counterproductive at both organisational and clinical levels. From an organisational perspective, each move requires resources, including porters, bed cleaning, escorts and bed management. Clinically, transfers can increase morbidity or length of stay and the potential for mistakes in the transfer details.

However, if the single sex standard is adhered to from the moment patients enter the emergency care pathway, our audit indicates that it is possible to achieve single sex accommodation (Bonner, 2009). Patient flow and placement is challenging, but, if single sex accommodation is accomplished in the AMU, it sets a precedent for all other areas of the hospital (RCP, 2007).

Audit aims Our aim was to audit compliance against the national single sex accommodation standard. We also wanted to look at patient perspectives of being nursed in mixed sex accommodation on an AMU.

AMU standards The consultant nurse, matron and senior sisters devised standards for the AMU based on national guidance (DH, 2009a; 2009b; 2009c; 2009d; DH and National Patient Safety Agency, 2009), modified minimally to suit local context.

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Innovation Single sex accommodation

Nursing Practice

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so we added a standard (second bullet point) for clarity, to ensure staff understood that patients must be nursed in a single sex bay, regardless of whether they were being assessed or admitted for a short stay (up to 48 hours). Our standards are:

- All patients being assessed and admitted to the AMU will be segregated into single sex bays;
- A single sex bay is applicable to the assessment and the admission area;
- If any patients are admitted to a mixed sex bay, their stay there should not exceed 24 hours;
- Patients in mixed sex areas will be kept informed and moved to a single sex bay within 24 hours;
- In accordance with the standard, exceptions are only permissible where patients require a rapid admission, and segregation into a single sex bay is not possible.

All exceptions will be monitored.

The DH guidance has been superseded (DH, 2010a; 2010b; 2010c), but the main messages remain the same. These are founded on the principles of eliminating mixed sex accommodation, choice, information, monitoring and exception only for patients requiring rapid admission.

Audit methods

The audit was conducted using a semi-structured survey instrument at patients’ bedside in the first 48 hours of their inpatient stay.

Results

During December 2009, 108 patients were surveyed. Of these, 100 were cared for in a mixed sex bay; the remaining eight were removed from the audit at this point as its aim was to explore perspectives of being nursed in a mixed sex bay. The survey revealed the following:

- Fifty-eight of the 100 patients were comfortable with being cared for in a mixed sex bay, while 42 were not;
- Eighty-two had not been told they would be in a mixed sex bay;
- Ninety-four were not kept informed of when they would be moved into a single sex bay;
- Sixty-nine were not moved into single sex bays within 24 hours, while 11 were moved – the remaining 20 were removed from the data for this question as they had been in hospital for 12 hours only;
- Thirty-nine felt their dignity and privacy had been compromised by being nursed in a mixed sex bay – the 61 who felt their dignity and privacy had not been affected were removed from the data for the remaining questions.

The 39 patients who were affected by being cared for in mixed sex bays were asked to complete the second part of the survey, exploring which part of the process had caused concern.

Graphs of the responses were made to demonstrate satisfaction or dissatisfaction in each area.

Analysis of patient comments

Comments from the 39 patients who had concerns about dignity and privacy were analysed. Five main themes were evident from the whole content of all responses (Table 1).

It would seem that when privacy is threatened, patients recall this above all other aspects of the care episode, perhaps because it is such a vivid experience.

Statement 6 from the questionnaire asked patients to rank the comment: “I felt I had enough privacy when I was being examined by the doctors or nurses” (Fig 1). We selected some comments to show where patients expressed concern about privacy. We also came up with some interpretations of the possible care issues taking place to prompt such comments.

“Curtains were not always closed properly, especially during the ward rounds and I felt really exposed to all the men in...”
Privacy and dignity

The comments indicate not only privacy but also dignity was being affected. Dignity is present when people feel in control, valued or comfortable (Baillie, 2007).

Maintaining patient privacy is a pivotal part of the nurse’s role and is inextricably linked to the care environment. The environment is much more than the building and unit layout; it also encompasses the culture among the staff and practices (Maxwell and Sigs worth, 2009). Privacy and dignity are inseparable in the context of care and undoubtedly heighten patients’ anxieties in the context of mixed sex bays.

Patient safety

Before the work to eradicate mixed sex bays on the AMU was undertaken, the practice of closing curtains around beds to segregate women and men was widespread.

This was based on the assumption that it eliminated privacy issues and adequately segregated male and female patients (Burden, 1998). Paradoxically, hospitals are segregated male and female patients it eliminated privacy issues and adequately practice of closing curtains around beds to segregate women and men was widespread.

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Conclusion

Patients’ comments revealed in the first audit cycle were communicated to the team through meetings and in an audit report.

Gradually, this feedback has had an impact upon care and raised awareness about patients’ perspectives on privacy and dignity if they are nursed in a mixed sex bay.

The audit showed that mixed sex bays do lead to dignity and privacy issues. We will continue to revisit the issue through surveys so that care can be improved.

This work shows that it is possible to introduce single sex bays on an AMU.

Setting out staff responsibilities and expectations, supported by a “zero tolerance” trust policy has led to a huge change in the way patients are placed and nursed on the unit (DH, 2010b).

The multidisciplinary team responded positively to the change and the nurse coordinators (predominantly sisters) work hard to maintain single sex bays.

Acute medicine is a notoriously challenging area in which to introduce single sex accommodation, and will be subject to variances according to hospital capacity. That said, in the words of one sister: “It has made our life a lot easier and it is so much better for the patients.” If staff feel happier, this should promote the single sex standard and make mixed sex bays, for the most part, a thing of the past.

The survey instrument and the local AMU guidelines are available on request: liz.lees@heartofengland.nhs.uk

References


Burden BJ (1998) Privacy or help? The use of curtain positioning strategies within the maternity ward environment as a means of achieving and maintaining privacy, or as a form of signalling to peers and professionals in an attempt to seek information or support. Journal of Advanced Nursing; 27: 1, 15-23.


Fig 1. Views on privacy during examination

This graph shows only 41% of patients sometimes felt they had enough privacy during examinations.

Patients in the survey who felt their dignity and privacy were compromised by being nursed in a mixed sex bay (n=39 of 100).