



Enhancing privacy and dignity

ACHIEVING SINGLE SEX ACCOMMODATION

NHS
Estates

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NHS
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Foreword

The Government has set the NHS a clear objective to work towards the elimination of mixed sex accommodation in 95% of trusts by the year 2002.

For many hospitals this has not been an easy task. They have had to plan major building works or reorganise the way they carry out services in order to ensure more patients receive their care in a single sex ward.

As part of the quality programme for the NHS, we are seeking to improve patients' experience of NHS services. We are working to ensure that patients are given more information about the services provided, that more is done to monitor performance from the perspective of patients, and that mechanisms are in place to deliver improvements where patients express concerns.

Achieving single sex accommodation forms a key part of the quality programme because patients have told us that it is a particular concern of theirs.

This report will assist hospitals in their work to achieve single sex accommodation.

Peter Wearmouth
Chief Executive
NHS Estates

Executive summary

The Government is committed to achieving single sex accommodation across the NHS. Three key objectives were established:

- 1 to ensure that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients;
- 2 to achieve segregated washing and toilet facilities across the NHS;
- 3 to provide safe facilities for hospital patients who are mentally ill, which safeguard their privacy and dignity.

The target is for 95% of trusts to achieve these objectives by 2002.

In 1998, a survey by the National Consumer Council indicated that patients do not like mixed sex accommodation. At a workshop hosted by the Department of Health, NHS staff considered the problem and came to the following conclusions:

- Research is needed to examine the impact of lack of privacy on recovery.
- Misinterpretation of standards is sometimes deliberate, but sometimes the standards themselves are not clear.
- Good design is dependent upon good briefing, and clinical staff should be involved in planning from an early stage.

NHS Estates plays a key role in producing guidelines and standards for good design. In particular, there are plans to:

- make sure guidance from NHS Estates is reviewed regularly;
- ensure greater clarity of standards (including what is/isn't compulsory);
- consider ways of ensuring there is consistency of quality in design and construction.

This report considers the issues for new facilities and illustrates ways of addressing the problems in the existing estate.

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Purpose of this report

The purpose of this report is to consider the issues and constraints of achieving single sex accommodation within the NHS. It begins by reviewing the commitments made by Government and examines some of the design solutions that have been proposed to achieve satisfactory solutions.

Context

In the early days of the NHS, acute general hospitals tended to segregate patients in a very straightforward way – wards were either medical or surgical, and men and women were accommodated separately within each. Most wards were of the old Nightingale design, and it was unusual for men and women to be nursed in the same room.

Over time, healthcare has become more specialised and ward design developed towards smaller “bays” of four or six beds. This has proved to be a more flexible solution in the sense that bays can be:

- a. clustered to take advantage of specialist clinical care; and
- b. designated male or female according to changes in demand.

However, while good practice has always dictated that men and women should not be cared for in adjacent beds, there has been erosion of this practice so that in some places mixed accommodation has become the norm.

The Government is committed to working towards the elimination of mixed sex accommodation in most situations. Three key objectives have been established (EL(97)3) as follows:

1. to ensure that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients;
2. to achieve segregated washing and toilet facilities across the NHS;
3. to provide safe facilities for hospital patients who are mentally ill, which safeguard their privacy and dignity.

The target is for 95% of trusts to achieve all three objectives by 2002.

Issues

Key issues demonstrate the multidisciplinary nature of the problem:

- Privacy and dignity is about far more than segregation of men and women.
- Segregation is about far more than bricks and mortar.
- Staff attitudes are fundamental to enhancing the quality of patient experience.
- Research is needed to examine the impact of lack of privacy on recovery.
- Sometimes standards are misinterpreted and sometimes the standards are not clear.
- Very high bed occupancy rates and complete gender segregation cannot easily co-exist – there is a need for imaginative solutions.

- There is a need for flexibility in the way accommodation is used.
- Good design is dependent upon good briefing – clinical staff should be involved in planning at an early stage.
- Clinical need sometimes overrides gender segregation (for example, in an emergency or in highly specialised units) but this does not excuse inactivity – in fact, greater attention to privacy and dignity is needed in these circumstances.

The problem and its solution are not resolved by the design solutions alone. The management of nursing units and the procedures in each ward interrelate with the design solution to achieve an acceptable solution.

Constraints

Clinical issues:

- Mixed clinical use of wards may result in substantial variations of gender mix.
- In smaller hospitals, wards cannot be single sex because of limited patient numbers and the need to accommodate patients with different clinical needs and different consultants.

Management pressures:

- With the constant need to reduce waiting lists, allowing wards to be placed out of use for refurbishment creates difficulties.
- Many hospitals no longer have a decant ward available to allow upgrading/alterations to be easily undertaken in a programmed way.

Physical/structural issues:

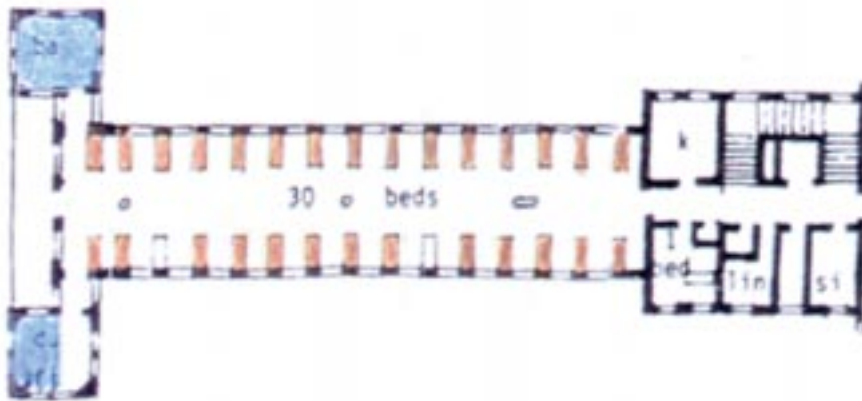
- Wards at upper levels of buildings may be difficult to alter because of service duct locations and structural constraints. Expansion beyond the external perimeter is unlikely to be achieved unless it can be repeated on the lower floor down to ground level.
- Internal reorganisation to provide separation of gender and additional toilets, without loss of bed spaces, may only be possible by utilising surplus circulation space or displacement of other facilities (offices).
- Restricted sites militate against expansion of ground floor accommodation to provide additional facilities.

History of ward design

Note: in the diagrams on pages 6 to 8, areas shaded blue indicate sanitary facilities. Beds are coloured to indicate preferred solutions to separate patients by gender. Further subdivision may be possible if bed bays have en-suite facilities.

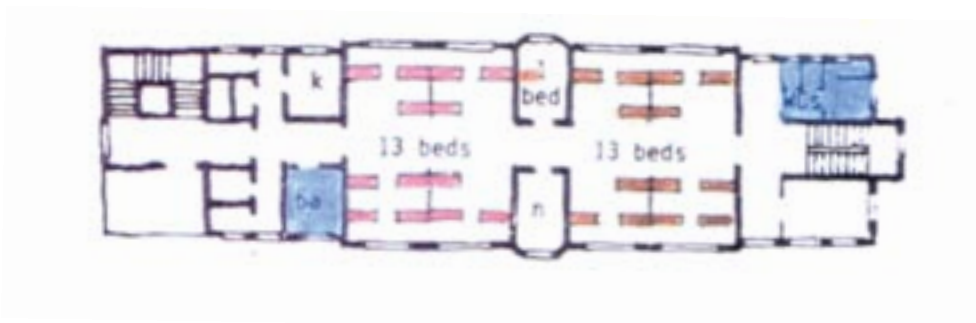
LONG-NAVE “NIGHTINGALE” WARD

In the past, the design of hospital wards followed a similar pattern of the long nave-like open bed space. In Britain this was known as the Nightingale Ward (1871). This type of design was unsuitable for mixing the sexes.



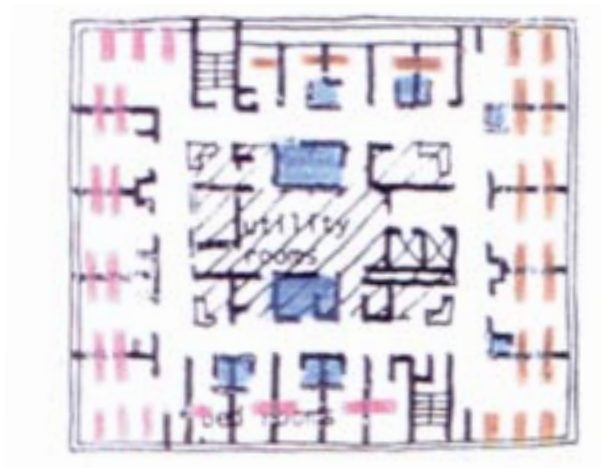
EARLY TWENTIETH CENTURY “SUB-DIVIDED” WARDS

Increasing awareness of factors affecting hygiene and improvements in living standards influenced the design of the early twentieth century sub-divided wards, which afforded a greater degree of visual and auditory seclusion to patients. The nursing base, which was opposite a single bedroom in the centre, segregated the sexes.



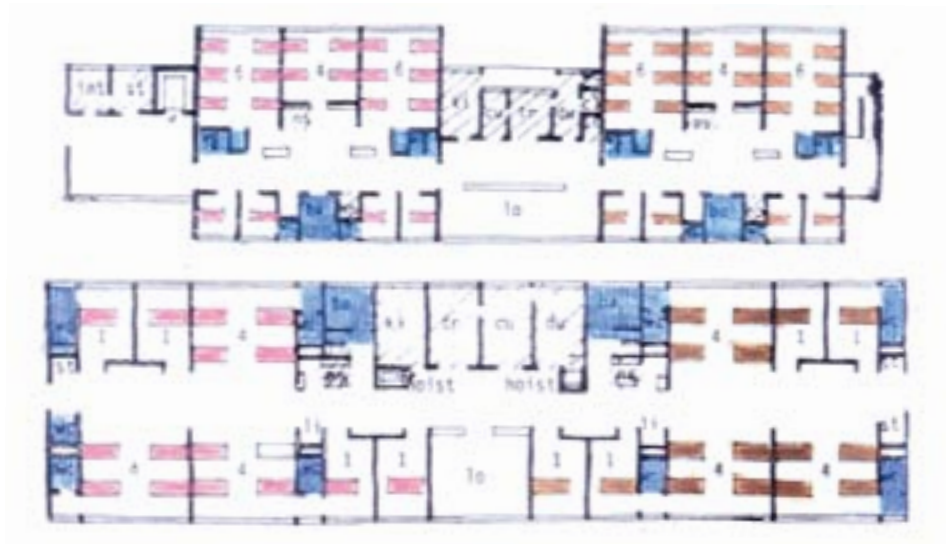
POST-WAR “RACETRACK”

In the 1950s and 1960s, provision of hospital buildings on small urban sites led to the development of tall hospital buildings with perimeter wards grouped around a central core of utilities and circulation with provision of 16 to 60 beds (or exceptionally more) in various mixes of patient-dependency categories. This ward layout provided a mixed sex ward with multi-bed bays for use either by female or male patients, and became known as “racetrack”.



1950s “NUFFIELD” WARDS

The Nuffield ward compromised on the issues of 100% observation and total segregation. Multi- and single-bed solutions were developed. The diagrams below indicate two-ward layouts with some multi-bed and some single-bed rooms for use either by female and male patients. Segregated wings are also possible.



Design considerations

This section identifies solutions for both new and existing accommodation.

NEW ACCOMMODATION

Guidance on the requirements for new accommodation is given in Health Building Notes and Design Guides. [See page 27](#) for further details.

HBN 04 'In-patient accommodation – options for choice' provides guidance on the planning and design of hospital accommodation for people with acute illness.

The most notable change in society today is the public's increased expectations about the quality of delivery of service. Expectations of the health service include:

- higher standards of care;
- improved hotel services; and
- to be afforded privacy and dignity during their time in the hospital.

Recent surveys have supported previously assumed data that a majority of patients would prefer to be nursed in a single room with en-suite facilities.

The proportion of single rooms in wards in most new hospitals in England is about 20–25%.

Single rooms (with en-suite facilities) address the key issues of privacy and dignity in ward accommodation, but raise other issues such as increased floor area and capital cost. Management and staffing issues also need to be considered.

The use of single rooms permits maximum bed occupancy levels to be achieved without compromising privacy and dignity issues.

Multi-bedded bays (often four beds) can also be enhanced by the provision of dedicated sanitary facilities contained within the entrance to the bed area.

Day space can also be provided either within the bed bay area or shared between two bays. This may result in an internal space adjacent to the circulation area but an external day space solution can be designed.

In most wards there is a mix of clinical cases and of gender. The management of the mix is often difficult and the design solution must offer staff the maximum flexibility to treat as many patients as possible at any time.

Solutions which provide a "barrier" of single rooms separating multi-bedded areas of opposite gender patients can provide the required flexibility and control (if adjacent to the nurse base).

Figure 1. This conceptual diagram shows how men and women can be accommodated separately within a single ward, and how a central bed area can be used flexibly to accommodate either men or women according to fluctuating levels of demand

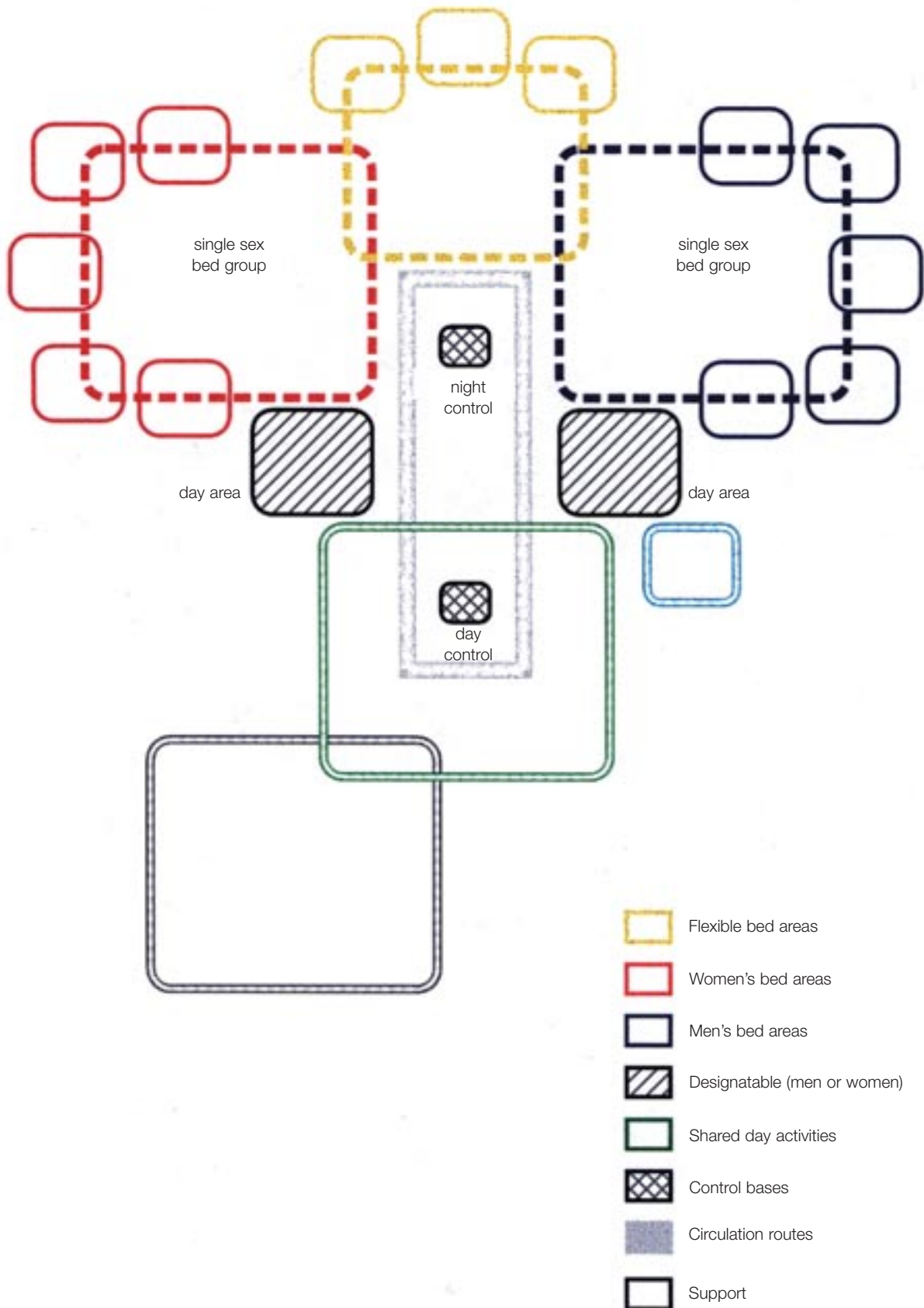


Figure 2. Single room with en-suite facilities: this provides privacy and dignity for patients and allows maximum use of all beds in the ward unit by either sex (source: HBN 04)

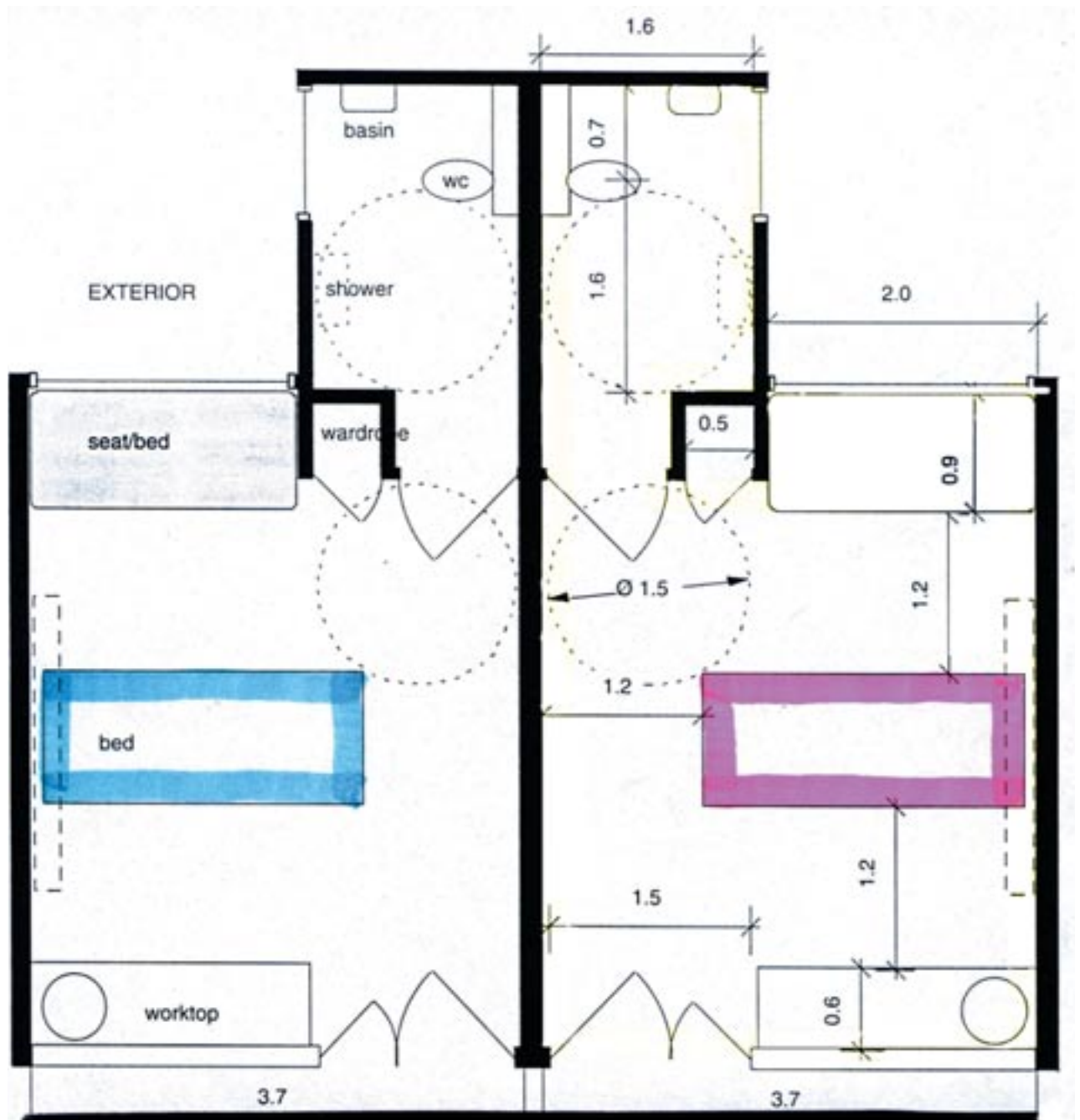


Figure 3. Four-bed bays with en-suite facilities within the bay. This solution achieves privacy and dignity in a single gender bay. Note that the location of the door into the sanitary facilities is remote from the bed locations and helps to maintain privacy for each bed area. The day area (green) is an internal space adjacent to the circulation area and only appropriate if beds in both bays and on the opposite side of the corridor have the same gender patients (source: HBN 04)

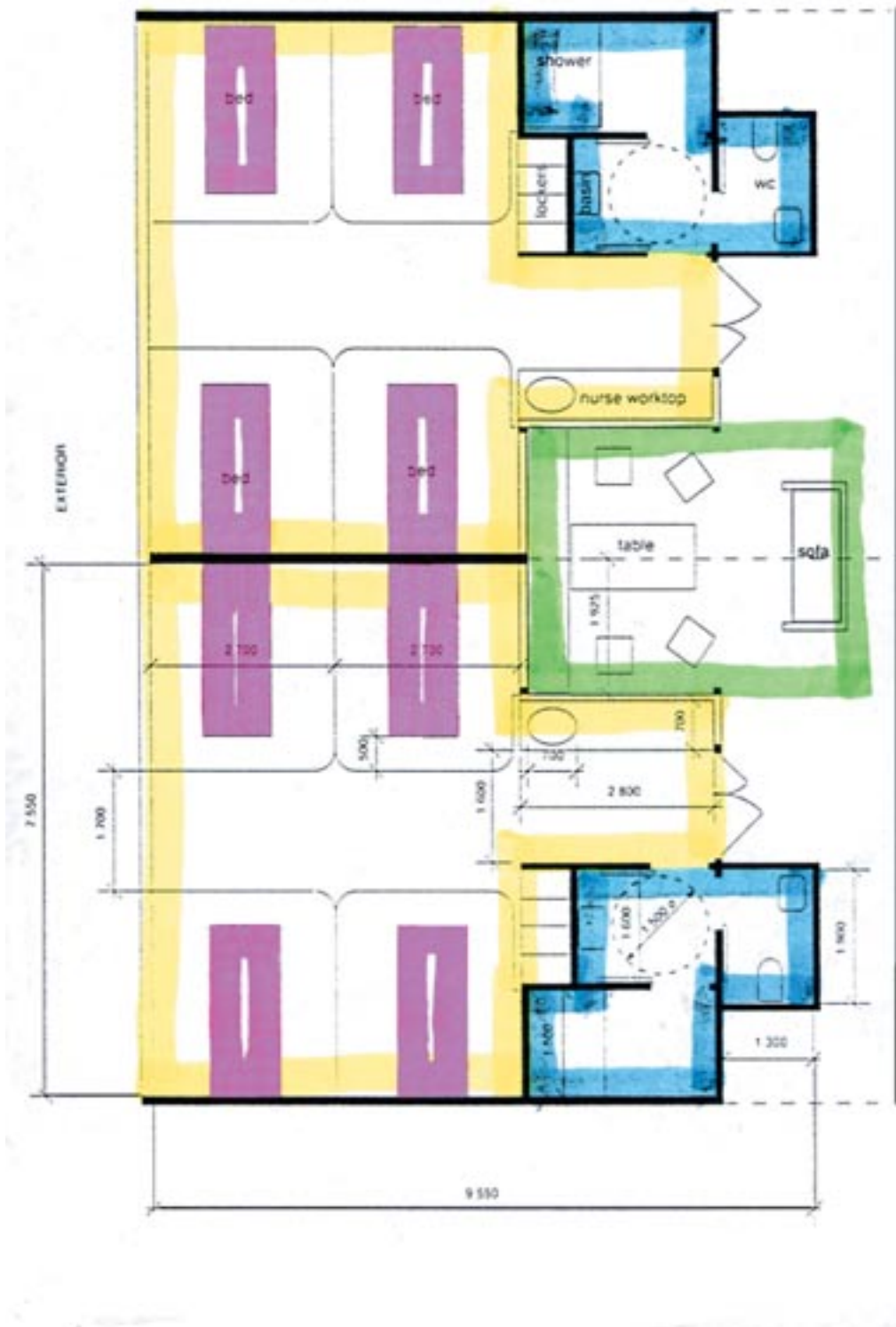
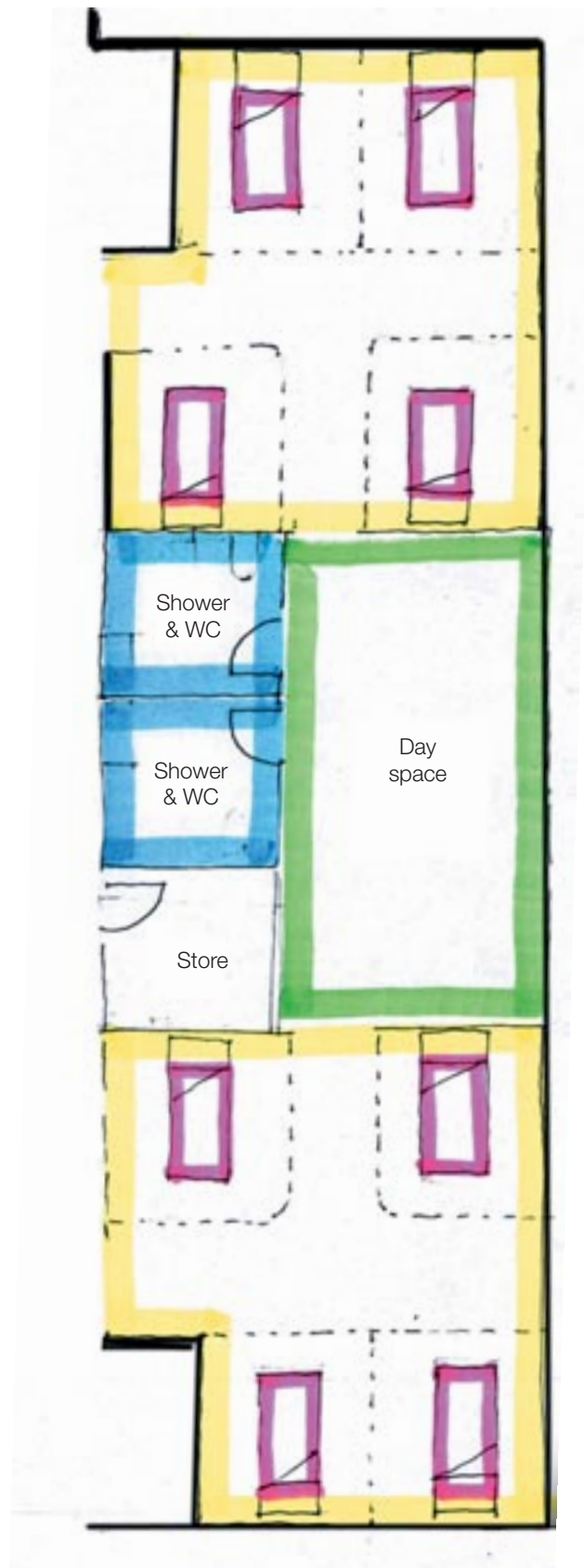


Figure 4. Six-bed bay with en-suite facility and day space suitable for single sex occupancy (source: HBN 04)



Figure 5. Alternative four bedded bays providing shared day space with an external outlook and shared en-suite facilities. Only appropriate where both bays have same gender patients



EXISTING ACCOMMODATION

Separation of male and female patients is most easily achieved by introducing single sex wards. In most situations, this is difficult because of limited availability of wards and the demands of clinical specialties each of which does not require an individual ward.

Provision of individual clusters of single- and multi-bedded areas (with dedicated sanitary facilities – en-suite where possible) for each sex and separated by doors, clinical spaces or a nurse base will achieve the objectives of privacy and dignity.

In wards which have a single entry location (i.e. finger-type wards as against racetrack solutions), it is helpful to locate the female accommodation furthest from the entrance. This avoids male patients having to pass through female areas for any reason. Women have to pass male areas only when leaving the ward for treatment or therapy.

The entrance into some sanitary facilities can be re-located from a corridor wall to an adjacent one within a multi-bedded bay and achieve an en-suite solution without major structural modifications.

Unless an area is dedicated to one sex, it is inappropriate for patients to have to cross a corridor to use sanitary facilities which are on the opposite side of that corridor.

Relocation of a nurse base may result in the psychological separation of male and female areas.

The following diagrams illustrate some of the problems and possible solutions to achieve privacy and dignity in existing ward accommodation. Every hospital will have a different set of circumstances and demands. Each solution to these problems will be unique, but there will be common themes and directions.

Solutions can be achieved without resorting to major building alterations or additions.

In some hospitals, wards with identical plans can comply while others fail to do so owing to the location of men and women bed bays. This is a management issue, not an estates problem, and can be resolved by constructive dialogue.

Provision of additional sanitary facilities may be necessary to achieve an acceptable level of dignity and some methods of doing so are illustrated.

Shared use of other ward accommodation, offices and other spaces, or revised policies to share utilities across several wards, may release floor area to address the problems. In many cases additional accommodation will be required if bed numbers are to be maintained.

Loss of beds is not encouraged as a solution to the need to eliminate mixed sex issues in the healthcare estate.

Figure 6. Standard **Nucleus** acute wards (28 beds). Limited separation of sexes is possible using the six bed bays and the four single rooms. Where possible, using the bays furthest from the street will reduce the possibility of gender mixing. Only two single rooms have en-suite facilities. The location of the staff base provides a barrier between the areas. The addition of sanitary facilities in the bay closest to the entrance will help in the distribution of facilities and achieve an improvement in the issue of dignity by reducing the number of patients moving out of ward areas to go to toilets. Later Nucleus ward designs increased the number and disposition of single rooms (see Figures 7 and 8)

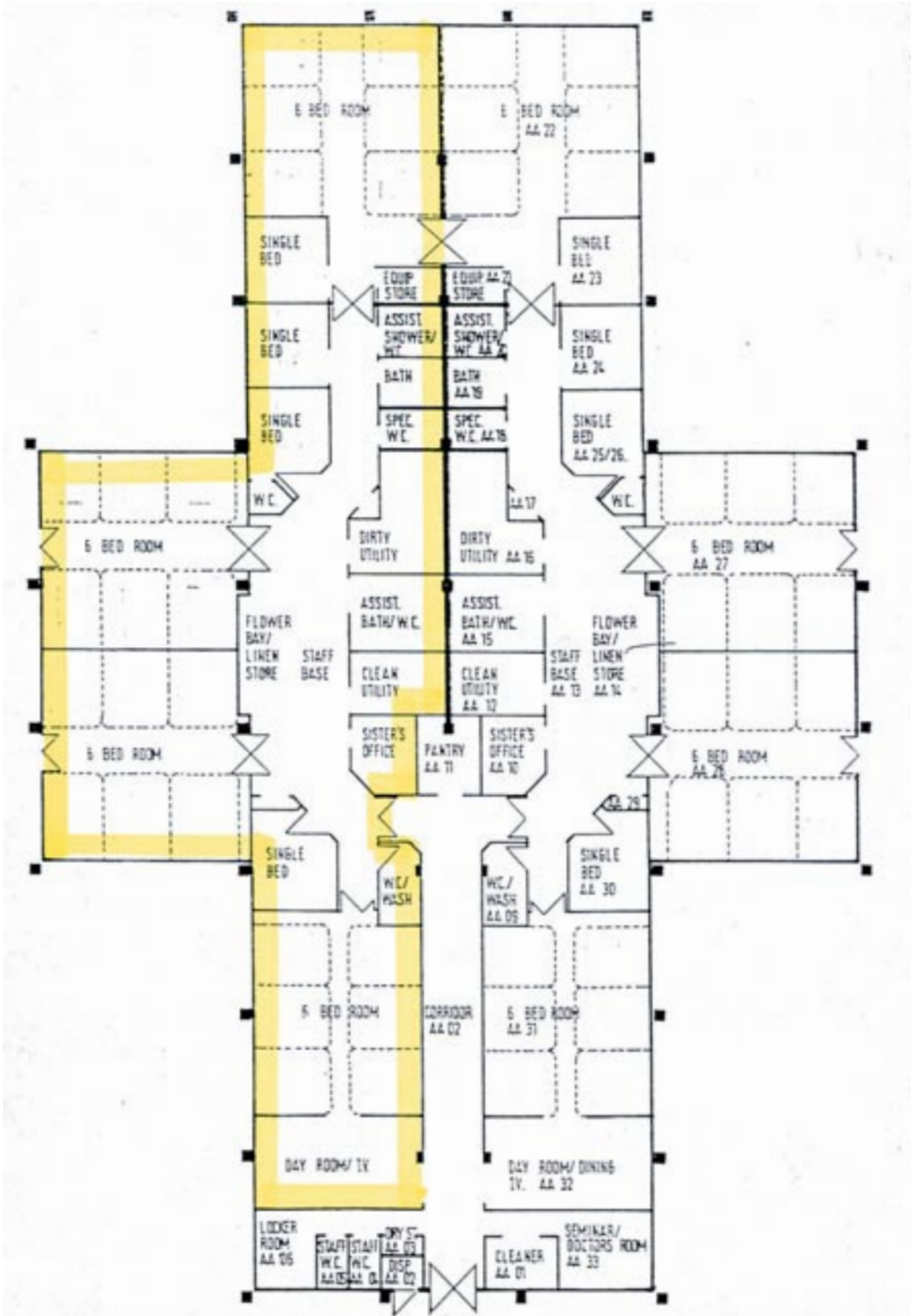
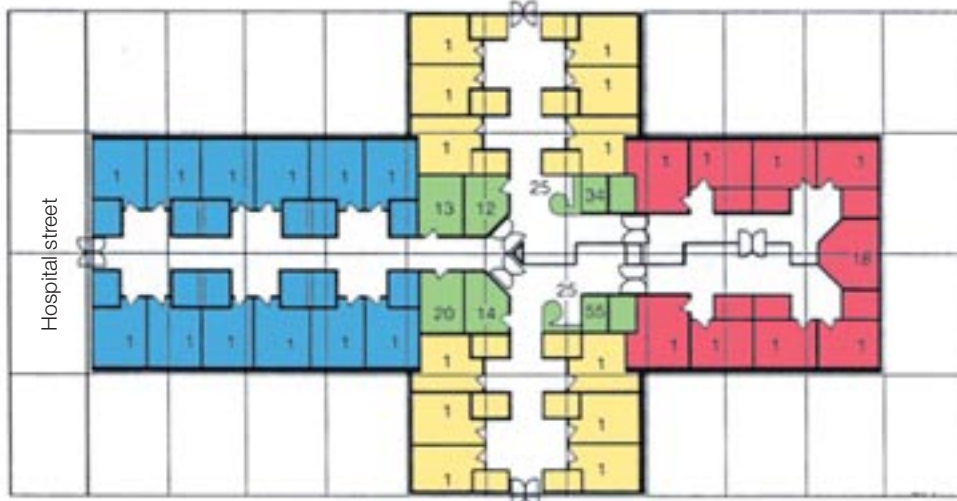
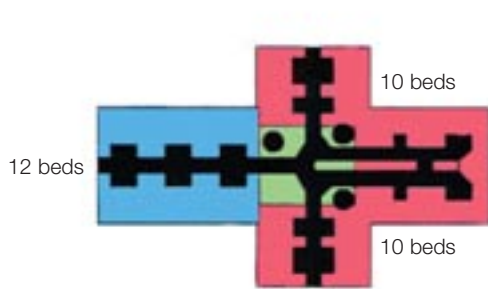


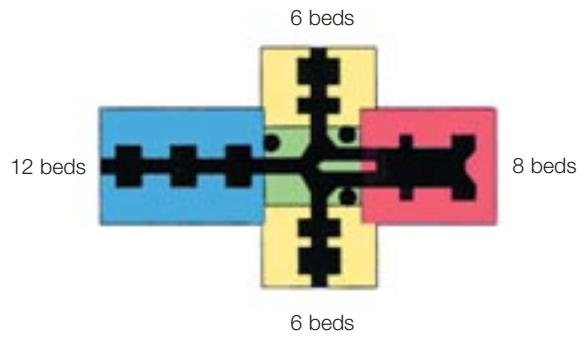
Figure 7. **Nucleus ward:** this plan shows how the nursing base can be used to divide a ward into separate men's and women's areas



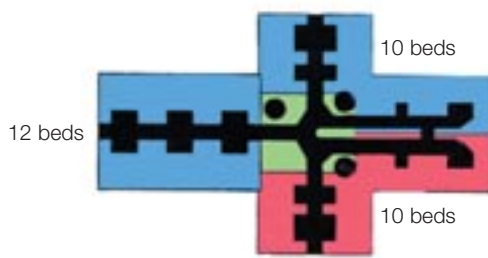
Nucleus single template 32-bed unit 1:500



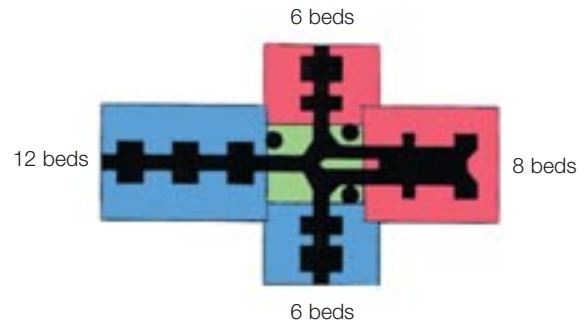
Layout of the 32-bed unit for 10 and 12 bed clusters



Layout of the 32-bed unit for 6, 8 and 12 bed clusters



Layout of the 32-bed unit for 10 and 12 bed clusters



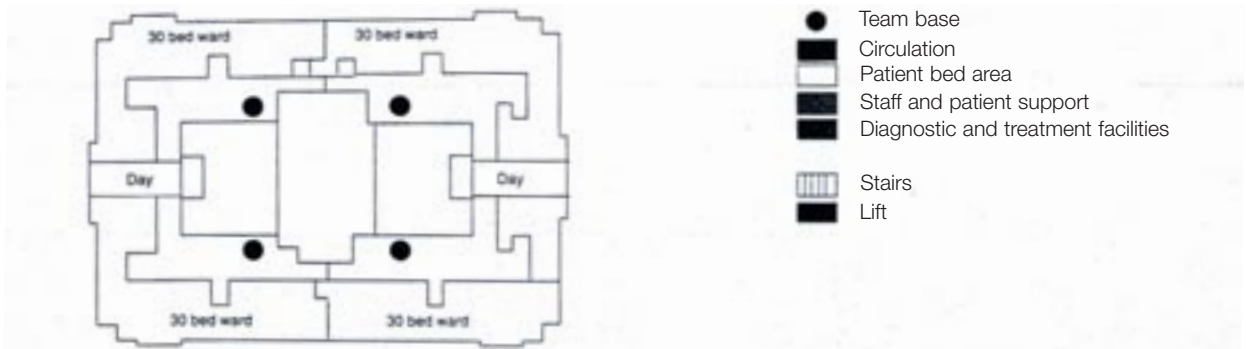
Layout of the 32-bed unit for 6, 8 and 12 bed clusters



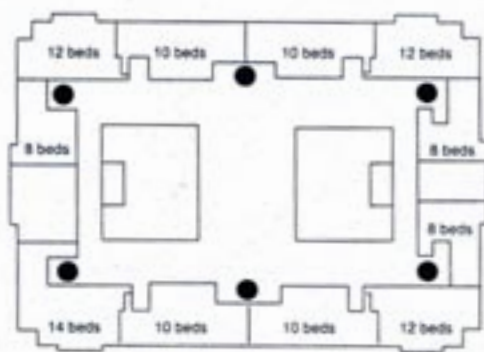
Figure 8: Separate male and female bed areas in a Nucleus ward



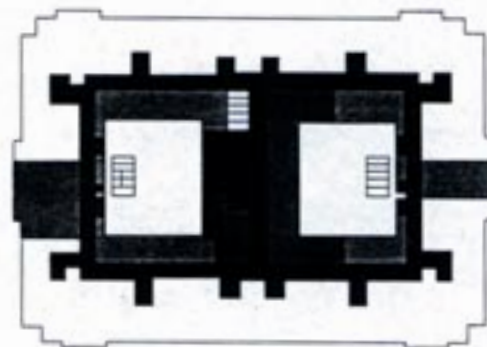
Figure 9. **L-shaped wards** with a mix of 4 or 6 bed bays and single rooms angled around a nurse base increase flexibility and the opportunity for sub-divisions to respond to clinical needs. The scheme illustrated achieved en-suite facilities to each group of bed areas (the access point to the sanitary facilities in the multi bed area impinges on the bed space closest to the door and is not ideal)



Before refurbishment: 4 wards with 120 beds



After refurbishment: 11 care teams with 114 beds



Zonal diagram



Figure 10. **L-shaped wards:** this plan can work with a 2/1 bay mix providing the two same sex bays are adjacent, but fails if the bays are split. The two single rooms are flexible in use. It may be possible to modify the layout of one WC to provide en-suite facilities to one six-bed bay. An additional toilet opposite the day space (outlined in green) would be beneficial





Notes:

- Disposition of toilets at either end
- Nurse base separates gender areas
- Female area furthest from the ward entrance to avoid male patients having to pass through female areas

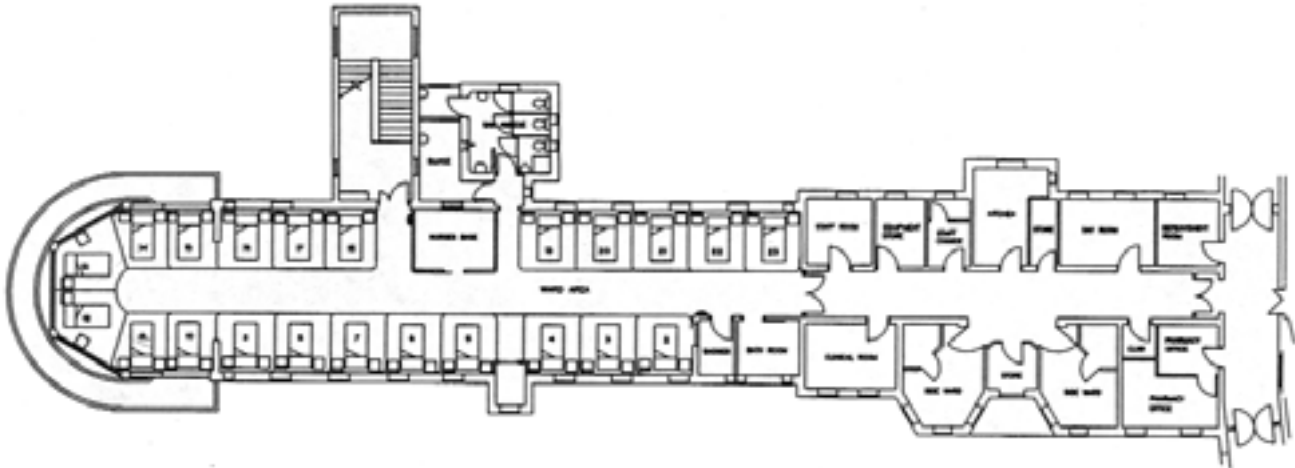
	Women's bed areas		Day spaces
	Men's bed areas		

Figure 11. Separate male and female multi-bed bays (finger wards)

Figure 12. **Nightingale wards** can be altered to address privacy and dignity issues if there is potential to expand the footprint. Narrow single rooms with en-suite facilities between spaces will achieve a solution with less than 40% of the original beds. Four bedded bays with side corridor and central toilet areas 50% bed reduction

The main issues are :

- toilet facilities at one end of ward or mid point on one side
- long narrow building
- central access
- potential loss of significant number of beds



Where there are several wards along a corridor, a new link to "open" ends would provide beds and sanitary facilities and achieve horizontal fire evacuation

- Staff base
- Circulation
- Patient bed area
- Staff and patient support (existing)
- Staff and patient support (new)

New build externally for additional toilets and bed bays

New external link to mid point in ward with bed areas and toilets either side

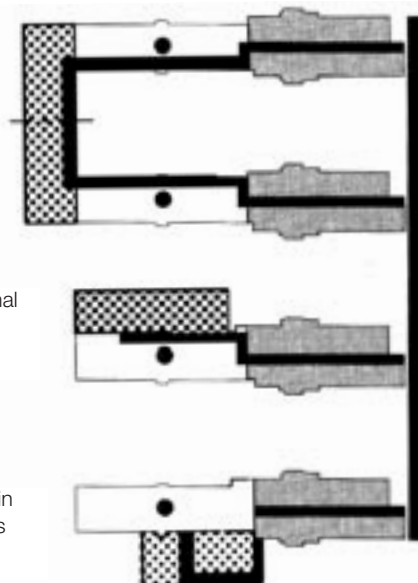
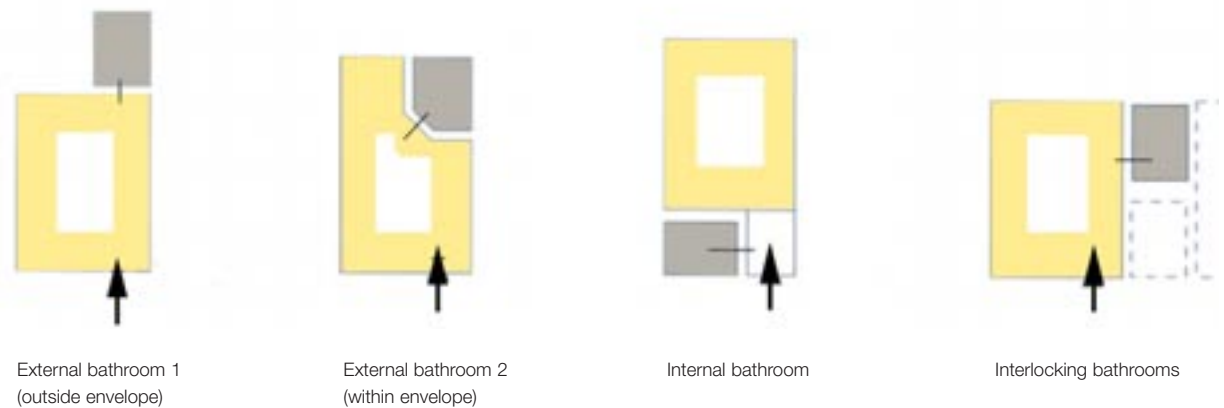
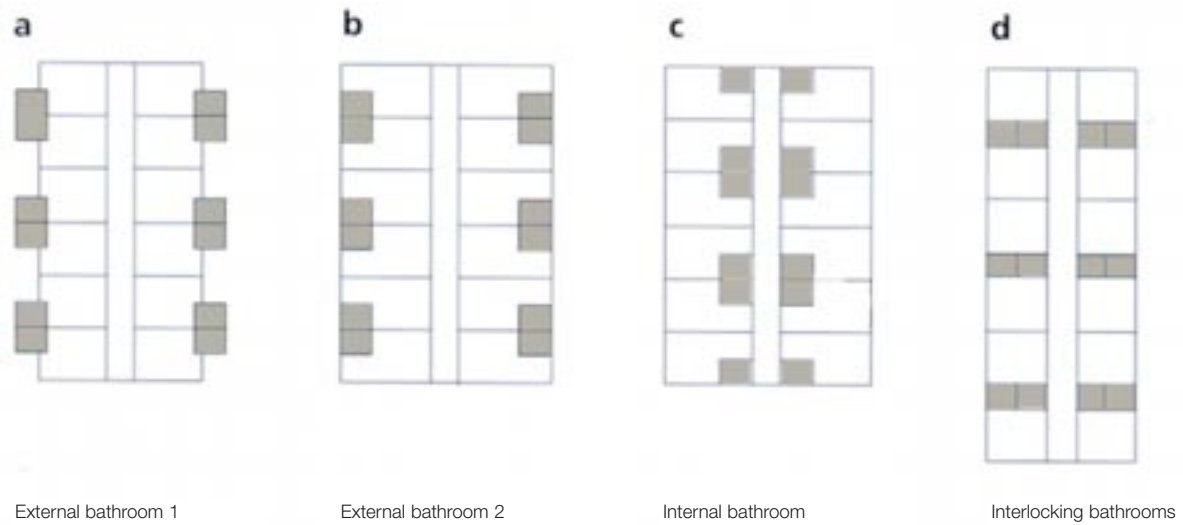


Figure 13. En-suite bathroom options for single rooms



- good observation to and from room
- efficient circulation
- minimum room width
- natural light and ventilation to bathroom
- reduces window area in bedroom
- bathroom service duct could be accessed externally
- can be bolted onto an existing building

- good observation to and from room
- efficient circulation
- minimum room width
- natural light and ventilation to bathroom
- reduces window area in bedroom
- bathroom service duct could be accessed externally
- increases floor area

- reduces observation to and from bedroom
- creates dead area behind doors
- increases area of unusable floor space
- maximises window area in bedroom
- bathroom service duct can be maintained from corridor

- good observation to and from room
- one internal bathroom per two bedrooms
- increases overall width of room
- maximises window area in bedroom
- one service duct has to be accessed from room

Audit checklist

This checklist is for local use by Health Authorities and NHS trusts. Its main aim is to help authorities evaluate their progress to achieving good physical separation of the sexes in hospital and identify issues to be tackled. In addition, the checklist addresses some issues which are considered to be best practice for upholding patients' privacy and dignity, particularly for those suffering from mental illness. **The information is not required by the Department of Health.**

The checklist is a framework and as such can be adapted to suit the users' needs, for example the format changed for individual wards, the content enhanced to include wider issues addressing privacy and dignity. Terms such as "regular" and "appropriate" should be agreed locally. In piloting the tool, NHS trusts suggested that this checklist could be used to carry out a full, baseline audit on an annual basis, with individual ward areas reporting to their organisations more frequently on an exception basis. Since this checklist focuses on process, the information which the audit yields should be considered alongside patient feedback, for example local surveys of patients and carers views, to help evaluate outcome.

Please tick boxes where statement applies

Corporate arrangements

- 1. All planned admissions are to single sex wards or single sex bays/ rooms within mixed wards.
- 2. Except in an emergency, written notification is always given to patients prior to admission about the layout of the physical accommodation, if this is mixed sex.
- 3. Where a patient is admitted as an emergency to hospital accommodation shared by both men and women, including patients admitted under the Mental Health Act, s/he is moved to appropriate accommodation within 48 hours.
- 4. Patients are given the opportunity to request alternative accommodation, where accommodation offered is shared by men and women.
- 5. Satisfactory arrangements are in place to respond effectively to patients who express concern about being admitted to mixed sex accommodation.
- 6. Where a patient refuses admission into hospital because of shared accommodation, a further admission date into appropriate segregated accommodation is offered within one month of the first date.
- 7. Unless substantial modification has taken place to segregate the sexes adequately (for example by the addition of bays, fixed floor-to-ceiling screening and segregated bathroom and toilet facilities), Nightingale wards accommodate single sex patients only.
- 8. The design of gowns used for theatre, radiology and other investigative procedures prevents the patient and others from being embarrassed.
- 9. Health Authorities set out specifically in agreements with NHS Trusts the minimum requirements for good physical separation of the sexes in hospital and how this should be monitored.
- 10. Patient perceptions of privacy and dignity are monitored, evaluated and acted upon on a regular basis (recommended as at least once a year), for example patient satisfaction surveys and monitoring of complaints.
- 11. Staff training addresses specifically how patients' needs and wishes for privacy and dignity (including cultural and religious beliefs) can best be met.

Please tick boxes where statement applies**Individual ward arrangements**

12. Hospital accommodation is arranged to ensure good physical segregation of bed areas for men and women at all times.
13. Washing and toilet facilities are individually designated as single sex. (The provision of unisex, single-occupancy toilets and bathrooms can serve as an interim measure until fully segregated facilities are available to meet the Patient's Charter standard.)
14. Toilets and bathrooms are reasonably adjacent to appropriate single sex bed areas.
15. Patients need not pass through alternate sex areas to reach toilets and bathrooms. Where patients pass near to alternate sex areas, adequate screening, for example blinds or curtains at windows and doors, is used to prevent embarrassment.
16. All toilet and bathroom facilities can be locked by the patient, though there is a nurse call system in place and hospital staff can gain access in case of emergency.
17. The quality and cleanliness of washing and toilet facilities is monitored on a regular (at least four times over 24 hours) basis.
18. Appropriate facilities are provided to uphold the privacy and dignity of patients who are disabled, whether temporarily (due to their illness or treatment) or permanently.
19. Quiet rooms or private spaces are provided for private discussion. They are accessible at all times and used frequently and appropriately by staff, patients, relatives and carers.
20. Patients wear appropriate clothing (day and night) which does not cause embarrassment or offence to themselves or others. Guidance on appropriate clothing is given to elective patients before admission. Staff are alert and take action to prevent embarrassing situations arising in hospital.
21. Nursing care plans encourage specific action to address the individual patient's privacy and dignity.

Additional arrangements for mental health in-patient facilities

22. Patients are offered the choice of a same sex keyworker.
23. Separate areas are available within the ward where patients and visitors of the opposite sex are not permitted.
24. There is an agreed policy and established protocols in place for ward staff who work with patients of the opposite sex.
25. Staff accompany other staff carrying out physical examinations or using restraint on members of the opposite sex.
26. Intimate searches are carried out by a member of the same sex. The patient's agreement is sought for this person carrying out the task.
27. Security measures (alarm systems, call buttons) to alert staff are available and accessible to patients. These are regularly checked.
28. Local observation policies are devised taking account of guidance contained in Chapter 18 of the Mental Health Act 1983 Code of Practice.
29. Speedy and robust arrangements are in place to deal effectively with staff or patients who sexually abuse or harass patients, staff or visitors.

This checklist appears in HSC 1998/143, 'Mixed sex hospital monitoring accommodation tool', Annex A

Conclusion

Going into hospital can be a frightening experience. Medical and surgical treatments are often invasive and unpleasant. All staff have a responsibility to make their patients' stay as pleasant as possible by respecting and maintaining their privacy and dignity. Achieving single sex accommodation plays a pivotal role in upholding patients' privacy, but it is not the whole story. Both patients and staff accept that there cannot be complete segregation at all times, but the clear message is that privacy matters.

The physical solution to provide privacy and dignity is an essential move forward to improving ward accommodation. Improving the environment through improved lighting, reduced sound transmission, better ventilation column, art and material finishes are also equally important. Research has shown that a quality environment helps patients to recover more quickly, need less medication and ensures staff give their best in caring for the sick.