95% of patients were admitted directly to single sex accommodation on the emergency clinical decisions unit (ECDU), EAU and heart care unit (HCU) by the end of September 2009.

In practice, single sex accommodation can be achieved if men and women have separate sleeping areas (such as single sex bays) and have separate toilets and bathrooms that they can reach without having to pass through (or close to) opposite sex areas. Ward layouts should minimise any risk of being overlooked or overheard by members of the opposite gender.

METHOD AND PROGRAMME DESIGN

The purpose was to empower frontline staff to make changes to current processes and ward organisation. Empowering staff to make this sort of change is important because they know what needs to be done to improve patient care.

The quality improvement methodology focused on wards testing changes in small areas before they were implemented on a wider scale. This approach ensured that frontline staff were able to test the changes, rather than having a change forced upon them. As staff developed the changes themselves, they also had ownership of them and therefore were more likely to sustain them.

In order to examine the current status of single sex accommodation at the trust, we needed to collect some baseline data. During December 2008, a matron undertook a two week trust based audit on the EAU. Of a total of 130 patients who were given the questionnaire and completed it, 25 (19%) were admitted to single sex accommodation, either a side room or single sex bay.

When examining this issue further, 17 (13%) patients were admitted to mixed sex accommodation to avoid a breach of the patient:toilet facility ratios. Furthermore, patient:toilet facility ratios were found to be as follows: EAU 23:3; ECDU 14:1; and HCU 10:1. It was evident that there was a need for improved separate washing and toilet facilities on all of the wards included in the pilot.

A faculty set up to address the issue of single sex accommodation identified three primary drivers. These are system components that will contribute to moving the primary outcome (Institute for Healthcare Improvement, 2008). On further exploration, the faculty team (consisting of relevant matrons, medical staff and nurses from the pilot wards, members from the bed management team and a member of the quality improvement directorate) identified secondary drivers that would be tested during the course of the project.

Improvement methodology uses driver diagrams to show a cascading set of “means” to drivers to achieve the study’s main aim (Fig 1).

Tests of change focused on three main areas: workforce and culture; facilities and planning; and communication. Small tests of change were conducted and evaluated and, following these, systems were developed to test these changes further.

When ward staff identified an idea for system change, they were encouraged to test it on a small scale using multiple PDSA cycles. This method of testing minimises the risk of being overlooked or overheard by members of the opposite gender.

FIG 1. SINGLE SEX ACCOMMODATION – DRIVER DIAGRAM

- Workforce and culture
  - Education of the shift coordinator for single sex planning
  - Move away from “one patient each” culture
  - Medics’ engagement; initial reviews within 4 hours of admission
  - Bed allocation – ward transfer within 2 hours
  - Discharge decision – vacate bed space within 2 hours

- Facilities and planning
  - More toileting facilities
  - Redesign of non-patient areas to make more room for proposed changes
  - Promote and increase use of discharge facilities
  - Allocate a seating area for pending discharges

- Communication
  - Patient experience trackers
  - Ward staff to liaise regularly with bed managers and A&E
  - Enhance communication between shift coordinators

FIG 2. THE MODEL FOR IMPROVEMENT

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?