Single Sex Accommodation

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For use in: Trust wide
For use by: All Staff
For use for: All Clinical Staff
Document owner: Deputy Director of Nursing
Approval Committee: Patient Safety & Quality
Status: (date approved) Approved

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Single Sex Accommodation
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Introduction
Colchester Hospital University NHS Foundation Trust (CHUFT) promotes a culture where patients are treated with professionalism, dignity and respect. The physical environment and the provision of single sex facilities are considered to be key factors in maximising patient dignity.

The Trust provides accommodation that complies with the Mixed Sex Accommodation Guidelines under HSC 1998/143, 2007, and NHS Single Sex standards, 2009. There is board level commitment for compliance with these standards, which are closely linked to the Trust’s strategic themes and values.

Purpose
The purpose of this policy is to outline the Trust’s arrangements for achieving compliance with the single sex guidelines, and standards. It sets out the specific standards for sleeping arrangements, and bathroom and toilet facilities.

The policy also details the roles and responsibilities of staff, and the process for monitoring compliance within the contents of this policy.

Related Documents
187 – Privacy and Dignity Procedure
331 – Assessing Mental Capacity Procedure including Deprivation of Liberty Guidance

1. Definition of Terms
Single sex accommodation standards:

The NHS standard is that, single sex accommodation will be provided in:
• Single sex wards (i.e. the whole ward is occupied by men or women but not both).
• Single rooms with adjacent single sex toilet and washing facilities (preferably en suite).
• Single sex accommodation within mixed wards, i.e. bays or rooms which accommodate either men or women, not both; with designated single sex toilet and washing facilities.

In addition, patients will not need to pass through opposite sex accommodation to access toilet and washing facilities, to access their own. Also, they must not be placed in an environment where sensitive conversations may be overheard by members of the opposite sex. (Source: Institute for Innovation and Improvement – Dec 2007)

Scope
The definition of mixed-sex occurrences will apply:
 a. Following admission.
 b. In all clinical areas where patients are admitted and at all points of the patient’s pathway. This includes Emergency Assessment Units (EAU), Coronary Care Unit (CCU) High Dependency Units (HDU) and Day Treatment Units, Radiology Departments (or any area where both genders are co-located and wear gowns). However in areas such as Accident and Emergency (A&E) and Critical Care staff will endeavour to ensure same gender patients are next or opposite each other to promote privacy and dignity at all times.

A Breach of the Standard can be reported by:
• a patient.
• a patient’s representative/carer.
• patient organisations such as Health Watch.
• staff on the ward.
• the Clinical Commissioning Group (CCG)

Gillick (or Frazer) Competent – Children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention.
2. Roles and Responsibilities

All Staff
All staff employed by the Trust, including bank/agency, and staff on temporary or honorary contracts, must comply with this policy.

Estates and Facilities Department
Estates and Facilities staff are responsible for ensuring that the building design is functional and supports compliance with single sex accommodation guidelines. Compliance with single sex guidelines must be taken in to consideration in any future estates and buildings programs.

Directorate Management Teams
Directorate Management Teams are responsible for ensuring there is local compliance with the guidelines. This must be evidenced and demonstrable through audit report, ward walkabout data, PLACE inspections, and standards toolkit audits.

Speciality Matrons and Ward/Department Sisters/Charge Nurses
Speciality Matrons and Ward/Department Sisters/Charge Nurses must check all areas on a daily basis, and following any ward bay moves, to ensure they are compliant.

3. Process

Compliance with Guidelines

Ward Areas
Compliance with the single sex guidelines is dependent on:
- the physical layout and design of the area.
- management of the patient placement process by duty Site Matron and Duty Manager.
- management of the physical environment on a daily basis, by Ward Sisters/Charge Nurses and Speciality Matrons. With particular reference to compliance with toilet and bathroom aspects of the guidelines.

Ward areas must comply with the NHS accommodation single sex standards. Patients on a mixed sex ward must be placed in a side room, or in a designated gender bay, with designated single sex toilet and washing facilities within or in close proximity to the bay.

Ward accommodation must be arranged to ensure that there is physical segregation of bed bays/rooms for men and women at all times. Segregation can be achieved if men and women have separate toilets and bathrooms that are in close proximity to the bay, and that can be reached without having to pass through opposite gender areas.

Ward Sisters/Charge Nurses must minimise any risk of patients overlooking or overhearing patients of the opposite sex. Where possible the ward should be split with single sex bays clustered together, or at different ends of the ward.

Curtains within bays must fit well and not gape open when closed. They will be no higher than 30cms above floor level. Staff must ensure that all patients, (particularly vulnerable patients) wear appropriate clothing to maintain their dignity.

In circumstances where open ended bays are adjacent to one another or opposite, these will be of the same gender. There will be no direct line of sight from one gender to another and the use of electronic doors will prevent this from happening.

If partitions are used to segregate patients of the opposite gender they must be fixed and of floor to ceiling in height.

To avoid patients being overheard, staff will where practicable ask visitors to wait in non-clinical areas or leave the ward if ward rounds are taking place.
**Toilets and Bathrooms**
Where there are no ensuite facilities in bays or rooms, toilets and bathrooms must be in close proximity to the appropriate single sex bed bays/rooms. The facilities must be designated by gender, using Trust approved signage. These signs are reversible and it is the responsibility of the Ward Sister/Charge Nurse/deputy to check that facilities are correctly signed following ward bay moves, and as a minimum once per shift.

In addition, patients must not pass through, or close to opposite sex areas to reach toilets and bathrooms.

Toilets and bathrooms must be lockable, and patients should be able to identify from the outside whether or not the facilities are occupied.

**Critical Care Unit**
Patients treated within Critical Care, once deemed fit for transfer to the ward, will be moved as soon as a bed is available. If for any reason there is a delay in transfer, the patient will be moved to a suitable area within Critical Care, providing there is bed capacity, to ensure they do not contravene single sex guidance. Therefore beds should be segregated where ever possible to avoid mixing.

**Mixed-Sex Occurrence Reporting**
A mixed-sex occurrence must be reported when the decision to allocate the patient to a bed space or environment, which does not enable care within same-sex accommodation, is made. In addition to the recording of the mixed-sex occurrence the numbers of patients affected by that mixed-sex occurrence should also be recorded.

Any possible mixed-sex occurrence must be discussed with the Site Team and Matron responsible for the area. If the situation can not be resolved and a mixed-sex breach does occur this must be reported to the Duty Manager and Executive on call, along with plans to resolve the situation. All mixed-sex breaches (or possible breaches) must be discussed at the daily bed meetings. It is the responsibility of the Deputy Director of Nursing and Associate Divisional Nurse Directors to ensure this. Reporting of breaches will be included on the daily situation report and a root cause analysis (RCA) completed (Appendix A). In the event of a possible breach, the Duty Manager will be informed by the Site Team; this will then be escalated to the Executive on call. Please refer to the flowchart ‘Decision to Mix’ for escalation and reporting procedure (Appendix B).

The method for mixed-sex occurrence recording should include identification of the clinical area, reason for mixed-sex occurrence (capacity, flow, inadequate facilities), type of mixed-sex occurrence (bed location, location of facilities) and whether the mixed-sex occurrence has occurred following the removal of a clinical justification where no appropriate alternative clinical accommodation can be found. Any breaches must be reported via the Trust Datix electronic incident reporting system to the Deputy Director of Nursing and Associate Divisional Nurse Directors.

**Root Cause Analysis**
It is recommended that each mixed-sex occurrence is investigated in order to identify the true reasons behind why such mixed-sex occurrences occur.

To aid the investigation and analysis of mixed-sex occurrences, it is advisable to use the Department of Health “Action to deliver same-sex accommodation Root Cause Analysis” tool or similar local tool (Appendix A).

All RCA forms will be completed, collated by the site team and reported and dealt with according to the flowchart in Appendix B.

**Patients Admitted in an Emergency**
As soon as patients are identified in A&E as potential admissions, their name as well as their gender will be identified to the site team and the Emergency Assessment Unit in order that the right
gender bed can be allocated within the four hour standard. Early identification will lead to safe high quality transfer through the emergency pathway. The speciality areas are required to identify beds early for both the emergency pathway and elective pathway in order to maintain safe flow and gender segregation. Specialities have a responsibility to move patients within departments to ensure this standard is maintained. It is recognised that in some emergencies, mixing of the sexes may be necessary due to the clinical needs of each individual patient; however an RCA will be required.

Greater protection will be provided where patients are unable to preserve their own modesty by nurses being present in the area, especially Critical Care Unit and A&E majors bay.

**Key Principles**

Clinical need must be judged for each individual patient; therefore it is difficult to give a categorical definition of clinical need. Judgment must be made by a senior member of staff if a breach is agreed on these grounds. This must be clearly documented and an RCA completed. If a patient is admitted into a bay, then either all patients must be same sex or mixing must be clinically justified for all patients in the room, not just the newly-admitted one.

Clearly, patient safety is paramount, but the requirement for segregation should not be ignored. It should be demonstrably possible for the large majority of emergency patients to have their clinical needs met within segregated accommodation.

Decisions should be based on the needs of each individual patient, not the constraints of the environment or the convenience of staff.

The reasons for mixing, and the steps being taken to put things right, should be explained fully to the patient and their family and friends. If a patient does not have the mental capacity to understand and/or agree the decision to mix must be discussed and agreed with the next of kin/carer. Staff should make clear to the patient that the Trust considers mixing to be the exception, never the norm.

Patients will be given the opportunity to refuse placement, based on religious, cultural and or beliefs system, where possible, and it is safe to do so alternative accommodation will be found for the patient at the earliest opportunity.

Greater protection should be provided where patients are unable to preserve their own modesty (for example when semi-conscious or sedated).

Where mixing is unavoidable, transfer to same-sex accommodation should be effected as soon as possible. Only in the most exceptional circumstances should this exceed 24 hours.

**Day Surgery and Ambulatory Care Areas**

The above standards apply to all Trust day care units and ambulatory care areas, and these areas will have designated segregated facilities, as follows:

- Treatment areas will be single sex.
- Changing areas/cubicles will be single sex.
- Bathroom facilities must be designated as single sex, and must be lockable.
- Curtains must be well fitting and no gaps.

Exceptions to the above may be acceptable in the case of very minor procedures where patients are not required to undress or otherwise be exposed. This must be approved by the Matron for the area, and every effort must be made to maintain the patient’s dignity.

In areas such as x-ray where patients are required to change, changing cubicles will be segregated. If this is not possible changing room doors should be solid and lockable.
Particular care must be taken to ensure that adequate screening is in place and that patients are dressed to maintain their dignity. Patients (or their significant others) admitted to a mixed-sex level 1 to 3 area will receive a full explanation of the reasons for admission to mixed sex area, and the purpose of the area and reassured that the intention to maintain privacy and dignity at all times.

**Children and Adolescents**
Children must be placed on a ward that is appropriate for their age and stage of development. Actual age is less important than the needs and preferences of the individual child or young person, in particular the needs of adolescents require careful consideration.

In general, adolescents prefer to be located alongside other people of their age; where possible they should be given this choice on admission. The care of children and young people must ensure that their separate needs, including any safeguarding concerns, are recognised and met.

**Parents**
In children’s units parents are encouraged to visit freely and stay overnight. This may mean that adults of the opposite sex share sleeping accommodation with children. Care should be taken to ensure this does not cause embarrassment or discomfort to individual parents/carers whilst the main focus remains centred on the child as a priority.

**Key Principles**
- Privacy and dignity is an important aspect of care for children and young people.
- Decisions should be based on the clinical, psychological and social needs of the child or young person, not the constraints of the environment, or the convenience of staff.
- Privacy and dignity should be maintained whenever children and young people’s modesty may be compromised (e.g. when wearing hospital gowns/nightwear), or where the body (other than the extremities) is exposed, or they are unable to preserve their own modesty (for example following recovery from a general anesthetic or when sedated).
- The child or young person’s preference should be sought, recorded and where possible respected.
- Where appropriate the wishes of the parents should be considered, but in the case of young people their preference should prevail.

**Transsexual and Transgender Patients**
Transsexual people (that is, individuals who have proposed, commenced or completed reassignment of gender) have legal protection against discrimination. In addition, good practice requires that clinical responses be patient-centered, respectful and flexible towards all transgender people who do not meet these criteria but who live continuously or temporarily in the gender role that is opposite to their natal sex.

**Key Principles**
- Transgender people should be accommodated according to their presentation (the way they dress, and the name and pronouns that they currently use).
- This presentation may not always accord with the physical sex appearance of the chest or genitalia.
- It does not depend upon them having a gender recognition certificate (GRC) or legal name change.
- It applies to toilet and bathing facilities (except, for instance, that pre-operative transgender people should not share open shower facilities).
- The views of the transgender person should take precedence over those of family members where these are not the same.

Those who have undergone full-time transition should always be accommodated according to their gender presentation. Different genital or breast sex appearance is not a bar to this, since sufficient privacy can usually be ensured through the use of curtains or by accommodation in a single side room adjacent to a sex-appropriate ward. This approach may only be varied under special circumstances where, for instance, the treatment is sex-specific and necessitates a transgender
person being placed in an otherwise opposite sex ward. Such departures should be proportionate to achieving a ‘legitimate aim’, for instance, a safe nursing environment.

In addition to these safeguards, where admission/triage staff is unsure of a person’s gender, they should, where possible, ask discreetly where the person would be most comfortably accommodated. They should then comply with the patient’s preference immediately, or as soon as practicable. If patients are transferred to a ward, this should also be in accordance with their continuous gender presentation (unless the patient requests otherwise).

If upon admission it is impossible to ask the view of the person because he or she is unconscious or incapacitated then, in the first instance, inferences should be drawn from presentation and mode of dress. No investigation as to the genital sex of the person should be undertaken unless this is specifically necessary in order to carry out treatment.

In addition to the usual safeguards outlined in relation to all other patients, it is important to take into account that immediately post-operatively, or while unconscious for any reason, those trans women who usually wear wigs are unlikely to be wearing them and so may be ‘read’ incorrectly as men. Extra care is therefore required so that their privacy and dignity as women is appropriately ensured.

Transgender men whose facial appearance is clearly male may still have female genital appearance, so extra care is needed to ensure their dignity and privacy as men.

**Particular Considerations for Children and Young People**

Gender variant children and young people should be accorded the same respect for their self-defined gender as are transgender adults, regardless of their genital sex.

Where there is no segregation, as is often the case with children, there may be no requirement to treat a young gender variant person any differently from other children and young people. Where segregation is deemed necessary, then it should be in accordance with the dress, preferred name and/or stated gender identity of the child or young person.

In some instances, parents or those with parental responsibility may have a view that is not consistent with the child’s view. If possible, the child’s preference should prevail even if the child is not Gillick competent.

More in-depth discussion and greater sensitivity may need to be extended to adolescents whose secondary sex characteristics have developed and whose view of their gender identity may have consolidated in contradiction to their sex appearance. It should be borne in mind that they are extremely likely to continue to experience a gender identity that is inconsistent with their natal sex appearance so their current gender identity should be fully supported in terms of their accommodation and use of toilet and bathing facilities.

It should also be noted that, although rare, children may have conditions where genital appearance is not clearly male or female and therefore personal privacy may be a priority.

4. **Training**
   Not applicable.

5. **Evidence Base**
6. Monitoring Compliance and Audit
   - Mixed-sex compliance and any breaches will be discussed at the daily bed meetings.
   - The specialist Matron for that area will conduct an RCA on all patients who have breached. The Deputy Director of Nursing and the Associate Divisional Nurse Directors will report to the Director of Nursing on the actions.
   - Compliance is reported to the Trust Board, as part of the Patient Safety and Patient Experience report and Trust Scorecard.
   - Patients will be surveyed for their views on compliance via patient survey and patient experience tracker.
   - Monitoring compliance is via RCA for all breaches of this policy.

Equality Impact Assessment
The potential for any adverse impact to arise during the implementation of the recommendations will be monitored and, if arising, will be addressed.

This policy is available on the Trust intranet. All staff are notified via email, of the policy and any amendments.
# Root Cause Analysis (RCA) Investigation Report

<table>
<thead>
<tr>
<th>Quick reference guide</th>
<th>Type your investigation report in the column below</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust:</td>
<td>Ward/Dept:</td>
</tr>
<tr>
<td>Investigation date:</td>
<td>Investigation number:</td>
</tr>
</tbody>
</table>

## SSA breach description and consequences

**Concise description**
Select all that are applicable

**Type of breach:**
- [ ] Shared sleeping
- [ ] Overlooking opposite sex accommodation
- [ ] Shared toilet/bathroom

*(copy and paste this tick √ over □)*

**Date of breach or investigation**

**Hospital number of primary breach:**

**Date of breach or investigation:**

**Number of patients affected**

*e.g. if one female patient in male 6 bedded bay this is 6 breaches not one*

**Hospital number of all affected patients:**

**Specialty**

*Healthcare specialty involved*

**Specialty**

*Specialty where breach occurred:*

*Specialty where patient(s) should have been (if known):*

**Effect on patient(s), if any**

*Actual effect on patient and/or service*

*e.g. patient safety, clinical care, privacy*

**Effect on patient(s), if any:**

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*Source: Deputy Director of Nursing*

*Status: Approved March 2017*

*Issue date: March 2013*

*Review date: March 2019*

*Document reference (17)021*
<table>
<thead>
<tr>
<th>Clinical justification</th>
<th>Clinical justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the clinical reasons/drivers for the breach? e.g. clinical safety, life threatening situation, Level 1, significant disruption/clinical risk from repeated moves. What was the priority? SSA or other clinical safety issues. (Please ensure these are represented in identification of Contributory Factors below)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Immediate/remedial action</th>
<th>Immediate/remedial action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be reviewed every shift or at daily bed management meetings. (Refer to DH guidance for good practice.)</td>
<td>How often was the breach reviewed? How long before the situation was remedied? What was the immediate/remedial action taken?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background and context</th>
<th>Background and context</th>
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</thead>
<tbody>
<tr>
<td>A brief description of the service type, service size, clinical team, care type, treatment provided etc.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope of investigation</th>
<th>Scope of investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the start and end points. List services involved. What instigated the investigation.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigation type, process and methods used</th>
<th>Investigation type, process and methods used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gathering information e.g. interviews Incident Mapping e.g. <em>tabular timeline, mapping patient journey</em> Identifying Care and service delivery problems e.g. <em>change analysis</em> Identifying contributory factors &amp; root causes</td>
<td>Please indicate which of the following were used: (copy and paste this tick √ over □) □ Single breach review □ Multiple breach review □ Patient/carer contact or interview</td>
</tr>
</tbody>
</table>
### Contributory factors framework

- Staff interviews
- Policy review
- Case study review
- Timeline/mapping patient journey
- Change analysis/multi-disciplinary team review
- Contributory factors framework/grid/'fishbone'
- Barrier analysis

### Explanation and discussion with patient(s) and relatives

**Explanation and discussion with patient(s) and relatives**

<table>
<thead>
<tr>
<th>Explanation and discussion with patient(s) and relatives</th>
<th>Explanation and discussion with patient(s) and relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were reasons and an explanation of the SSA breach given to patient/relatives?</td>
<td>(copy and paste this tick ✓ over □)</td>
</tr>
<tr>
<td>Was the issue of SSA breach vs multiple moves prior to preference/choice/consent discussed?</td>
<td>Explanation given: Yes □ No □</td>
</tr>
<tr>
<td>Any dissatisfaction about situation</td>
<td>Written information provided: Yes □ No □</td>
</tr>
</tbody>
</table>

**Details:**

- Any adverse comment/response from patient(s): Yes □ No □

### Chronology of events

- Any timeline included in the report should be a summary (How patient admitted, any transfers, patient's condition)
- Either describe events and reasons or use timeline/patient journey map below or both

### Notable practice

- Points in the breach or investigation process where care and/or practice had an important positive impact and may provide valuable learning opportunities
e.g. exemplar practice, involvement of the patient etc
<table>
<thead>
<tr>
<th>Care and service delivery problems</th>
<th>Care and service delivery problems</th>
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</thead>
<tbody>
<tr>
<td>A themed list of the key problem points. (See supplementary guidance on CDP/SDP’s)</td>
<td></td>
</tr>
<tr>
<td>Contributory factors</td>
<td>Contributory factors</td>
</tr>
<tr>
<td>A list of significant contributory factors e.g. patient condition, staff knowledge, culture, environment (See supplementary guidance and Contributory factors framework)</td>
<td></td>
</tr>
<tr>
<td>Root causes (numbered)</td>
<td>Root causes</td>
</tr>
<tr>
<td>These are the most fundamental underlying factors contributing to the incident that can be addressed. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient.</td>
<td></td>
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<tr>
<td>Lessons learned (numbered)</td>
<td>Lessons learned</td>
</tr>
<tr>
<td>Significant practice issues identified which may not have contributed to the breach but it is important that learning and improvement take place</td>
<td></td>
</tr>
<tr>
<td>Recommendations (numbered and referenced)</td>
<td>Recommendations</td>
</tr>
<tr>
<td>Recommendations should be directly linked to root causes and lessons learned. They should be clear but not detailed (detail belongs in the action plan). It is generally agreed that key recommendations should be kept to a minimum where ever possible.</td>
<td></td>
</tr>
<tr>
<td>Arrangements for shared learning</td>
<td>Arrangements for shared learning</td>
</tr>
<tr>
<td>Describe how learning has been or will be shared with staff and other organisations e.g. through bulletins, team meetings, professional networks, NPSA etc</td>
<td></td>
</tr>
</tbody>
</table>

Author

Job title

Date
## Patient journey: Process mapping and timeline

<table>
<thead>
<tr>
<th>Delete as appropriate</th>
<th>Emergency admission/Elective surgical/Elective medical</th>
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<tbody>
<tr>
<td></td>
<td>A&amp;E</td>
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<tr>
<td></td>
<td>Admission ward</td>
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<td></td>
<td>ITU/HDU if appropriate</td>
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<tr>
<td></td>
<td>Transfer to ward 1</td>
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<td></td>
<td>Transfer to ward 2</td>
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<td></td>
<td>Date of discharge</td>
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<td>Delete row as appropriate</td>
<td>Ward 1 on admission</td>
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<td></td>
<td>Theatre</td>
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<td></td>
<td>ITU/HDU if required</td>
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<td></td>
<td>Transfer back to Ward 1</td>
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<tr>
<td></td>
<td>Transfer to Ward 2</td>
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<td></td>
<td>Date of discharge</td>
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<tr>
<td>Delete row as appropriate</td>
<td>A&amp;E</td>
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<tr>
<td></td>
<td>Admission ward</td>
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<tr>
<td></td>
<td>Transfer to ward 1</td>
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<td></td>
<td>Transfer to ward 2</td>
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<td></td>
<td>Transfer to ward 3</td>
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<td></td>
<td>Date of discharge</td>
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</tbody>
</table>

**Date/Time**

**Correct patient journey**

**Actual patient journey**

**Variation to correct patient journey and reason(s) why**
<table>
<thead>
<tr>
<th><strong>Action plan</strong></th>
<th>Action</th>
<th>Action 1</th>
<th>Action 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Root cause</strong> (number as per investigation report)</td>
<td></td>
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<tr>
<td><strong>Effect(s) on patient(s)/service(s)</strong></td>
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<tr>
<td><strong>Recommendation(s) to address root cause</strong> (or rationale, if no action or recommendation is set. Number as per investigation report)</td>
<td></td>
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<tr>
<td><strong>Action(s) to achieve recommendations</strong> (number as per investigation report)</td>
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<tr>
<td><strong>Level for action</strong> (organisation, directorate or team etc) Local or escalate</td>
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<td><strong>Implementation by whom</strong></td>
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<td><strong>Implementation by when</strong></td>
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<tr>
<td><strong>Resource required (time)</strong></td>
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<td><strong>Resource required (money)</strong></td>
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<td><strong>Resource required (other)</strong></td>
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### Evidence of completion

| What is the measure of success? |  |  |
| Monitoring and evaluation arrangements |  |  |
| Sign-off by |  |  |
| Author |  |  |
| Job title |  |  |
| Date |  |  |

Action plans should be SMART (Specific, Measurable, Achievable, Reasonable and Timed) and should be developed and agreed with relevant stakeholders. Mechanisms must be in place to monitor implementation and achievement of action plan.

Please send completed report to Patient Safety & Quality via incidents.management@colchesterhospital.nhs.uk
Decision to Mix Sex Reporting Flow Chart

Executive Lead/Director of Nursing

RCA to Director of Nursing within 48 hours of decision to mix

RCA to Deputy Director of Nursing and Associate Divisional Nurse Directors within 24 hours

SITE TEAM MATRON / MATRON

Discuss with senior nurse and Duty Manager

Incident form completed

Decision made to mix sex. Ward/Department informed by Senior Nurse

RCA Completed

Inform Duty Manager

Out of Hours Discuss with Duty Manager

PATIENT MOVED TO APPROPRIATE SAME SEX BAY

If mixed sex occurrence not resolved within 12 hours inform CEO or Executive on call if out of hours

Review

2hr

4hr

8hr

12hr

Monthly Report to Board

Monthly report to PCT performance team

PATIENT MOVED TO APPROPRIATE SAME SEX BAY

If mixed sex occurrence not resolved within 12 hours inform CEO or Executive on call if out of hours

2hr

4hr

8hr

12hr

Monthly Report to Board

Monthly report to PCT performance team

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Review date: March 2019
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