

Action to deliver same-sex accommodation

Root cause analysis

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Contributory factors framework
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RCA investigation report



DH INFORMATION READER BOX

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For Recipient's Use	

1. Aims and philosophy

Patient safety and patient experience are of primary importance in delivering high-quality care.

The recognised definition for same-sex accommodation (SSA) is detailed in this guidance. In considering compliance with this standard, it is important to note that patient experience and opinion will always be the final determinant of whether NHS accommodation is managed as a same or mixed-sex area.

SSA mixed-sex occurrences should always be considered as exceptions rather than the norm and staff must always be able to provide clinical justification for any SSA mixed-sex occurrences.

(Mixed-sex accommodation) = An SSA mixed-sex occurrence, which requires a root cause analysis (RCA)

(Mixed-sex accommodation) – (Clinical justification) = An unacceptable SSA mixed-sex occurrence, which requires a root cause analysis.

The Department of Health’s aim is to support staff in improving the patient experience through the reduction of, and ultimately the elimination of, mixed-sex accommodation. It has produced a toolkit to aid the investigation and analysis of SSA mixed-sex occurrences in order to identify the true reasons (root causes) behind why such mixed-sex occurrences occur.

The aim of this work is to promote a culture where organisations do not accept SSA mixed-sex occurrences. Objectives include encouraging ownership of the issue; empowering staff to take action to reduce or eliminate mixed-sex occurrences; and assisting staff to know when to escalate their concerns and action plans.

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Trusts that positively manage SSA strive to achieve the right bed for a patient, at the right time and for the right reasons. The right reasons include safety/clinical care, age and specialty, not just single sex. These organisations and their staff appreciate that if a female patient is placed in a six-bedded bay with five men, this is not one mixed-sex occurrence but six mixed-sex occurrences.

Some trusts are eliminating mixed-sex admission wards and reverting to same-sex wards. Even where this is not possible, teams are often able to achieve a majority of same-sex bays and ensure that any mixed-sex occurrences which are clinically justifiable are limited to one bay.

Often there is a view that the current layout is the problem and that a new build will resolve this, but this is rarely the case. Mixed-sex occurrences still occur frequently in trusts that have new builds and conversely mixed-sex occurrences have been successfully minimised in some more challenging environments. There are often many reasons for mixed-sex occurrences other than building design, and many of these can be resolved locally.

There has been a perception that some areas, such as admission wards, intensive treatment units (ITUs), high dependency units (HDUs) etc, are exempt from meeting the standards for SSA, but this is not the case. Some areas have been exempt from reporting in the past, but the Department of Health's intention is that these areas must still work towards compliance. Even in ITUs, staff should attempt, whenever possible, to have a female side and a male side. (For children and adolescents, SSA needs should be considered as appropriate to age/maturity.)

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2. About the toolkit

This is a diagnostic tool to aid investigation into areas where there are high levels of SSA mixed-sex occurrences. Alternatively, it can be used to investigate an actual mixed-sex occurrence. It is based on the RCA approach and primarily represents a learning opportunity.

The tool will provide a systematic and evidence-based method of finding out what factors or events lead to SSA mixed-sex occurrences. The results will help your organisation both to gain a better understanding of the causes and contributory factors associated with SSA mixed-sex occurrences and to take action to reduce the risk of them occurring elsewhere in the future.

The areas identified for local practice improvement may be many and varied – and new builds/renovations are not always the solution. Advice on local actions/solutions is included in the toolkit.

This toolkit and SSA RCA investigations should not stand alone. Rather, this process should be integrated into risk management, clinical governance, process mapping, planning services and environment. It can assist with identifying where changes to systems or service delivery have had detrimental knock-on effects.

RCA investigations will assess the current situation and true root causes, and appropriate action can subsequently be taken. The process should then be repeated as appropriate to check if mixed-sex occurrences have been reduced or eliminated.

Feedback

We would welcome your comments and suggestions about this toolkit. Please complete the form at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104970 and click on the submit button on the form to email your response.

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3. RCA toolkit

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3.1 What to do?

Agree what your local triggers are for initiating an RCA. These may include:

- areas with clusters of mixed-sex occurrences
- findings from the NHS in-patient survey
- complaints
- a significant mixed-sex occurrence incident
- a need to evaluate a service or evidence gathering for planning/bids, or
- an annual snapshot audit (as part of a rolling risk-management monitoring programme).

Identify your area for RCA investigation. Then undertake either:

- an RCA for multiple SSA mixed-sex occurrences – this is the process of investigating a number of similar incidents **that have not previously been investigated**, to determine root causes and develop an action plan to address these issues, or
- an RCA for an actual SSA mixed-sex occurrence or complaint – if several patients are affected by a mixed-sex occurrence then just carry out one report for all the mixed-sex occurrences, not a separate report per patient.

In both cases the RCA report writing template provided in this toolkit will help both to guide you through the RCA process and to complete a robust written report.

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3.2 Who should use the toolkit?

- SSA investigations should be undertaken by senior managers, bed managers, ward managers, matrons, risk managers and anyone else interested in reducing and learning from SSA mixed-sex occurrences.
- Unless very familiar with RCA, most managers should conduct SSA investigations with the support of their risk manager (in order to make best use of their RCA experience and objectivity).
- Local staff should be involved to make use of their local knowledge and to promote ownership.

3.3 How long will the RCA take?

The investigation, analysis and report writing may take between 2 and 3 hours, maybe less for the investigation of a single mixed-sex occurrence. Once familiar with the tool, it will take less time to complete. A multi-incident investigation following identification of mixed-sex occurrence clusters from the in-patient survey data may take longer.

3.4 How to submit your completed report

Organisations should establish their own local arrangements for undertaking investigations and collecting these reports centrally.

Normally this will involve completed RCA reports being forwarded to your organisation's risk manager for collation and aggregated data review.

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4. Principles of investigation

The key purposes of the investigation and subsequent report are to learn from mixed-sex occurrences, incidents and complaints, and to subsequently share that learning.

The RCA investigation process must be open and transparent, be based on evidence and must seek to look for improvements rather than to apportion blame. There is full National Patient Safety Agency guidance available at www.npsa.nhs.uk/rca

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4.1 Care and service delivery problems identified in the investigation

These are defined as every point at which something happened that **should not** have, or where something **should** have happened but did not.

Care delivery problems (CDPs) are unsafe acts, omissions or errors by individuals.

Service delivery problems (SDPs) are unsafe/unacceptable conditions and are concerned with the organisation and its systems.

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The wording of CDPs and SDPs needs to be specific. (As such, 'Communication failure' is insufficient and 'Nurse did not inform bed manager that patient was male' is more appropriate.)

Also, CDPs and SDPs need to describe **what** happened and not **why** it happened. (As such, 'Not enough training on SSA' is incorrect whereas 'Staff members rarely knew about the SSA policy' is appropriate.)

The CDPs and SDPs should then be analysed, with the most time allotted to those considered most significant.

4.2 Contributory factors and root causes identified in the investigation

These are factors that influenced or directly led to the SSA mixed-sex occurrence. They must be based on evidence or information collected during your investigation, and not on assumptions. A contributory factors framework is provided in this guidance and lists some potential contributory factors for SSA mixed-sex occurrences.

Root causes are the most significant or frequently occurring contributory factors that, if addressed, will be the most effective means of reducing or eliminating recurrence of mixed-sex occurrences and complaints.

4.3 Action planning following the investigation

There is an action plan template included in the report template but you may wish to use local templates if preferred. The action plan should be completed and agreed with the relevant stakeholders and local action should be taken where possible. If the solutions require escalation, then the report and action plan should be forwarded to the appropriate committee and recorded on the risk register.

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4.4 Analysis and escalation of action during the RCA process

Issue	Nature of problems	Reflection point
Care and service delivery problems (CDPs and SDPs)	Unsafe acts and unsafe conditions E.g. things that happened that shouldn't have or things that should have happened but didn't	<i>Continue on with the analysis – keep asking why</i>
Contributory factors	Specific reasons behind CDPs and SDPs E.g. process design (patient journey); staff errors; system failure; formal vs. informal policy; organisational issues, etc.	<i>Keep asking why</i>
Root causes	Fundamental (core, key and recurrent) contributory factors causing CDPs and SDPs	For local action, e.g. ward/ dept, directorate, Clinical Governance Committee



Drill down to at least this level before considering solutions

Escalate if the following issues apply:

Leadership issues	For clinical governance committee/board action
Societal issues	For strategic health authority (SHA)/DH action
Economy issues	For primary care trust (PCT)/SHA/DH/ Government action

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4.5 Hierarchy of effectiveness for solutions and actions

Albert Einstein said: 'We can't solve problems using the same kind of thinking we used when we created them.'

We need to carefully consider the actions, solutions or interventions we put in place following SSA mixed-sex occurrences to ensure that we make a tangible difference for the future.

4.5.1 Preventative actions/interventions should:

- Target the elimination of root causes
- Offer a long-term and sustainable solution to the problem
- Have an overall positive impact on other procedures, resources and schedules
- Be SMART (specific, measurable, achievable, reasonable and timed).

4.5.2 Stronger actions/interventions

- Leadership/culture change
- Tangible involvement and action by leadership in support of zero tolerance of mixed-sex accommodation
- Eliminate mixed-sex accommodation
- Process engineering controls (interlock/forcing function) – 'Right bed, first time'
- Simplify the process (e.g. admissions) and remove unnecessary steps
- Standardise processes or care plans
- Review use of wards and admission wards
- Architectural changes.

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4.5.3 Moderately strong actions/interventions

- Increase in staffing/decrease in workload
- Enhanced documentation/communication
- Redundancy of task/process

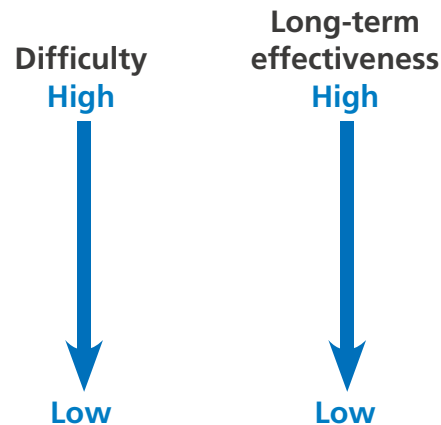
4.5.4 Weaker actions/interventions

- Warnings and labels
- New procedure/memorandum/policy
- Training
- Additional study/analysis

4.5.5 Types of action/intervention

It is important to note that the easier the solution is to implement, generally the less effective or sustainable the improvement is. For example:

- Culture change
- Technical system enhancement
- Process redesign
- Retraining/counselling
- Punitive/disciplinary



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4.6 Report writing

- Consider the audience and keep the report clear. It should be free of jargon, acronyms and names, and use plain English. Write your report using your organisation's style and font.
- Reports should be written in the third person, e.g. refer to the patient, the doctor, the organisation, etc.
- Names of staff should not feature and do not include locations, exact titles or gender, which can inadvertently lead to identification of staff.
- The report must be evidence based and sources of evidence should be referenced.
- Full guidance is available at www.npsa.nhs.uk/rca

4.7 Record keeping and information security

Working documents used in your investigation, such as timelines and analytical work, should be filed safely and clearly labelled with the investigation code and number. If there is outside scrutiny or a further investigation, your working records and evidence may be needed and should be easy to locate.

Documentation should be stored in a lettered or numbered index file, with each item of evidence given an individual reference.

4.8 Aggregating data and sharing learning from SSA investigations

Once completed and actioned, all SSA investigation reports should be retained centrally for future reference/action. You should consider existing local processes in deciding who manages circulation, monitoring, aggregation and eventual reporting on findings. It is important that the RCA outcomes are embedded into the organisations wider process for aggregating Serious Untoward Incidents (SUIs)/quality monitoring. Often this involves forwarding completed and actioned RCAs to the organisation's risk/patient safety manager.

The risk/patient safety manager may wish to:

- involve patient and public involvement forum or foundation trust members in this review, or
- review justifications provided for SSA mixed-sex occurrences.

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5. Contributory factors framework

This tool is a prompt for the factors to be considered and is not an exhaustive checklist.

Patient factors	Components
Clinical condition	<ul style="list-style-type: none"> • Complexity of condition • Seriousness of condition • Clinical drivers for mixed-sex occurrence
Specialty factors	<ul style="list-style-type: none"> • Age • Specialty care required • Outlier • Problems with patient experience/satisfaction during episode of care
Mental/psychological factors	<ul style="list-style-type: none"> • Existing mental health disorder • Trauma
Interpersonal relationships	<ul style="list-style-type: none"> • Staff to patient and patient to staff • Patient to patient

Staff factors	Components
Physical issues	<ul style="list-style-type: none"> • Fatigue
Psychological issues	<ul style="list-style-type: none"> • Stress (e.g. distraction/preoccupation) • Motivation (e.g. complacency, low job satisfaction) • Cognitive factors (e.g. attention deficit, preoccupation, overload)
Personality issues	<ul style="list-style-type: none"> • Risk averse/risk taker

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Task factors	Components
Guidelines, procedures and policies	<ul style="list-style-type: none"> • Not up-to-date/not reflecting current best practice • Not available at appropriate location (i.e. not accessible when needed) • Unclear/ambiguous • Not useable or irrelevant/unrealistic • Not adhered to/not followed
Decision-making aids	<ul style="list-style-type: none"> • Availability of aids, e.g. risk assessment tool • Difficulty accessing senior/specialist advice • Lack of easy-access flow charts and diagrams • Incomplete information, e.g. test results, information, history
Procedural or task design	<ul style="list-style-type: none"> • Staff do not agree with the 'task/procedure design' • Stages of the task not designed in such a way that each step can realistically be carried out – i.e. 'Right bed, first time' • Mixed-sex occurrences due to system failure or design

Team factors	Components
Role congruence	<ul style="list-style-type: none"> • Lack of shared understanding/responsibility for SSA • Role definitions misunderstood/not clearly understood
Leadership	<ul style="list-style-type: none"> • Ineffective leadership – clinically • Ineffective leadership – managerially • Leadership responsibilities unclear/not understood
Support and cultural factors	<ul style="list-style-type: none"> • Lack of support networks for staff • Team reaction to mixed-sex occurrences • Team perception and attitude to SSA/privacy and dignity • Blocks from certain disciplines or managers

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Communication factors	Components
Verbal communication	<ul style="list-style-type: none"> • Ambiguous verbal commands/directions • Directed to inappropriate person(s) • Incorrect communication channels used
Written communication	<ul style="list-style-type: none"> • Patient information regarding SSA not available to manage patient expectations and perceptions • Communications directed to the wrong person(s)

Education and training	Components
Competence	<ul style="list-style-type: none"> • Lack of knowledge • Lack of skills • Length of experience • Quality of experience • Task familiarity
Supervision	<ul style="list-style-type: none"> • Adequacy of supervision
Availability/accessibility	<ul style="list-style-type: none"> • On-the-job training – unavailable or inaccessible • Team training – unavailable or inaccessible • Training on/awareness of SSA policy

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Work environment factors	Component
Administrative factors	<ul style="list-style-type: none"> • General efficiency of administrative systems, e.g. bed management • Reliability of administrative support
Design of physical environment	<ul style="list-style-type: none"> • Area design: e.g. mixed bays, Nightingale, ITU/HDU, partitions or walls, ward configuration • Location of and access to toilets and bathrooms • Location of skills and equipment
Environment	<ul style="list-style-type: none"> • Use of admission wards • No same-sex unit for speciality
Staffing	<ul style="list-style-type: none"> • Skill mix • Workload/dependency assessment
Workload and hours of work	<ul style="list-style-type: none"> • Type of shift/shift length • Extraneous tasks • Capacity issues – e.g. exceeding capacity levels possibly due to PCT contract pressures or higher than normal level of emergencies
Time	<ul style="list-style-type: none"> • Delays caused by system failure or design • Time of day

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Organisational factors	Components
Organisational structure	<ul style="list-style-type: none"> • Hierarchical structure, not conducive to discussion/problem sharing • Tight/unclear boundaries for accountability and responsibility • Clinical model versus the managerial model
Organisational culture	<ul style="list-style-type: none"> • Quality/safety/efficiency balance • Leadership example (e.g. poor visible evidence of commitment to SSA) • Acceptance of SSA mixed-sex occurrences – not achieving 'Right bed, first time' • Staff not empowered to take local action or escalate if required
Priorities	<ul style="list-style-type: none"> • Conflict of targets/priorities – internal or external • External assessment driven, e.g. Star Ratings/FT application
Externally imported risks	<ul style="list-style-type: none"> • Associated with locum/agency staff • Associated with private finance initiative
Other factors	<ul style="list-style-type: none"> • Increased length of stay • Bed status/occupancy levels

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6. Example RCAs

These examples are fictitious and are for reference and training purposes only.

- [Multiple incident review \(1\) RCA](#)
Example investigation of an SSA mixed-sex occurrence involving one or more patients
- [Multiple incident review \(2\) RCA](#)
Example investigation of a cluster of several instances of SSA mixed-sex occurrences

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Example 1: SSA RCA

Example of multi-incident review RCA report following a same-sex accommodation (SSA) mixed-sex occurrence

Fictitious example – For training purposes only

Trust: [Rivers NHS Trust](#)

Ward/dept: [Admission ward](#)

Investigation date: [20 February 2009](#)

Investigation number: [RCA 123](#)

SSA mixed-sex occurrence description and consequences

Two female general medicine patients were admitted to a male bay on a urology ward.

Type of mixed-sex occurrence: Shared sleeping
 Overlooking opposite sex accommodation
 Shared toilet/bathroom

Date of mixed-sex occurrence or investigation: [Mixed-sex occurrence on 15 February 2009](#)

Number of patients affected: [9 patients \(2 female and 7 male\)](#)

Specialty

Specialty where mixed-sex occurrence occurred: [Urology](#)

Specialty where patient(s) should have been (if known): [General medicine](#)

Effect on patient(s), if any: [Both female patients concerned about privacy and dignity](#)

Clinical justification

[There were no clinical reasons for this mixed-sex occurrence](#)

[The priority was admitting the patients](#)

Immediate/remedial action

How often was the mixed-sex occurrence reviewed? [Each shift](#)

How long before the situation was remedied? [47 hours](#)

What was the immediate/remedial action taken? [Moved patients to female bed on obs and gynae ward](#)

Background and context

A female patient was admitted to A&E on 15 February complaining of abdominal pain. The patient was placed in a male bay on the admission ward but this was considered an acceptable exemption. Following assessment the patient was admitted as a general medicine patient under Consultant X. However the female general medicine patient was admitted to a male bay on a urology ward. The patient stayed in a mixed-sex bay for 3 days. This is a service where there are regular and higher-than-average numbers of SSA mixed-sex occurrences

Another female patient was in a single room but was opposite a male bay. The patient liked the door open but when she was getting out of bed her legs were exposed to the male patients in the male bay. Also as she was situated in a male bay, she had to use different toilet/bathroom facilities down by the female bay. This resulted in the patient walking past the male bay to get to the toilet/bathroom

Scope of investigation

The investigation was instigated by a same-sex accommodation mixed-sex occurrence

The investigation was commenced on 18 February and was completed on 20 February 2009

The investigation involved A&E, general medicine, urology and bed management

Investigation type, process and methods used

- Single mixed-sex occurrence review
- Multiple mixed-sex occurrence review
- Patient/carer contact or interview
- 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 given: Yes No

Written information provided: Yes No

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

Details: [Female patients expressed concerns about their privacy and dignity](#)

Chronology of events

[See patient journey map below](#)

Patient journey: Process mapping and timeline

Emergency admission

	A&E	Admission ward	Transfer to ward 1	Transfer to ward 2	Transfer to ward 3	Date of discharge
Date/time	15.02.09/ 10.15	15.02.09/ 12.30	15.02.09/ 17.00	16.02.09/ 15.00	17.02.09/ 9.00	20.02.09
Correct patient journey	Female patient arrived in A&E with abdominal pain	Placed in female bay on admission ward before 14.15pm	Transferred to female bay on general medicine ward for treatment	Should already be in female bed on general medicine ward	Should already be in female bed on general medicine ward	Discharge by 20 Feb 09
Actual patient journey	Female patient arrived in A&E with abdominal pain	Placed in male bay on admission ward	Transferred to male urology ward	Transferred to female bay on obs and gynae ward	Transferred to female bay on general medicine ward	Discharged on 20 Feb 09



Variation to correct patient journey and reason(s) why	None	Mixed-sex occurrence Female patient next to male patients. Accepted practice to mix sexes	Mixed-sex occurrence Female patient in male bay and also outlier patient. Gen med ward full	Not SSA mixed-sex occurrence but extra move which disrupted patient care and increased safety risk	None but was not 'Right bed, first time'	None
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Notable practice

In the first instance, staff on the urology ward did explain to the 4 patients in the bay that high levels of admission had resulted in having to mix sexes, and an apology was given

Care and service delivery problems

- The first female general medicine patient admitted to 4-bed male bay on urology ward by bed manager
- Second female patient placed in single room opposite male bay
- Failure by team to recognise privacy and dignity issues for female patient in single room facing male bay

Contributory factors

- Higher than usual level of general medicine admissions at time of SSA mixed-sex occurrence
- Insufficient general medicine beds to allow for flexibility of bed use
- General acceptance of SSA mixed-sex occurrences at all levels
- Lack of appreciation that gender placed in single rooms should be compatible with any facing bay, and that patient should not have to pass bay of opposite sex to reach toilet/bathroom

Root causes

1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional and/or clinically justifiable circumstances
2. Lack of recognition of issues regarding overlooking opposite sex and regarding proximity/location of appropriate toilet/bathroom

Lessons learned

Admissions ward management not sufficiently managed in terms of performance monitoring
The patient was not in the 'Right bed, first time' and experienced two extra bed moves. This caused disruption to care and could have compromised clinical safety and increased the risk of infection. It would also impact negatively on the patient experience

Recommendations

1. Carry out a full review of SSA in admission wards and consider allocation of male and female areas
2. Review allocation of beds locally and optimum capacity levels in order to reduce conflict in organisational targets
3. Escalate cultural issues to the board for high-level and measurable action on strategy and leadership

Arrangements for shared learning

Share findings and recommendations with other departments experiencing SSA mixed-sex occurrences and include them in piloting solutions

Action plan

Incident number:	Action 1 ↓	Action 2 ↓	Action 3 ↓
Root cause (number as per investigation report)	1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional clinically justifiable circumstances	1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional clinically justifiable circumstances	2. Lack of recognition of issues regarding overlooking opposite sex and regarding proximity/location of appropriate toilet/bathroom
Effect(s) on patient(s)/service(s)	Female patient concerned about privacy and dignity. Risk of disruption to care and risk of infection	Female patient concerned about privacy and dignity. Risk of disruption to care and risk of infection	Female patient concerned about privacy and dignity
Recommendation(s) to address root cause (or rationale, if no action or recommendation is set. Number as per investigation report)	3. Escalate cultural issues to the board for high-level and measurable action on strategy and leadership. (Zero tolerance policy to SSA mixed-sex occurrences)	2. Review allocation of beds locally and optimum capacity levels in order to reduce conflict in targets	1. In context of a full review, escalate need to raise awareness and include in SSA policy
Action(s) to achieve recommendations (number as per investigation report)	1. Managers to report, be individually accountable and lead by example	2. Review contract with PCT to set more appropriate capacity/performance targets	3. Include in SSA policy. Raise awareness with staff
Level for action (organisation, directorate, team etc) Local or escalate	Organisation level	Organisation level	Organisation level
Implementation by whom:	Nurse director	Chief executive	Nurse director
Implementation by when:	31.05.09	31.03.10	31.05.09
Resource required (time)	Training and audit	1 day	Training and audit
Resource required (money)	£2,000.00	Negotiated minimum reduction in payments	£2,000.00 as for Action 1
Resource required (other)	N/A	N/A	N/A

Evidence of completion

What is the measure of success?	Measurable and sustained reduction in SSA mixed-sex occurrences	Beneficial change in contract	Measurable and sustained reduction in SSA mixed-sex occurrences and complaints
Monitoring and evaluation arrangements	Quarterly open stats published and discussed for action	Progress reports to board	Quarterly open stats published and discussed for action
Sign-off by:	Nurse director	Chief executive	Nurse director
Author	Sarah Brown		
Job title	Ward Manager, General Medicine		
Date	20 February 2009		

Example 2: SSA RCA

Example of multi-incident review RCA report following a same-sex accommodation (SSA) Mixed-sex occurrence

Fictitious example – For training purposes only

Trust: [Rivers NHS Trust](#)

Ward/dept: [Admission ward](#)

Investigation date: [23 March 2009](#)

Investigation number: [RCA 246](#)

SSA mixed-sex occurrence description and consequences

On review of trust data on mixed-sex occurrences, there were a significantly high number of mixed-sex occurrences that were considered exemptions.

Type of mixed-sex occurrence: Shared sleeping
 Overlooking opposite sex accommodation
 Shared toilet/bathroom

Date of mixed-sex occurrence or investigation: [Investigation on 23 March 2009](#)

Number of patients affected: [140 patients from 16–20 March 2009](#)

Specialty

Specialty where mixed-sex occurrence occurred: [Admission ward](#)

Specialty where patient(s) should have been (if known): [Admission ward](#)

Effect on patient(s), if any: [Concern about privacy and dignity](#)

Clinical justification

[There were no clinical reasons to mix the sexes. It was purely the configuration of the ward as it was considered exempt from SSA standards](#)

[The priority is admitting patients within 4 hours and the admission ward is used for this purpose](#)

Immediate/remedial action

How often was the mixed-sex occurrence reviewed? [It was not considered a mixed-sex occurrence](#)

How long before the situation was remedied? [On average about 8 hours](#)

What was the immediate/remedial action taken? [No immediate action as not considered a mixed-sex occurrence. Eventually moved from admission ward to specialty ward](#)

Background and context

[The admission ward is mixed sex and its purpose is to take patients from A&E to avoid a 4-hour wait while a specialty bed is found for admission. Trust perception is that admission wards are considered exempt from the requirement to meet and monitor the definition for SSA](#)

Scope of investigation

The investigation was instigated as a result of a high number of SSA mixed-sex occurrences being classified as exempt

The investigation was commenced on 23 March 2009 and completed on 27 March 2009

The investigation involved A&E, admission ward and bed management

Investigation type, process and methods used

- Single mixed-sex occurrence review
- Multiple mixed-sex occurrence review
- Patient/carer contact or interview
- 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 given: Yes No

Written information provided: Yes No

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

Details: [Concerns about privacy and dignity](#)

Chronology of events

Not applicable

Notable practice

Staff ensure that they explain to patients that the admission ward is a mixed-sex ward and that they will be moved to the correct ward as quickly as possible

Care and service delivery problems

- Delays to patient care if priority is given to ensuring compliance with SSA
- Lack of flexibility of beds

Contributory factors

- Staff perception that it is acceptable to mix sexes on admission wards
- General acceptance of admission ward/SSA mixed-sex occurrences at all levels
- Configuration of ward does not promote SSA

Root cause

1. Cultural attitude to SSA mixed-sex occurrences on admission wards

Lessons learned

Admissions ward management is not closely managed in terms of performance monitoring

Recommendations

1. Carry out a full review of SSA in admission wards and consider allocation of male and female areas
2. Review allocation of beds locally and optimum capacity levels in order to reduce conflict in targets
3. Escalate cultural issues to the board for high-level and measurable action on strategy and leadership

Arrangements for shared learning

Share findings and recommendations with other departments experiencing SSA mixed-sex occurrences and include them in piloting solutions

Action plan

Incident number:	Action 1 ↓	Action 2 ↓	Action 3 ↓
Root cause (number as per investigation report)	1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional clinically justifiable circumstances	1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional clinically justifiable circumstances	1. Cultural attitude to SSA mixed-sex occurrences does not ensure that mixed-sex occurrences occur only in exceptional clinically justifiable circumstances
Effect(s) on patient(s)/ service(s)	Potential concerns about privacy and dignity for a wider patient group	Potential concerns about privacy and dignity for a wider patient group	Potential concerns about privacy and dignity for a wider patient group
Recommendation(s) to address root cause (or rationale, if no action or recommendation is set. Number as per investigation report)	3. Escalate cultural issues to the board for high-level and measurable action on strategy and leadership. (Zero tolerance policy to SSA mixed-sex occurrences)	2. Review allocation of beds locally and optimum capacity levels in order to reduce conflict in targets	1. Carry out a full review of SSA in admission wards and consider allocation of male and female areas
Action(s) to achieve recommendations (Numbered)	3. Managers to report, be individually accountable and lead by example	2. Review contract with PCT to set more appropriate capacity/ performance targets	1. Implement SSA wards from 2 existing wards
Level for action (organisation, directorate, team etc) Local or escalate	Organisation level	Organisation level	Directorate level
Implementation by whom:	Nurse director	Chief executive	Director of emergency services
Implementation by when:	31.05.09	31.03.10	30.08.09
Resource required (time)	Training and audit	1 day	Reconfiguration
Resource required (money)	£2,000.00	Negotiated minimum reduction in payments	Minor estate changes
Resource required (other)	N/A	N/A	Portering services

Evidence of completion

What is the measure of success?	Measurable and sustained reduction in SSA mixed-sex occurrences	Beneficial change in contract	Creation of SSA wards
Monitoring and evaluation arrangements	Quarterly open stats published and discussed for action	Progress reports to board	Progress reports to board
Sign-off by:	Nurse director	Chief executive	Director of emergency services
Author	Jane Smith		
Job title	Risk Manager		
Date	27 March 2009		

7. RCA investigation report

PLEASE READ – Full installation instructions for this template are detailed below (you will only need to install this once on each PC)

To set this template up:

To enable the template to function properly you must save and access it from your **'Templates folder'**.

To do this: Open the document in **Word**. Click on **'File'** and then click on **'Save as'**.

Go to the bottom of the box that opens and, from the **'Save as type'** drop-down box, select **'Document template'** and then click **'Save'**.

Please note that the functionality of this template will be adversely affected by making changes to the original document layout, or by attempting to use it without first saving and accessing it via the templates folder.

To find this document once installed in your Templates Folder:

In **Word**, go to **'File'** and select **'New'**. In the task pane which then opens on the right-hand side, find **'Templates'** and select **'On my computer...'** Find the template entitled 'RCA Investigation Report Template'.

Once created, each individual report can be saved, accessed and updated from any folder. However, each new report will need to be set up using the original template from your **'Templates Folder'**.

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Writing your report

1. Write your investigation report

- Refer to summary guidance (in left-hand column) as you go. Supplementary guidance is also provided.
- If an investigation produces no information against a heading, add an explanation as to why this is the case.
- If issues arise that require a new heading, this can be added as a new row.

2. On completion, delete the guidance to produce your final report

- Save the document with the chosen file name for each individual investigation report.

[Click here for the Word Template](#)

You may prefer to print and complete the form by hand.

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Definitions

SSA can be provided in the following:

- **Same-sex wards** – i.e. where the whole ward is occupied by men or women, but not both
- **Single rooms** – with adjacent same-sex toilet and washing facilities (preferably en-suite), or
- **Within mixed-sex wards** – i.e. bays or rooms that accommodate either men or women, not both, with designated same-sex toilet and washing facilities, preferably within or adjacent to the bay or room.

Partitions:

- All partitions separating male and female areas should be full height, rigid and fixed to the building structure.
- ‘Full height’ does not necessarily mean fixed to the ceiling if this would cause problems in areas with high ceilings, such as old Nightingale wards or where air flow and lighting issues prevail.
- Partitions should be high enough to ensure that patients perceive that they are in a separate room.

Room:

- A single or multi-bedded sleeping area, which is fully enclosed with solid walls and a door.

Bay:

- A single or multi-bedded sleeping area, which is fully enclosed on three sides with solid walls. The fourth side may be open or partially enclosed. The use of curtains between bays is not acceptable as they offer little privacy and would not provide a safe and secure environment in mental health units.

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Adjacent bath/shower rooms and toilet facilities:

- Where bath/shower rooms and toilets are not provided as en-suite facilities.
- These should be located as close to the bay or room as possible and clearly designated as either male or female facilities.
- Patients should not have to walk through areas occupied by the opposite sex in order to reach the facilities.

Children:

- *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals identified that children, and in particular adolescents, need special consideration while in hospital and organisations will need to demonstrate that they can offer SSA. The report refers to *Getting the right start: National Service Framework for Children, Young People and Maternity Services. Part 1: Standard for Hospital Services.**

Mental health:

- In mental health units, sharing of either sleeping or toilet/bathroom facilities should never occur.

Day wards and admission/assessment wards:

- Admission/assessment units and day surgery units should be treated as any other area and should be segregated accordingly (especially if overnight stays are required).

Specialist areas:

- When the need to treat/admit takes precedence over SSA (i.e. there are sound clinical reasons), staff attitudes and actions make a huge difference to the patient experience. Evidence of adequate discussion and explanation to the patient/carer should be demonstrated and patients' expectations should be met.

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- NHS Institute for Innovation and Improvement (2007) *Privacy and dignity – The elimination of mixed sex accommodation: Good practice guidance and self assessment checklist*, DH
- Chief Nursing Officer (2007) *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals*, DH
- DH (2004) *Getting the right start: National Service Framework for Children, Young People and Maternity Services. Part 1: Standard for hospital services*, DH

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