Safety, privacy and dignity in mental health units

Guidance on mixed sex accommodation for mental health services
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Annex A
1. **Summary**

1.1 In *Modernising Mental Health Services*, the Government outlined its vision for safe, sound and supportive mental health services for working age adults. As part of the strategy to provide safe services, NHS Trusts need to ensure that all patients are protected from physical, psychological or sexual harm while they are being treated in mental health facilities, and to recognise that the needs of male and female patients may be different. This guidance outlines the practical steps which NHS staff should take to ensure the safety, privacy and dignity of patients, and suggests good practice for building design.

1.2 The Government is committed to phasing out mixed sex hospital accommodation and no new mixed sex wards will be approved. The NHS has been set the clear objective to work towards the elimination of mixed sex accommodation in 95% of Health Authority areas by the year 2002. This guidance reinforces earlier guidance designed to ensure that the safety, privacy and dignity of inpatients are protected. It adds to the existing minimum building requirements for mental health units, and provides examples of good practice in estates design. This guidance will help to ensure that new NHS buildings meet the objectives which have been laid down.

1.3 The key changes introduced by this guidance are:

- All mental health units should comply with the operational policy guidelines in section A.

- HSC 1998/143 included an optional checklist of issues for Trusts managing mental health services to address so as to ensure the safety and security of patients. **The points in this checklist should be adopted by all mental health trusts, and are included in Section A of this guidance.**

- All new-build mental health units should take account of the design guidance for new-build mental health units in section B, which introduces a new requirement that **secure day rooms to which women patients only have access must be provided.**

- NHS Trusts with responsibility for managing mental health services are asked to report to Regional Office mental health leads on the action they have taken in response to this guidance **by 31st August 2000.**
2. Policy background

2.1 EL (97) 3, issued on 24 January 1997, required health authorities to set local performance targets, with Trusts within their boundary, to deliver the following objectives:

- Ensure that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients;

- Achieve fully the standard for segregated washing and toilet facilities across the NHS; and

- Provide safe facilities for patients in hospital who are mentally ill which safeguard their privacy and dignity.

This guidance specifically addresses the third objective and is for the use of NHS Trusts which manage mental health services.

2.2 EL (97) 43 asked health authorities to report on the position against these three objectives. The resulting report, published in February 1998, showed that 95% of health authorities were on course to achieve the objectives by 2002. This target has now been incorporated in the Treasury’s Output and Performance Analysis as a commitment for the NHS, following the Comprehensive Spending Review.

2.3 HSC 1998/143 (21 August 1998) introduced central monitoring arrangements to enable the NHS Executive to track health authorities’ progress on delivering the objectives. The first annual report showed that 93% of Health Authorities now expect to achieve all three objectives by 2002. Ministers expect the NHS to make greater efforts to achieve the objectives and so it is important that the NHS gives increased emphasis to this target.

2.4 The NHS Executive expects the further guidance for mental health services contained in this document to be followed for all new build projects, and as good practice for building improvements, conversions or making the best use of existing accommodation. Implementation of the guidance will be monitored by Regional Office Mental Health Leads.
This section provides guidance to enable Trusts to meet the overall objective of providing safe facilities for patients in hospital who are mentally ill, which safeguard their privacy and dignity. It should be read in conjunction with both *Modernising Mental Health Services* and the *National Service Framework*.

*Modernising Mental Health Services*, the Mental Health Strategy published in December 1998, sets out the Government’s vision for safe, sound and supportive mental health services. The new National Service Framework for Mental Health has set out national standards and performance indicators and defined service models for mental health care. This guidance now outlines the safeguards which Trusts are expected to follow to protect women’s safety, dignity and privacy.

3. The safety of residential settings

3.1 Residential care, whether in hospitals or other buildings, should be safe for patients and for staff. Providing a safe environment is especially important in settings where women may be in a small minority, for example Regional Secure Units. As a minimum requirement, male and female patients should have separate sleeping accommodation, separate toilets and separate washing facilities. Social and therapeutic activities in mental health units should generally be available to men and women together, with appropriate use of risk assessment.

3.2 Managers and staff should be aware of all safety concerns, and alert to the possibility of assaults, not just to other residents but also to staff. This applies to hospitals and smaller residential community settings, as well as secure facilities, and accommodation for people with learning disabilities. Women may not feel safe mixing with men whose behaviour is disturbed or possibly violent or who have a history of abusing women. Some women may have been abused in the past and may have concerns about being situated in close proximity to men. Mixed sex accommodation can also be a matter of concern for patients in some ethnic minority groups who may, in consequence, refuse admission to hospital on cultural and religious grounds. Managers and staff should also be aware of the possibility of assaults and abuse between patients of the same gender and policies and procedures should reflect this.

3.3 The key to ensuring the safety of patients is to provide a safe and supportive environment. The safety of patients raises organisational issues as well as building design issues. This section covers the organisational issues, and the requirements for building design are outlined in detail in section B.
The NHS Trust Board is responsible for putting in place policies and procedures to address patient safety, privacy and dignity. The Board should ensure that policies are formulated, monitored and reviewed regularly, and that staff have the necessary training to operate them sensitively and with proper regard for patients’ concerns.

4. Trust-wide philosophy, policies and practice

4.1 The following guidelines may be used as a freestanding Action Plan, or to develop standards and audit as part of the quality improvement process. Trust Chief Executives should ensure that:

4.2 Policies

4.2.1 An officer at a senior level within the Trust is appointed to have responsibility for women’s safety, privacy and dignity.

4.2.2 Consideration is given to setting up a Patients’ Issues working group, with contributions from Trust staff, the Health Authority, Local Authority, CHC and representatives from local user and women’s groups.

4.2.3 Written guidelines for staff, which outline the arrangements to ensure the safety of all patients, are available in every ward, department and residence.

4.2.4 Patients are offered a choice in allocation of a key worker, where possible offering choice of sex of key worker but also considering ethnicity, age and professional issues.

4.2.5 Assessment and admission policies are developed and based on the assessed needs of individuals. Key issues include whether or not there is a history of abuse, needs in terms of relationships, and personal choice as to whether there is a wish to mix socially with men or women.

4.2.6 The needs of and risks to vulnerable men (as well as women) are recognised and addressed.

4.2.7 There is an agreed policy and established protocols in place for ward staff who work with patients with particular reference to vulnerable patients and those of the opposite sex.

4.2.8 Trust policies lay down that a member of the same sex should carry out intimate searches with a second person acting as witness. The patient’s agreement should, where possible, be sought for the person carrying out this task (see Chapter 25 of the Code of Practice, 1999 edition).

4.2.9 Trust policies on management of aggression and seclusion should take account of the dignity of the patient in respect of clothing, observation and gender of staff providing supervision (see Chapter 19 of the Code of Practice, 1999 edition).

4.2.10 Speedy and robust arrangements are in place to deal effectively with staff, visitors or patients who sexually or physically abuse or harass patients, staff or visitors.
4.3 **Monitoring**

4.3.1 All incidents of violence or threatening behaviour towards patients should be reported by staff and recorded. Trends in incidents should also be assessed and reported to the Trust Board regularly.

4.3.2 The Board should monitor all complaints to enable identification of problems relating to safety and dignity over the care and treatment of both female and male patients.

4.3.3 Patient surveys should also be considered as a means of assessing patients' and relatives' views about services and to ascertain their concerns.

4.4 **Review**

4.4.1 Policies and guidelines on the protection of patients should be reviewed every year or sooner in the light of experience, incidents or changes to the service. The review should include the involvement of patients and users and should be documented.

4.5 **Training**

4.5.1 Training policies should be in place, which address the protection of patients, assist staff to be more aware of the safety and the special needs of women patients, to understand and appreciate ethnic, cultural and gender differences, and to address any concerns relatives may have about these issues. Individual development plans of staff should identify what training is needed or undertaken around these issues.

4.6 **Information**

4.6.1 Information about services should be given prior to admission, if possible, or on admission, and should be available in different languages and formats, appropriate to local needs.

4.6.2 All patients should if possible receive details prior to admission about the type of accommodation to which they will be admitted, whether mixed or single sex or single room and the name of the consultant and ward manager.

5. **Ward environment and culture**

5.1 **At individual ward and department level**, the key issues which policies and standards should address include **assessment of patients’ needs, supervision, security and support**.

5.2 **Assessment**

5.2.1 The initial assessment of each patient's needs should include consideration of the risk of the patient being abused, or of abusing others. Staff should find out if the patient would prefer to stay in a single-sex or mixed environment. The assessment should include providing access to a named or associate nurse, and offering the patient a keyworker of the same sex. Assessment should aim to identify at an early stage any patients who may be predatory or likely to abuse or offend. This may
require proactive management to prevent inappropriate/unwanted behaviour. Similarly, patients at risk of self-harm should be identified.

5.2.2 The patient should be involved in drawing up his or her care plan, which should be explicit about the individual's concerns and needs. When the plan is completed by staff, the patient should be given the opportunity to comment on the plan. Risk assessment and management should be a continuous prominent feature of care plans. They should identify both patients who pose a risk of assault or intimidation, and those patients who are known to be vulnerable because of their illness or likely behaviour. Individual strategies may need to be developed for vulnerable patients, for example, where patients may be sexually disinhibited because of their illness.

5.3 **Support**

5.3.1 Women patients should have access to a female member of staff at all times, and an escort of the same gender should always be available (particularly in secure psychiatric facilities when a patient poses a risk of escaping). Staff carrying out physical examinations should either be of the same sex or there should be a same sex chaperone present. Women should have access to appropriate toiletries and sanitary protection.

5.3.2 Where possible, women patients should have the opportunity to associate together in women-only lounge areas, if they so wish, and to take part in women-only therapy groups and social activities. This should apply particularly in units where women patients are in the minority, for example, in some secure settings.

5.3.3 Patients should be given access to local organisations, advocacy projects, religious and cultural groups from their own ethnic community. Voluntary organisations and/or local user groups should be involved in planning, evaluating and monitoring of services.

5.3.4 Women patients should have access, where possible, to a female doctor for physical health care, if they so wish.

5.3.5 Patients should be given clear information on how to raise concerns and to whom.

5.4 **Security**

5.4.1 If restraint is used, a member of staff of the same sex should be present as soon as possible. Security measures, for example alarm systems or call buttons, to alert staff may need to be available and accessible to patients, staff and visitors, and should be checked regularly.

5.4.2 Single rooms are helpful in promoting privacy, but there should be an overarching, fail safe system for entry into rooms if staff are concerned about patients' security. Single sex bays or rooms within mixed accommodation should have locks on the bedroom doors to ensure privacy and safety, with staff having a master key. However, it is important that an assessment is made of the patient's vulnerability to self-harm and/or suicide before placing any patient in single room accommodation.
5.4.3 The toilet and bathing facilities should be clearly labelled in a way which can be understood by patients from minority ethnic groups and those with visual or cognitive impairment and be designated male or female and located in separate areas, close to female/male sleeping areas.

5.5 Supervision

5.5.1 Ward managers should ensure that there is appropriate observation of all women patients who have been assessed as at risk or vulnerable to sexual exploitation by men. Similarly, ward managers should ensure patients who are regarded as a risk to others are appropriately supervised. Women patients and vulnerable men should have appropriate staff supervision at night to make them feel safe.

5.5.2 Speedy and robust arrangements must be in place to deal effectively with staff or patients who sexually abuse or harass patients, staff and visitors. Whether there is a complaint or not, all incidents of women patients being threatened, pestered or harassed are investigated and recorded, including verbal comments as well as more obvious harassment, and reported to the responsible officer for monitoring purposes.

5.5.3 Incidents should be reported quickly to the police, where necessary, and good liaison should be maintained with the local police should an incident of sexual abuse or harassment occur. Agreed protocols in advance will ensure effective and sensitive liaison.

6. Patients with special needs

6.1 Older people

6.1.1 All the above considerations apply to older people. Furthermore, research shows that older people, especially women, tend to find mixed sex accommodation less acceptable than young people do. Older people may be both more sensitive to mixing with members of the opposite sex, and less willing to voice any complaints. Arrangements also need to take into account of any physical frailty. Older people with disabilities are more likely to require assistance with intimate personal care so there needs to be sufficient staff of appropriate gender for these care tasks. Disinhibition and inappropriate sexual behaviour are common features of dementia so units for such patients need both space for people to move about but also sufficient rooms to allow privacy.

6.2 Children and young people

6.2.1 The Mental Health Act Code of Practice issued in March 1999 provides general guidance on the facilitation of visiting and the need for child – friendly facilities for visits to detained patients by children. HSC 1999/222 (LAC(99)32) provided further detailed guidance for hospitals, Social Service Departments and registered mental nursing homes on hospital policies for child visits to psychiatric wards and units, following the guidance in the Code at paragraph 26.3. Separate directions and guidance has been issued in relation to child visits to the high security hospitals (HSC 1999/060: Visits by children to Ashworth, Broadmoor and Rampton Hospitals Directions.)
6.2.2 Where, exceptionally, children or adolescents have to be admitted to adult wards, separate written guidance is to be drawn up that takes account of any special risks to them or needs they may have arising from their age and/or illness. In drawing up care plans for children and adolescents any potential risks and needs should be discussed fully with them and also with their parents or those with parental responsibility.

6.2.3 It is recognised that both the size of psychiatric units for children and adolescents and the number of beds in any geographical area may limit the flexibility for providing the same choices as it is intended for adults. However, children and young people deserve the same consideration in order to provide care that is safe, protects their dignity and offers appropriate privacy. Care needs to be taken to ensure that all vulnerable young people, particularly those who have experienced abuse, are protected.

6.2.4 All in-patient settings for children and young people must address these issues and take appropriate steps to both raise awareness of the gender specific needs of their patients and also develop policies that enhance their safety and dignity. All new units for children and young people should ensure that the design fully takes into account the principles set out in this document.

6.3 **Mothers and babies**

6.3.1 Mother and baby units should be self-contained and separate from the general psychiatric ward. Health visiting staff or, where appropriate, midwifery staff attend the mother and baby in hospital. Where opportunities arise as a result of refurbishment or the design of new facilities, consideration must be given to providing accommodation that has the flexibility to meet individual needs.

6.4 **Action if standards are not met**

6.4.1 **If in an emergency** it is necessary to treat a patient in circumstances that do not accord with this guidance, the following steps should be taken:

- Senior management should be informed at the earliest opportunity and steps taken to rectify the matter;

- the patient’s rights to privacy should be protected by a member of staff ensuring that other users of the facility do not intrude upon the patient, particularly in sleeping accommodation, toilets or bathrooms.
Outline guidance on estates issues concerning mixed sex hospital accommodation was given in Annex A of EL (97) 3 and Annex C of HSC 1998/143. This guidance amplifies the earlier guidance and relates to mental health facilities, where the issues may be more complex than in general acute wards. In general acute wards, patients are usually in hospital for a limited time when they are acutely ill, and are then discharged into the community. Patients in mental health facilities may, however, be in them for much longer periods, during which they are likely to be more mobile. As noted above patients’ needs may also vary, depending on such factors as their gender, ethnicity, pathology, vulnerability and age.

7. Principles

7.1 Patient choice

7.1.1 Where patients are admitted as booked admissions, they should continue to be informed in advance if they are likely to be admitted to a ward shared by men and women. Where patients are admitted as an emergency, the patient’s views and wishes should, if possible, be ascertained when they are admitted. The physical design of mental health facilities should allow for patients who are vulnerable, or who prefer to live in the company of members of the same sex to do so.

7.2 Privacy and dignity

7.2.1 Single bedrooms will be provided in new units to provide patients with privacy, subject to an assessment of the risk of self-harm and/or suicide of an individual patient. Bedroom doors should be lockable from inside the room but staff must be able to override the lock in case of an emergency. Sleeping areas must be segregated according to the existing guidelines, and must have direct access to sanitary facilities. Where en-suite toilets and/or bathrooms are provided, this will also improve privacy and maintain patients’ dignity.

7.2.2 The layouts of new designs must prevent members of one sex having to walk through an area occupied by the other sex, to reach toilets or bathrooms. Separate male and female only toilets and bathrooms must be provided in line with existing Patient’s Charter guidance.

7.3 Protection of vulnerable patients

7.3.1 Design should focus on protecting vulnerable patients from assault, and provide flexibility in the use of accommodation.
7.4 Women-only day rooms

7.4.1 As a new requirement with effect from the date of this guidance, all business cases for proposed new build mental health units must provide separate day rooms, to which women only have access.

8. Additional considerations

8.1 Security and Control

8.1.1 Designs should provide secure (lockable) zones within the building. There should be secure lockable external access. In addition, there should be well-located controls/observation bases. Designs should eliminate features which present risks to patients safety. Layouts should allow good observation and avoid ‘nooks and crannies’. Sharp edges, ligature points and high temperature surfaces and water must be avoided.

8.2 Access to Secure Outside Space

8.2.1 External space is a very important element in a therapeutic environment for mentally ill patients. Controlled access from recreational spaces to the outside areas is essential and sub-division of large areas to permit separate sex use would be beneficial. Flexible use of outside space with appropriate supervision depending on patients' needs and choice should be considered.

8.3 Quality Environment

8.3.1 The accommodation should provide for pleasant grouping of bedrooms, attractively arranged and furnished day activity spaces, and pleasant external views from main rooms.

Planning configurations should avoid long dark corridors. Attention should be paid to providing good quality building finishes, colours, lighting and furnishing.

8.4 Flexible use of Accommodation

8.4.1 Design solutions should allow flexible allocation of accommodation to respond to the varying gender mix. This may include flexible and designatable accommodation for single sex use. Designs should also allow for short-term flexibility in allocating activity spaces.

9. Applications

9.1 The provisions apply to both acute and longer stay mental illness accommodation, including units for children, adolescents and older people, and psychiatric intensive care units. Policy should be applied fully in all new design solutions and as comprehensively as possible when altering/extend existing accommodation.
9.2 **Current Guidance**

9.2.1 Advice and guidance on bedroom and sanitary facilities in ward accommodation is provided in the following paragraphs of Hospital Building Notes:

- HBN04 'In patient Accommodation Options for Choice' 3.10 to 3.25,
- HBN35 'Accommodation for People with Mental Illness' 3.10 to 3.13.

Design Guide Medium Secure Psychiatric Units 4.3.

10. **Design Considerations**

10.1 The gender balance of admissions can vary widely over a period of time and these fluctuating demands for either male or female beds are more easily dealt with if there is a flexible use of the accommodation. In mental health accommodation the maximum level of flexibility should be provided to resolve the elimination of mixed sex accommodation and also provide the flexibility to accommodate the varying illnesses and conditions encountered. This is more easily achieved in small cluster grouping of single beds with en-suite facilities in groups of approximately five, rather than in finger wards accommodating up to 15 or 18 beds on either side of a central corridor. The introduction of multi-purpose spaces between these clusters increases the flexibility available for managing the accommodation.

10.2 In Nightingale accommodation and the more recent 'open' or multi-bedded bay ward accommodation, visual and acoustic separation is difficult to achieve. The Nightingale ward with the nurse space at the entrance and sanitary accommodation at the extreme ends of the ward makes it very difficult to satisfactorily accommodate both sexes in such a space without extensive re-design, sub-division and the provision of additional sanitary facilities and day spaces.

10.3 For existing accommodation, the sub-division of existing ward accommodation with staff bays positioned so that supervision of respective care groups can be adequately achieved offers the most acceptable solution. In such situations, it is always preferable for the female accommodation to be furthest from the main hospital circulation. This avoids the need for male patients to pass through the female areas to access other parts of the hospital. The situation where females have to pass male areas of accommodation to enter the main area of the hospital would be limited to occasions when they need to leave the ward area for treatment or therapy.

10.4 The following design considerations should be assessed by design teams in providing new accommodation or considering modification to existing:

- Use standard room modules which allow building uses to change use to suit new needs.
- Place social spaces between groups of bedrooms so that they can be suited with one or the other.
- Circulation areas should be flexibly designed to accommodate informal social activity through local widening, window seats, door clustering and by keeping individual sections short so that they can be assigned territorially.
Large rooms should be capable of sub-division including the possibility of more than one access point being available.

Buildings can be used to enclose and define external space forming courtyards and gardens, where some degree of security and supervision is required.

Locate social spaces to provide views into external areas and avoid dead end corridors.

Provide alternative choice of route around a building allowing people to meet or avoid each other.

Ensure daylight to all corridors or circulation spaces and provide adequate external views to ensure that spaces do not create a sense of fear for patients.

Provide a range of semi private and public spaces outside the private bedroom, which will allow people a different level of participation with the life of the unit.

Provide external covered areas where people can smoke converse or meditate even during inclement weather.

11. Design Solutions

11.1 Design solutions must be integrated with operational policies for people with mental health problems. As these patients are generally not bed bound solutions are likely to differ from those for general acute accommodation. Considerations of security and supervision, as outlined in Section A, will form a major part of these policies.

11.2 For new accommodation the requirements laid down in Health Building Note (HBN 35) and the Design Guide for Medium secure psychiatric units recommends:-

- To preserve patients’ privacy, a requirement for single bedrooms (preferably en-suite) with a minimum of separate washing facilities;

- To preserve patients’ dignity, toilets should either be en-suite, or adjacent to bed areas. Bedrooms should be in physically well-separated areas with doors separating circulation areas;

- Dayspaces may be provided either as part of bed bay areas, or as a separate room. Day spaces can be separated by doors, control positions and common areas.
11.3  For **existing accommodation**, the challenge is to provide facilities within the constraints and layouts of adjacent space and services locations.

- **To preserve patients’ privacy**, single rooms may be provided, and this may be achieved by the suitable sub-division of larger bed bays with complete partitions.

- **To preserve patients’ dignity**, en-suite WCs may be introduced, or external pods added to provide separate sanitary facilities.

- **Dayspaces** may be provided by converting or flexible use of support accommodation to provide a day room, or by using a bedscape to enlarge a bed bay area. Alternatively, day space may be built on externally and may be shared between bed bays.

The design examples at Annex A, indicate methods of addressing the elimination of mixed sex accommodation in new developments and in some existing situations. The diagrams are not intended to represent real designs but divide the component zones and illustrate relationships, which offer varying degrees of segregation.
**ANNEX A**

**New Accommodation**
- Relationships for maximum flexibility
- Relationship for expandability
- Model showing various solutions
- Larger model showing flexibilities
- As above
- As above

**New/Existing Accommodation**
- Single room with external en suite

Alternative en suite solutions and possible modification to provide single sex multi-bed bay solution with day space and toilets (outside bed area)
New Accommodation

Relationships for maximum flexibility
Safety, privacy and dignity in mental health units

Relationship for expandability
Model showing various solutions

Safety, privacy and dignity in mental health units

Ground Floor Plan (as designed)
Larger model showing flexibilities
Larger model showing flexibilities

Safety, privacy and dignity in mental health units
Safety, privacy and dignity in mental health units

Larger model showing flexibilities
New/Existing Accommodation

Single room with external en suite

Safety, privacy and dignity in mental health units
Alternative en suite solutions and possible modification to provide single sex multi-bed bay solution with day space and toilets (outside bed area)