

National Guidelines on Accessible Health and Social Care Services



A guidance document for staff on the provision of accessible services for all



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

people caring for people



Údarás Náisiúnta Míchumais
National Disability Authority

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Thanks also to all of the staff and service users who made submissions during the consultation phase of this work and who were significant stakeholders in the development of these guidelines.

We would also like to thank in advance all those who will, in the coming months, read and implement the guidelines. We hope that the **National Guidelines on Accessible Health and Social Care Services** will be a useful guide for staff and, in turn, will make a real difference to the service user's experience of health and social care services in Ireland.

Foreword

The **Disability Act 2005** is a positive action measure, which provides a statutory basis for making public services accessible. It gives effect to the underlying principle that mainstream public services provided to the general public must also serve people with disabilities as an integral part of the service they provide.

The health service is obliged to ensure that its buildings, its services, the information it provides, and how it communicates with people, are all accessible to people with disabilities. These Guidelines offer the practical guidance to make that a reality.

This document, the **National Guidelines on Accessible Health and Social Care Services** has been written to give practical guidance to all health and social care staff about how they can provide accessible services. While these guidelines refer to specific disabilities, if we take steps to routinely provide accessible services for all, we will positively influence the experience of everybody who uses our services.

The ethos of accessibility is reinforced by **A Future Health, A Strategic Framework for Reform of the Health Service 2012 - 2015**, published by the Department of Health in November 2012; by legislation such as the **Disability Act 2005**, the **Equal Status Acts 2000 – 2008**, by the **National Healthcare Charter 'You and Your Health Service'** and the many other health and social care policies and procedures.

The guidelines describe a standard to which we can aspire. They detail what obligations are in statute to provide accessible services. They also serve as a resource for health and social care professionals who may be planning services in the future.

Many of the key initiatives outlined in the guidelines to make services more accessible are cost neutral. Consideration, compassion and open communication are free. Time spent identifying a person's needs is an investment in safe, effective care which can prevent unnecessary risks to the individual and the staff member, and negative feedback.

We hope that the guidance will help all staff to build on their existing knowledge and to recognise that people with disabilities are often experts in what they need. The key message reinforced throughout the guidelines is Ask, Listen, Learn, Plan and Do.

We look forward to services working in partnership to ensure that the **National Guidelines on Accessible Health and Social Care Services** make a positive difference to the experience of all those who use Ireland's health and social care services.

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1. Introduction

1.1 Providing responsive care for service users

It is important that health and social care services provide appropriate and responsive care for all service users. In the course of their lives, some people will have regular interaction with the health and social care services. They may have a disability or a prolonged illness, or because of a pre-existing condition may be more vulnerable to other illnesses. Many people who have continuous contact with services do not consider themselves ill.

An understanding of the needs of service users with disabilities is important for every person employed or contracted by the HSE.¹ This understanding will help ensure that people who work in the health and social care services, in whatever capacity:

- are equipped with the knowledge and skills to identify and where possible meet the needs of patients with disabilities
- design premises and systems with those needs in mind
- communicate with service users in ways that are appropriate to their needs

1.2 Some key facts about disability in Ireland:

The National Disability Survey 2006 reported that between one in five and one in ten persons has a long-term disability. Most people will experience some degree of disability over the course of their life; however, as people get older, the proportion of people with a disability rises. Based on the following statistic, the number of people with a disability will increase in the coming years:

“Each year the total number of people over the age of 65 years grows by around 20,000 persons and the population over 65 years will more than double to over one million by 2035. People are living longer – those aged over 65 years increased by 14% since 2006.”²

Disability may be classified into a number of groupings, for example:

- physical disability
- sensory disability – impaired sight, impaired hearing, or impaired speech
- intellectual disability
- mental health conditions

The **National Disability Survey 2006** showed that the most common forms of disability in Ireland are, in order of frequency:

1. Difficulties with mobility or dexterity
2. Pain
3. Mental health difficulties
4. Memory difficulties
5. Breathing difficulties
6. Hearing loss
7. Impaired vision
8. Intellectual disability

Disabilities vary in terms of the nature and degree of difficulty experienced for each individual. Some people experience more than one kind of disability at the same time. In general, the number of people with some degree of impairment is much larger than the numbers with total loss of function.

We need to be aware that there are both visible and hidden disabilities

- **Visible disabilities:** Sometimes, it is very obvious that a person has a disability, such as a blind person who uses a white cane or someone who uses a wheelchair
- **Hidden disabilities:** It is not immediately obvious when someone has a hidden disability. Not all people who have a visual impairment need a white stick or use a guide dog. Someone's appearance will not tell you if they have epilepsy, or if they are likely to get panic attacks

Extract from: NDA document "Providing public services to people with disabilities. A Self-Study Guide"

- The most common types of disability in Ireland are mobility disabilities
- About 184,000 people have difficulty walking more than 15 minutes
- About 31,000 people use a wheelchair. Many more people – about 83,000 – use walking aids, or a stick
- Other common disabilities in Ireland are dealing with pain, difficulty remembering information, or having mental health difficulties
- Some people are born with a disability
- Many more people deal with a temporary disability because of injuries or illness

1.3. A range of solutions

Where possible, it is important to offer a range of solutions that meet the individual needs of people with disabilities. Something that works well for a person with a partial loss of function may not be the best solution for someone with a more severe difficulty. For example, someone who walks with difficulty may find it easier to manage steps than a ramp, once there is a handrail, while a wheelchair user would need a ramp to negotiate a change in level.

2. Purpose

2.1 Purpose of guidelines

The purpose of these guidelines is to:

- assist health and social care providers to comply with legal obligations under the **Equal Status Acts**, the **Disability Act 2005**, the associated statutory Code of Practice on Accessibility of Public Services and Information provided by Public Bodies, and health and social care policy and procedures
- assist health and social care providers to meet the principles of the **National Healthcare Charter, You and Your Health Service**
- assist health and social care providers to meet the provisions of the **National Standards for Safer Better Healthcare 2012 (HIQA)**
- provide a resource for Access Officers to support health service staff respond to the access requirements of people with disabilities in all health and social care settings
- provide a guidance document for use in education and training in relation to disability, accessibility and customer care
- provide a reference manual for all staff in all health and social care settings

2.2 Structure of guidelines

The guidelines are divided into two sections – Part One includes guidelines for use in all health and social care settings and Part Two includes guidelines for specific service areas.

While each guideline can be used as a stand-alone document, a greater understanding can be achieved by reading all of the guideline documents.

Part One: Guidelines for all health and social care settings

Guideline One: Developing accessible health and social care services

Guideline Two: Developing disability competence

Guideline Three: Accessible services - general advice

Guideline Four: Communication

Guideline Five: Accessible information

Guideline Six: Accessible buildings and facilities

Guideline Seven: Consent

Guideline Eight: Role of family members and support persons

Part Two: Guidelines for specific services

Guideline Nine: Accessible GP surgeries, health care centres and primary care centres

Guideline Ten: Accessible Hospital Services

Guideline Eleven: Accessible Emergency Departments

Guideline Twelve: Accessible maternity services

The guidelines contain links to further information and resources, as well as contact details for disability organisations.

3. Scope

These Guidelines were developed in a partnership between the National Disability Authority and the Health Service Executive, and with input from an Advisory Group, drawing on:

- research evidence
- focus groups and interviews with people with disabilities and their organisations
- feedback on drafts

A background paper, commissioned by the NDA, sets out the material that underpins this guidance. This paper summarises research findings, reviews other guidance on health services and disability, and considers the points raised in the consultation with Irish disability organisations.

The Guidelines are available in paper and electronic format, and have links to other sources of guidance and information – see Resources section.

4. Legislation and related policies, procedure and guidelines

4.1 Overview of legislation and other related healthcare policy

It is a legal requirement to provide accessible health and social services for service users. The following section, while not exhaustive, sets out the key pieces of legislation and policy which are important in providing accessible services for people with disabilities.

The **National Guidelines on Accessible Health and Social Care Services** are written to complement existing policies, procedures and legislation governing health and social care in Ireland. The guidelines do not replace other policies of the HSE or indeed contravene existing legislation in any way.

These guidelines should be read in conjunction with other governing documents of the HSE and the legislation so that staff can provide the best possible service to all patients and service users of health and social care services. Matters appropriate to other procedures will continue to be treated in the same manner and in accordance with these agreed procedures.

Examples of relevant documents include: **National Consent Policy; National Healthcare Charter; Equal Status Acts 2000 – 2008; Integrated Care Guidance: A practical guide to discharge and transfer from hospital; Your Service Your Say – Policy and Procedure for the Management of Consumer Feedback to include Comments, Compliments and Complaints; On Speaking Terms; the Medical Council Guide to Professional Conduct and Ethics for Registered Medical Practitioners; the Disability Act 2005 and the Health Act 2004.**

The **National Guidelines on Accessible Health and Social Care Services** will be reviewed at regular intervals to ensure that the content of the document is in line with new policy changes or developments in healthcare.

The following are some of the key documents for your information.

4.2 The National Healthcare Charter, You and Your Health Service

The **National Healthcare Charter, You and Your Health Service** was developed following wide consultation with and input from the Irish public, service users, staff, the voluntary and statutory sector, patient advocacy groups and individual advocates, the management team of the HSE, the Department of Health, the Health Services National Partnership Forum and regulatory bodies.

The result of this consultation is a charter document which sets out eight principles of expectation and responsibility which underpin high quality, people-centred care. The first principle of the charter “Access” sets out our commitment to provide health and social care services which are organised to ensure equity of access to all who use them. The charter also clearly acknowledges that patients and service users have responsibilities to meet so that they are active participants in their care.

4.3 Future Health, A Strategic Framework for Reform of the Health Service 2012 – 2015

Future Health will allow the health and social care services to move towards a new integrated model of care that treats patients at the lowest level of complexity that is safe, timely, efficient and as close to home as possible. In providing accessible care, as outlined in these guidelines, services will support the goals of **Future Health** to provide care that is preventative, planned and well-coordinated.

**Extract from: Future Health, A Strategic Framework for Reform of the Health Service
2012 – 2015**

Keeping People Healthy: The system should promote health and wellbeing by working across sectors to create the conditions which support good health, on equal terms, for the entire population.

Patient-centredness: The system should be responsive to patient needs, providing timely, proactive, continuous care which takes account, where possible, of the individual’s needs and preferences.

Lack of Integration: “We need much better integrated delivery systems based on multi-disciplinary care. This will reduce costs and improve quality.”

“Achieving integrated care means that services must be planned and delivered with the patient’s needs and wishes as the organising principle. It is preferable that the term integrated care rather than “integration” be used so that it is clear that the focus is where it should be i.e. on patients and families and the services they need rather than on funding systems, organisation or professionals. Each of these will be important levers in enabling and facilitating integrated care – but they in themselves are not the objectives.”

In practical terms, this means that services must recognise that people with disabilities have a degree of expertise in the own requirements and that, by the applying the guidelines “Ask, Listen, Learn, Plan, Do”, services can provide more integrated care. (See Guideline One: Developing Accessible Health and Social Care Services for more information).

Different health service settings or specialties should not operate as individual silos unless there is good reason. Liaison between professionals is important to identify the services needed for individuals and to enable professionals to deliver integrated care that is centred on the individual and their needs. This should happen in whatever setting those needs are met from time to time. For example, where appropriate:

- Teams working in primary, specialist, rehabilitation and hospital care can share their knowledge and experience so that person-centred care becomes the norm
- Those treating general illnesses can liaise with those providing specialist care or support for the underlying disability; and
- Hospitals can put in place discharge planning and follow-up with the person’s GP and specialist disability support, to ensure continuity of care and support on discharge. This is essential, especially for those with a severe and prolonged disability

4.4 Integrated Care Guidance: A practical guide to discharge and transfer from hospital

Professionals should refer to the **Integrated Care Guidance: A practical guide to discharge and transfer from hospital**.³

4.5 The Equal Status Acts 2000 – 2008

The Equal Status Acts 2000 - 2008⁴ apply to all services in the public, voluntary and private sectors. These Acts make discrimination on grounds of disability illegal.

The Acts also require reasonable accommodations of people with disabilities and allow a broad range of positive action measures. Services and premises must reasonably accommodate someone with a disability. However, they are not obliged to provide special facilities or treatment when this costs more than what is called a nominal cost. What amounts to nominal cost will depend on the circumstances, such as the size and resources of the body involved.

³ This practical guide to integrated care is designed to support healthcare providers to improve their discharge and transfer processes from the acute hospital setting back into the community and thereby, support the delivery of high quality safe care. The National Integrated Care Guidance has been developed by the National Integrated Care Advisory Group under the auspices of the Quality and Patient Safety Division. <http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/integratedcareguidance/IntegratedCareGuidancetodischargefull.doc.pdf>

⁴ The Equal Status Acts 2000–2008 promote equality, makes sexual harassment and harassment, victimisation and certain kinds of discrimination (with some exemptions) across nine grounds illegal. One of these grounds is disability.

The definition of disability covers the broad range and kinds of disability, and is not limited to people with more serious difficulties. It is broadly defined, including people with physical, intellectual, learning, cognitive or emotional disabilities and a range of medical conditions. Further information on the Equal Status Acts 2000 – 2008 is available from the Equality Authority <http://www.equality.ie/en/Publications/Information-Publications/Your-Equal-Status-Rights-Explained.html>.

4.6 Part 3, Disability Act 2005

Part 3, Disability Act 2005 (Access to Buildings and Services and Sectoral Plans) covers the public sector, and its focus is on those who experience more significant difficulties.⁵ It sets out what public bodies must do where this is practicable and appropriate, as follows:

- Mainstream services must include people with disabilities
- Where a person with a disability requests it, they must be given assistance to use a service
- Public services, in communicating with people with disabilities, must use appropriate forms of communication when communicating with people; for example, with people who have problems with vision, problems with hearing, or those who have an intellectual disability
- Public areas must meet minimum standards of accessibility. By end 2015, they must meet the standards set out in Part M of the Building Regulations 2000 and, by January 1 2022, they must meet the standards set out in Part M of the Building Regulations 2010; and
- The goods and services procured must be accessible to people with disabilities

Under the legislation, as a public body, the health service must have at least one Access Officer to provide or arrange the provision of assistance and guidance for people with disabilities when they are accessing its services.

The Health Service Executive has a National Complaints Officer (referred to as an Inquiry Officer in the act) who deals with appeals and complaints about failure to provide accessible services, premises, information or communication. There is a further avenue of appeal to the Ombudsman.

4.7 National Disability Authority Code of Practice and Guidance

There is a statutory **Code of Practice on Accessibility of Public Services and Information provided by Public Bodies**⁶ which gives guidance on how to comply with the Disability Act requirements. Compliance with the Code of Practice is taken as compliance with the Act.

⁵ The legal definition of disability in relation to a person means “a substantial restriction in the capacity of that person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment”

⁶ <http://nda.ie/Good-practice/Codes-of-Practice/Irish-Code-of-Practice-on-Accessibility-of-Public-Services-and-Information-Provided-by-Public-Bodies/>

For further information, see the Guide to the **Disability Act 2005** (http://www.justice.ie/en/JELR/Pages/Guide_to_Disability_Act_2005).

The National Disability Authority's accessibility toolkit (<http://accessibility.ie>) contains general information on how to make services, buildings, information and websites more accessible to people with disabilities. This website is updated regularly.

4.8 National Consent Policy

Extract from the National Consent Policy:

“Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him / her to understand the nature, potential risks and benefits of the proposed intervention or service.”⁷

The need for consent extends to all interventions conducted by or on behalf of the HSE on service users in all locations. The ethical rationale behind the importance of consent is the need to respect the service user's right to self-determination (or autonomy) – their right to control their own life and to decide what happens to their own body.

It includes social, as well, as health care interventions and applies to those receiving care and treatment in hospitals, in the community and in residential care settings. How the principles are applied, such as, the amount of information provided and the degree of discussion needed to obtain valid consent, will vary with the particular situation. Except in emergency situations, an interpreter proficient in the service user's language is required to facilitate the service user in giving consent for interventions that may have a significant impact on his or her health and well-being. Where practicable, this is best achieved in most cases by using a professional interpreter.

Knowledge of the importance of obtaining consent is expected of all staff employed or contracted by health and social care services. To ensure that they are aware of their obligations when seeking consent and for guidance on obtaining valid consent from people with disabilities, staff should read the **National Consent Policy**.

4.9 The National Emergency Medicine Programme

Professionals should refer to **The National Emergency Medicine Programme – A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland**. This document gives helpful advice specific to the Emergency Medicine programme relevant to accessibility.

4.10 Other

The **UN Convention on the Rights of Persons with Disabilities (CRPD)**, which was adopted on 13 December 2006 and signed by the Irish Government in December 2007, has not yet been ratified. This and emerging legislation, such as the **Assisted Decision Making (Capacity) Bill** and the Health Information Bill, may impact on the content of guidelines and require them to be reviewed at the appropriate time.

5. Glossary of Terms / Definitions

5.1 Glossary

In these Guidelines, the term ‘accessible’ means user-friendly for people with disabilities.

Accessible building

An accessible building is one that people with disabilities can readily enter, move around, use comfortably and exit safely.

Accessible communication

Accessible communication means communicating with people with disabilities in ways they can readily follow.

Accessible information

Accessible information means that people with disabilities can readily access and understand it.

Accessible service

An accessible service is one which is geared to serve people with disabilities alongside other service users.

Disability

The legal definition of disability, as set out in the Disability Act 2005, used in relation to a person means “a substantial restriction in the capacity of that person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment”

Easy to read

Easy to Read is the term for very simplified text with pictures, which is important for people with literacy problems or limited English.

Health and Social Care Professional

Health and social care professional is generally used as an umbrella term to cover all the various health and social care staff who have a designated responsibility and authority to obtain consent from service users prior to an intervention. These include doctors, dentists, psychologists, nurses, allied health professionals, social workers.

Plain English

A way of presenting information that helps someone understand it the first time they read or hear it.

Service user

We use the term 'service user' to include:

- People who use health and social care services as patients
- Carers, parents and guardians
- Organisations and communities that represent the interests of people who use health and social care services; and
- Members of the public and communities who are potential users of health services and social care interventions

The term 'service user' also takes account of the rich diversity of people in our society, whether defined by age, colour, race, ethnicity or nationality, religion, disability, gender or sexual orientation, and who may have different needs and concerns.

We use the term 'service user' in general, but occasionally use the term 'patient' where it is most appropriate.

5.2 Appropriate Terms to Use

When writing or speaking about people with disabilities, it is important to put the person first. Catch-all phrases, such as ‘the blind’, ‘the Deaf’ or ‘the disabled’, do not reflect the individuality, equality or dignity of people with disabilities.

Listed below are some recommendations for use when describing, speaking or writing about people with disabilities.

Some examples of appropriate terms:

Term no longer in use:

the disabled
wheelchair-bound
confined to a wheelchair
cripple, spastic, victim
the handicapped
mental handicap
mentally handicapped
normal
schizo, mad
suffers from (for example, asthma)

Term Now Used:

people with disabilities or disabled people
person who uses a wheelchair
wheelchair user
disabled person, person with a disability
disabled person, person with a disability
intellectual disability
intellectually disabled
non-disabled
person with a mental health disability
has (for example, asthma)

Reproduced from the **NDA Guidelines on Consultation**

Source: Making Progress Together, 2000 - People with Disabilities in Ireland Ltd.

5.3 Abbreviations

ASL	American Sign Language
BSL	British Sign Language
CD	Compact Disc
DCSP	Directorate of Clinical Strategy and Programmes
DHSSPS	Department of Health, Social Services and Public Safety
DVD	Digital Versatile Disc
ECN	Emergency Care Network
ED	Emergency Department
EDD	Estimated Date of Discharge
EDIS	Emergency Department Information Systems
ELOS	Estimated Length of Stay
EM	Emergency Medicine
EMA	Emergency Multilingual Aids
EMP	Emergency Medicine Programme
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
IRIS	Irish Remote Interpreting Service
ISL	Irish Sign Language
IT	Information Technology
LIU	Local Injury Unit
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
NALA	National Adult Literacy Agency
NCBI	National Council for the Blind of Ireland
NDCS	National Deaf Children's Society
NDA	National Disability Authority
NECS	National Emergency Care System
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence

NPSA	National Patient Safety Agency
PA	Personal Assistant
PDD	Patient Discharge Data
PHN	Public Health Nurse
PPG	Policy, Procedure or Guideline
SCIE	Social Care Institute for Excellence
SDU	Special Delivery Unit
SLIS	Sign Language Interpreting Service
UK	United Kingdom
UN	United Nations
US	United States
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WC	Water Closet

6. Roles and Responsibilities

6.1 All Staff

Each member of staff working in health and social care services has a responsibility, relevant to their own role, to ensure that services are accessible to people with disabilities, and that their interactions and communication with people with disabilities are appropriate, respectful, and are delivered in ways that people with disabilities can receive and understand.

Medical, nursing, and other professional and therapy staff have a responsibility to listen and to communicate appropriately, and to take account of concurrent issues in relation to the person's disability in their treatment programmes.

Receptionists and administrative staff have a responsibility to ensure that people with disabilities are informed of appointments and are called for their turn in ways that can be received and understood.

Care assistants, porters, catering and cleaning staff who interact with patients and service users in the course of their work have a responsibility to communicate in ways that can be understood.

Maintenance and cleaning staff may maintain accessibility of buildings and facilities by ensuring that there are no obstructions which could hinder accessibility or cause a hazard.

Frontline staff should seek to resolve, at all times, concerns and queries from patients and service users at the first point of contact with the patient / service user and / or their advocate. Where this is not possible, they should seek advice from the relevant line manager or from a specialist disability organisation, depending on the issue. If the issue cannot be resolved at this level, further advice can be sought from the Access Officer.

6.2 Senior management role

Senior managers have a responsibility to support and promote the provision of accessible services for all service users. All health and social care management should aim to ensure that the capacity of the service is developed to fully support people with disabilities in mainstream health services. The following are key tasks / responsibilities for senior managers:

To comply with all policies, procedures and legal obligations:

- Ensure compliance with legal responsibilities under the **Equal Status Acts 2000 – 2008 and the Disability Act 2005.**

To provide leadership to other staff:

- Set out roles and responsibilities
- Ensure all other staff access appropriate disability training
- Ensure access officer(s) are in place and are released for and have accessed appropriate training; and
- Ensure that staff are aware of the National Healthcare Charter and the 8 principles of Access, Dignity and Respect, Safe and Effective Services, Communication and Information, Participation, Privacy, Improving Health, Accountability, the availability of these guidelines and other relevant policies

To ensure that all mainstream service planning, service delivery or performance evaluation systems are developed so that services are accessible for all service users and support compliance with the relevant policies, procedures, guidelines and legislation:

- Integrate accessibility into service planning in each service; for example:
 - Build-in systems to ensure the individual's needs are co-ordinated across different levels or centres of care
 - Develop patient and service user information systems that ensure that the accessibility requirements of service users and information on managing any pre-existing conditions can follow through their patient journey across different health services
- Ensure that delivering on accessibility requirements is built into systems for managing and monitoring performance of staff and departments; and
- Budget to meet accessibility commitments

To ensure that, as part of the regular planning cycle, senior managers set goals and clear priorities which will allow them to meet legal requirements and enhance accessibility:

- Set goals and clear priorities for achieving accessibility
- Set key performance indicators or comply with the provision of data for existing national performance indicators on accessibility
- Ensure there are policies and / or protocols that set out how accessibility is to be achieved in each local area; and
- Put in place a system for reporting and reviewing what has been achieved and for planning and agreeing the next steps

6.3 Access Officer role

The appointment of Access Officers is a legal obligation under Part 3 of the **Disability Act 2005**. The Act requires that Access Officers be appointed to all sites where the general public use health and social services. The Act also extends to organisations that have a service agreement with the HSE; for example, those organisations that are funded under Section 38 and 39 of the **Health Act 2004**.

Section 26 (2) of the **Disability Act 2005** requires health and social care services to authorise at least one member of staff to act as an 'Access Officer', to provide or arrange for and co-ordinate the provision of assistance and guidance to persons with disabilities in accessing its services. Please note, this is not specifically the role of staff from Disability Services, and staff from any background should be considered.

Given that the HSE provides health and social care services in hundreds of locations throughout the country, access officers are necessary where there are service users, patients and clients; for example, hospitals, primary care centres, health and social care clinics and / or locations where health and social care is delivered.

The role is not limited to physical access, such as car parking, ramps or wheelchair access, but extends to all aspects of the patient / service user journey including the provision of accessible information, consultations and procedures, appointments and applications for service provision.

It is the duty and role of all health and social care professionals at all levels to attend to the access needs of people with disabilities. Access Officers will not replace this duty. Rather, Access Officers will provide additional support to frontline services to attend to the access needs of people with disabilities.

Most access and disability issues are already being managed effectively by frontline services on a day-to-day basis. This role will not take from this existing practice. In instances where an issue cannot be dealt with locally, this matter can be referred to the National Specialist in Accessibility for further support. The HSE appointed a National Specialist in Accessibility in 2010 whose role is to provide guidance, advice and strategic support in the promotion of access to mainstream health services for people with disabilities.

People with disabilities face many barriers in accessing health and social care services. Some of these barriers are owing to a poor physical environment. However, most of the existing barriers are owing to a lack of understanding of how to accommodate a person's disability. Access Officers will play a key role in supporting the organisation to address some of these barriers and, in doing so, in ensuring greater accessibility for people with disabilities. The role is designed to support health service staff respond to the access requirements of people with disabilities in all health and social care settings. Access officers will be provided with on-going comprehensive training, information and resources materials to enable them carry out this role.

The role of an Access Officer in health and social care services is to support health service staff to respond to the access requirements of people with disabilities in all health and social care settings. The main duties of an Access Officer are to:

- Respond to and deal with requests from health service staff for assistance regarding access issues where such requests have not been dealt with or cannot be managed at the first point of contact
- Advise health service staff on the provision of information in an accessible format
- Develop protocols for responding to specific requests for assistance and document how such assistance can be sourced
- Disseminate information on best practice regarding accessibility
- Liaise with relevant disability organisations if necessary and / or support frontline services to do so as appropriate
- Log and appropriately record responses to requests and queries
- Promote awareness of the role of access officer as appropriate
- Liaise with the National Specialist in Accessibility and

It is not the role of an Access Officer to:

- Provide one-to-one advocacy for people with disabilities
- Relieve frontline staff of their access responsibilities to patients / clients / service users
- Be a one stop shop on all matters of disability; and
- Deal with complaints (these should be directed through **Your Service, Your Say**). If the issue cannot be resolved or the patient / service user is not satisfied with how the issue has been dealt with, s/he can refer the matter to the HSE complaints system, '**Your Service, Your Say**' or may refer the issue onwards to the Office of the Ombudsman or the Office for the Ombudsman for Children. Further details of 'Your Service, Your Say' are available on www.hse.ie

Part One

Guidelines for all Health and Social Care Settings

The guidelines describe a standard which we can aspire to. They are written in the knowledge that services may not have financial resources to implement all measures outlined; however, there is an obligation on individuals to ensure that they know what is required of them by law. They also serve as a resource for health and social care professionals who may be planning services in the future.

Many of the key initiatives you can take to make services more accessible are cost neutral. Consideration, compassion and open communication are free. Time spent identifying a person's needs is an investment in safe, effective care which can prevent unnecessary risks to the individual and the staff member.

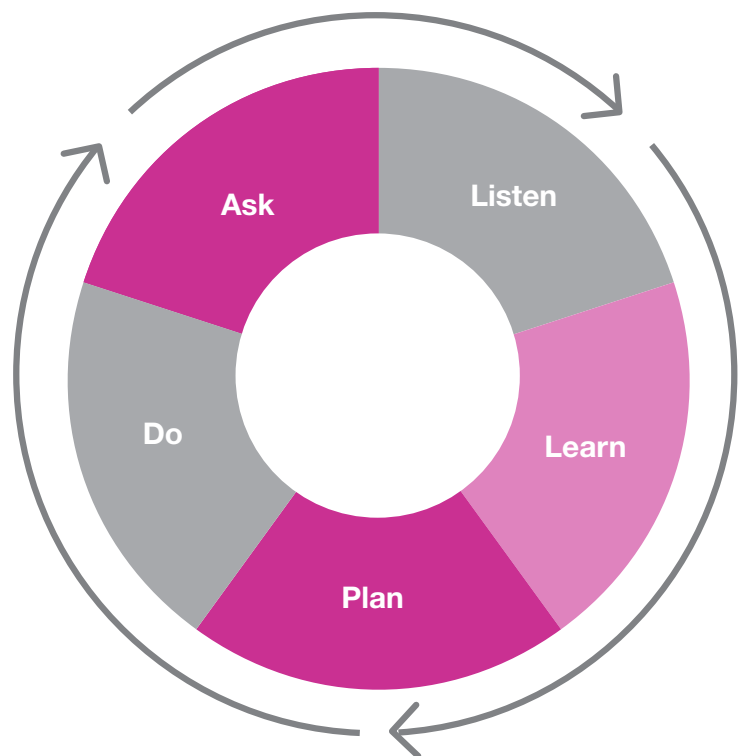
1. Guideline One

Developing accessible health and social care services

1.1 Ask, Listen, Learn, Plan, Do

Mainstream systems and practices should be designed to ensure that they are accessible for all services users. When developing accessible services, the following approach may be of assistance to you: Ask, Listen, Learn, Plan, Do. Figure 1 is a circular diagram which is a visual representation of the Ask, Listen, Learn, Plan, Do process. It also demonstrates the cyclical or recurring nature of this process.

Fig. 1:
Developing
accessible services



Ask

Consult with individuals, advocates, disability organisations and staff working closely with individuals to identify patient and service user needs in your area.⁸

- Ask simple questions to find out if service users have any specific requirements that must be accommodated; for example, “Is there anything we can do to assist you?”
- Become aware of what could constitute obstacles or difficulties for people with disabilities using your services
- With the consent of the person with a disability, family members, carers or support workers may also be able to guide on any specific needs

Listen

Recognise that people with disabilities and staff, family members, personal assistants, advocates and disability organisations working closely with individuals are often experts in patient and service user needs.

- Listen attentively to their feedback
- Listen to any suggestions made for addressing their requirements

Learn

Ensure that you have sufficient information to help you to improve service provision.

- Complete any necessary research so that you can learn about the requirements of individuals
- Read the relevant policies, procedures, guidelines and legislation

⁸ The National Advocacy Unit provides guidance on service user involvement and participation.

Plan

While it will not always be possible to meet patient or service user requirements, health and social care services can strive to understand service user needs and, where reasonable, practical and appropriate, they can make positive changes to how services are provided. Where appropriate:

- Set out a programme of action to address identified issues
- Develop a plan in consultation with relevant people to support you to make the services you provide more accessible
- Set out clear protocols and guidance for staff
- Build in coordination across different levels of care
- Set out roles and responsibilities
- Establish and embed policies

Do

Adopt policies and protocols that:

- set out the standard steps to follow to achieve accessible services; and
- integrate accessibility into your general protocols for service provision
- Implement the adopted policies and protocols
- Provide clear leadership
- Provide training and mentoring
- Establish systems to monitor and review delivery in practice
- Offer a feedback and complaints mechanism
- Ensure feedback informs review of policies and practices
- After a period of time it will be necessary to begin the cycle again

1.2 Examples of policies, procedures or guidelines for staff

When an agreed standard policy, procedure or guideline (PPG) is in place and implemented, staff are aware of what they can do locally to make services more accessible. Please note that the HSE PPGs are available on the intranet site.

Examples of policies, procedures or guidelines (PPGs) which are advisable for services, or where there are pre-existing national health and social care service PPGs which staff should adopt and apply locally, are detailed below:

- Identifying a person's accessibility requirements
- Reviewing pre-admission planning, in-patient care and discharge planning to ensure that they are accessible (See **Integrated Care Guidance: A practical guide to discharge and transfer from hospital**)
- Co-ordination of care across General Practice (GP) and hospital services and liaison with the team dealing with the person's primary disability, where appropriate, and maintaining confidentiality as is required dependent on the case
- Patient consent (See **National Consent Policy**) and decision-making
- Evacuation in an emergency from health or social care settings
- Ensuring that buildings are well-maintained, that all accessibility features are operating correctly
- Ensuring that there are no obstructions which could hinder accessibility or cause a hazard

2. Guideline Two

Developing disability competence

2.1 Building capacity and understanding for all staff

All health and social care staff should display a positive attitude towards service users. Appropriate training is key to ensuring that staff:

- are aware of the patient and service users needs in the area of accessibility and specific accessibility concerns for people with disabilities, and
- develop the competence and confidence to address these effectively

People with disabilities can face a range of accessibility problems or barriers. For example:

- buildings
- transport
- equipment
- failure to communicate in appropriate ways
- lack of accessible information
- attitudes
- ignorance
- discrimination

Disability training can help staff recognise these barriers and learn practical ways in which they can be addressed.

Local managers should facilitate capacity building for staff. This can be done by arranging awareness training which includes general material on accessible services and communication, as well as tailored training relating to the specific role and setting.

2.2 Online training resource

The National Disability Authority's Disability Equality Training e-learning is available online at elearning.nda.ie, and also on HSELand.ie, the HSE's online resource for Learning and Development (www.hseland.ie) under "Personal Development". This course is free of charge; it takes about an hour and a half to complete and provides a general introduction to customer service for people with disabilities.

2.3 Tailored disability training

In some instances, it can be helpful to have training which is tailored to inform participants about a particular disability. For example, Deaf awareness training can explore communicating with Deaf people in more depth.

2.4 Professional education, training and professional standards

Professional education and training and continuous professional development of health and social care personnel should routinely include training on accessibility as an intrinsic part of their curriculum.

Medical, nursing and therapy schools, professional training bodies, such as the colleges of professional specialties, and regulatory bodies, such as the Irish Medical Council, have a role to play in this regard. Standards set by professional bodies should make provision for accessibility issues.

Staff providing general health and social care need to receive appropriate training to allow them to competently support patients and service users presenting for treatment of medical conditions other than their disability.

Clinical, nursing and allied health professionals should receive training in managing the interplay of different medical conditions and, in particular, where a person's disability may impact on their care plan; for example, how to care for:

- A patient with a spinal injury when they are in hospital with an unrelated condition, as they may need additional supports regarding posture, bowel care and avoidance of pressure sores; or
- A patient with a cognitive impairment who presents with a fractured hip, when they may forget that they need to immobilise it; or
- A patient who is in labour when they are Deaf

3. Guideline Three

Accessible services - general advice

3.1 Do not assume - ask

People with disabilities are generally experts on their specific accessibility requirements. Not everyone with a disability needs assistance and an accessibility need may not be apparent, so it is important to:

- Ask each person if they would like assistance and about any special requirements they may have
- Ask for instructions, if an offer of help is accepted
- Listen attentively to what their requirements are and how they can be addressed
- Allow the person to help and direct you, if you do not know what to do. The person will indicate the kind of help that is needed
- Not be offended if your help is not accepted, as many people do not need any help; and
- Document any relevant accessibility or communication resources or requirements

Do not assume that a person with a disability would be unable to answer questions about their health or their symptoms. Ask the person themselves in the first instance.

3.2 Making an appointment

Identify any accessibility requirements

When booking, for example, appointments or procedures, contact the person and provide them with an opportunity to inform you of any accessibility requirements.

Primary contact for appointments is usually by letter. However, where services are aware of a disability, primary and / or follow-up contact should be appropriate to the person's needs, and may be made by letter, telephone, email⁹ or text message.

Establish from service users their preferred method of communication, taking into consideration their level of disability; for example, it may be necessary for a person with a visual impairment to receive communication via email or telephone instead of letter.

It is important to note that the method of communication may be different for each person depending on their disability. Also, two people with the same disability may have different communication needs.

Two way appointment systems

Many appointment systems are one-way only or require a person to telephone if they want to change their appointment. These are inaccessible to people who are Deaf or have impaired speech. It is essential to have a two-way system so that all service users may respond; for example, to cancel or change an appointment. This may mean reviewing the existing response methods in an area. Have a system in place to ensure that such messages are responded to promptly.

Using text messages

Where available, use a mobile number or a telephone landline that accepts text messages. (Please note text message services are not available in all areas at present).

- Publicise the number in your service user information; for example, on your website and in your hospital, GP surgery or health centre
- If text is the method used, always give a quick acknowledgment to a text message, even if you do not know the answer to the question that is asked, so that the person knows you have received their message

3.3 Show flexibility when scheduling appointments

Please note that the following section does not mean that preferential treatment will be given to people with disabilities, but rather that services should exercise consideration for the circumstances of a case where appropriate.

Setting an appointment time

Where possible, services should be flexible about appointment times and visiting hours where they impact on the provision of accessible services. For example:

- Early morning appointments may be unrealistic for people who need more time to get ready or who need a carer or Personal Assistant to help them
- Finding accessible transport may also be more difficult early in the morning
- A later appointment may facilitate family members, personal assistants, or support persons to accompany a person with a disability to attend an appointment or to be there to assist with feeding, drinking, or using the toilet as necessary

Minimising the waiting times for an appointment

It may be appropriate, when possible, to minimise waiting times for a person with a disability when they are attending for appointments where their disability may cause them to experience

unnecessary anxiety, distress or pain. For example, a person with a cognitive disability may become agitated or distressed in a new environment or find remaining in one place for a long time difficult.

It can be helpful to take this into consideration when scheduling appointments; for example, the first appointment after lunch may have the shortest waiting time. It can be helpful to schedule appointments with an interpreter so that waiting times and cost of interpretive services are minimised.

Allow additional time for appointments where necessary

Some service users may need more time to communicate effectively with you. Schedule longer appointments where necessary; for example, in cases where the person has a cognitive impairment or impaired speech, or the person communicates through lip-reading or via an interpreter.

Allow enough time for a person with a disability to get from one place to another at her / his own pace.

3.4 Missed appointments

When a person with a disability misses an appointment, it can be helpful to check whether this was due to inaccessible information or to an inaccessible building or service. Act on the feedback provided.

3.5 Plan visits for routine check-ups or surgery in advance

Where there is a pre-planned visit, such as a routine check-up or pre-planned surgery, it is possible to identify and plan in advance to meet any accessibility requirements.

Contact the person before admission and provide them with an opportunity to inform you of any accessibility requirements they will have on the day.

A pre-visit may be helpful in some situations to familiarise the staff and patient. For example, pre-visits to a hospital or clinic can help build trust for a person with an intellectual disability, so that they are more comfortable and in control when they are admitted to hospital or when they attend for treatment.

Let other staff know when and where the person is arriving and what the plan is.

3.6 Queuing to be seen

Visual Display Units in waiting rooms and public areas can inform people of appointments, directions, information or queuing information. A visual system could be a ticket machine, a visual display or a white board.

If possible, have both an audible and visual system for letting people know their turn. This is to ensure that people with impaired vision and people who are hard of hearing or Deaf are aware that they are being called for their turn.

If you use a ticket system for the queue, ensure that the ticket machine is at a height where a wheelchair user or a person of short stature can reach it (and that there is an alternative for people who are blind).

Inform people how they will be called and the location of the visual display units, so that they can sit where they can see or hear when they are called.

In the absence of a visual display unit in the waiting room, make sure that people with impaired vision or those who are Deaf or hard of hearing are informed when it is their turn to be seen.

3.7 Filling forms

Ask if the person needs assistance filling in a form.

Services should also consider having easy-grip pens available for those with manual dexterity problems.

If the receptionist's counter is too high, for example, for a wheelchair user, you may need to step around it to complete your business with the patient / service user.

A clipboard can be helpful for people unable to reach the counter when filling out forms or signing documents.

If possible, it may be helpful to provide the option for the form to be accessed and completed on-line in advance of an appointment.

3.8 Information and notices

Provide information about how you can accommodate someone's disability; for example:

- Contact details for the person who will deal with queries about accessibility if you cannot answer their query
- The symbol for a hearing loop, if available
- A notice about your policy on Guide Dogs and Assistance Dogs; and
- A notice on the provision of an Irish Sign Language Interpreter on request

3.9 Mobility aids

Many people with physical disabilities rely on mobility aids, such as manual and electric wheelchairs or mobility scooters, and walking aids, such as crutches, walking frames and walking sticks. **Do not:**

- move mobility aids without permission from the owner (unless they are causing an obstruction which urgently needs to be moved)
- push a person's wheelchair or take the arm of someone walking with difficulty, without first asking if you can be of assistance
- lean against a person's wheelchair when talking to them. For a wheelchair user, their chair is part of their personal space

3.10 Focus on the person

During a consultation, focus on the person, not their disability. There can be a risk that clinicians could attribute symptoms to a person's underlying disability, and thus miss some signs of an unrelated health condition.

- Take the person's presenting health condition / clinical needs into consideration.
- Give consideration to their underlying disability and the potential impact (if any) of the same on the presenting health condition and / or their care plan
- Be flexible in order to address individual needs

3.11 Concurrent therapeutic or care needs

An individual's primary disability or other pre-existing condition may involve specific treatment or care protocols. It is important to know about these when diagnosing and treating another condition.

-
- Talk to the person, their carer, GP, consultant or key worker in their disability support service as appropriate, as they are important sources of information
 - Identify any specific care or therapeutic requirements related to existing health conditions or to their disability, such as requirements in relation to personal care, feeding, lifting, posture, prevention of pressure sores or bowel care

3.12 Maintain confidentiality

Confidentiality is a basic principle in the provision of health and social care.

A person's privacy could be compromised if there is intimate or sensitive information being conveyed or discussed with third parties without their consent.

Health and social care providers should be mindful of this when communicating with third parties, such as family members, personal assistants, staff, advocates etc. Staff should use their discretion to ensure that they do not compromise the individual's right to confidentiality.

Relying on children and family members to interpret or translate is not recommended on ethical and legal grounds. The document '**On Speaking Terms**' (<http://www.hse.ie/eng/services/publications/>) gives more information on this. However, there may be some situations where this is unavoidable; for example, an emergency situation where a family member is asked to translate for a Deaf service user. However, this should be the exception. Children should not be asked to interpret or translate for their parents.

3.13 Health Promotion

All patients and service users should be considered in the development of any health promotion strategy:

- Provide health promotion information and guidance in a range of accessible formats
- Ensure people with disabilities are included in any population screening programmes and health checks as deemed clinically appropriate; for example, a mammogram

Health screening premises and equipment should be designed so that all patients and service users can use them. If this is not the case, efforts should be made to offer an alternative. For example, a Magnetic Resonance Imaging (MRI) scan requires a patient to remain still for a period of time; some patients may need sedation prior to undergoing this scan.

3.14 Integrated Discharge Planning

“To ensure service users are discharged or transferred safely and on time requires full assessment of their individual healthcare needs, planning and co-operation of many health and social care professionals.”¹⁰

Make a plan for continuity of care and support after discharge in accordance with the **Integrated Care Guidance: A practical guide to discharge and transfer from hospital**. The following nine steps are taken from the document “**Discharge and transfer from hospital—The nine steps quick reference guide**”.

“Discharge and transfer from hospital—The nine steps quick reference guide”.

Step one: Begin planning for discharge before or on admission

Pre-admission assessments conducted for planned admissions to hospital, such as elective procedures, or alternatively at first presentation to the hospital for unplanned admissions.

- Most accurate pre-admission medication list should be identified prior to administration of medication in the hospital
- Prior history of colonisation with a multi-drug resistant organism, example, Methicillin-resistant Staphylococcus Aureus (MRSA) or healthcare associated infection should be recorded in healthcare record, and healthcare staff informed as per local hospital policy
- Timely referrals are made to multidisciplinary team and receipt of referrals recorded on integrated discharge planning tracking form within 24 hours of receiving referral

NOTE: this includes referrals from hospital to primary care services

- Each service user should have an estimated length of stay (ELOS) / estimated date of discharge (EDD) identified within 24 hours of admission and documented in the healthcare record, related to the estimated length of stay required (Special Delivery Unit, 2013)

Step two: Identify whether the service user has simple or complex needs

The service user’s needs are assessed either prior to admission or on first presentation and indicate whether the service user has simple or complex needs.

- The ELOS / Predicted Date of Discharge (PDD) is determined by whether the service needs are simple or complex
- The service user is placed on an appropriate clinical care programme care pathway, relevant to the service user’s diagnosis, to support seamless care and management

Step three: Develop a treatment plan within 24 hours of admission

All service users have a treatment plan documented in their healthcare record within 24 hours of admission, which is discussed and agreed with the service user / family and carers.

- The treatment plan includes a review of pre-admission against admission medication list, with a view to reconciliation
- Changes to the treatment plan are communicated to the service user and relevant primary care services as appropriate, and documented in the healthcare record

Step four: Work together to provide comprehensive service user assessment and treatment

The multidisciplinary team comprises of the appropriate healthcare professionals to proactively plan service user care, set goals and adjust timeframes for discharge where necessary.

- Regular multidisciplinary team meetings or case conferences for complex care cases are held where appropriate
- Roles and responsibilities for proactive management of discharge are clarified

Step five: Set a predicted date of discharge / transfer within 24 – 48 hours of admission

The ELOS / PDD is identified by the admitting consultant in conjunction with the multi-disciplinary team, during pre-assessment, on post admission ward round or within 24 hours of admission to hospital (for simple discharges) and 48 hours (for complex discharges), and documented in the healthcare record.

- The ELOS / PDD is agreed by specialty and proactively managed against a treatment plan by a named accountable person (SDU, 2013)
- The ELOS / PDD is displayed in a prominent position
- Changes to the treatment plan and ELOS / PDD are documented in the healthcare record (SDU, 2013)

Step six: Involve service users and carers so they make informed decisions and choices

The treatment plan is shared with the service users, and they are encouraged to ask questions about the plan.

- Develop information pack for service user / carer, example, medications list, care of any indwelling devices such as intravascular lines or urinary catheters, wound care and instructions for the service user to share with their GP, community pharmacist and other relevant healthcare provider
- Counsel and educate the service user, considering the needs of service users with poor vision, hearing difficulties, cognitive deficits, cultural and language barriers.

Step seven: Review the treatment plan on a daily basis with the service user

Practitioners talk to the service user daily about progress.

- The treatment plan is monitored, evaluated and updated (where necessary) and changes to the treatment plan and ELOS / PDD are documented in the healthcare record (SDU, 2013)
- Any problems or actions required are identified and are escalated or resolved as necessary

Step eight: Use a discharge checklist 24 – 48 hours before discharge

The family / carers, Primary Care Team / GP, Public Health Nurse (PHN) and other primary and community service providers are contacted at least 48 hours before discharge to confirm that the service user is being discharged and to ensure that services are activated or re-activated.

- Discharge arrangements are confirmed 24 hours before discharge (SDU, 2013)
- Clinical teams conduct discharging ward rounds at weekends (SDU, 2013)
- Process in place for delegated discharging to occur between clinical teams or to other disciplines, within agreed parameters (SDU, 2013)

Step nine: Make decisions to discharge / transfer service users each day

Each service user discharge is effected no later than 11am on the day of discharge (SDU, 2013).

- Discharge medication reconciliation and development of the discharge medication communication takes place in a planned and timely fashion, preferably on the day before the service user leaves the hospital
- Primary Care services and homelessness services should be notified when a service user who is homeless or living in temporary or insecure accommodation is due for discharge

Helpful tips

- While it is important to respect the person's privacy, it is also important that family members, carers, support persons or those assisting them understand key information for their safety; for example, what medication should be taken and when, and under what conditions the person needs to return to the hospital
- Liaise with the person and others as appropriate (their family, carers, relevant service providers, including disability services or the medical team) around discharge arrangements, aftercare and follow-up. Confirm discharge arrangements as appropriate
- Prepare an information pack and provide information and education to the service user and the family / carer in the appropriate language, verbally and in written form. This should be provided in a format that is accessible to them, where possible. See page 37 - 38 in the "Integrated Care Guidance" for what information to include in an information pack.
 - If follow-up is required, ensure that a communication method appropriate to the service users accessibility needs is identified prior to discharge
 - Signpost a person towards disability organisations for support, information about benefits and services that they can avail of in the community and, where possible, tell them who to contact in specialist disability services

4. Guideline Four

Communication

4.1 General principles of good communication

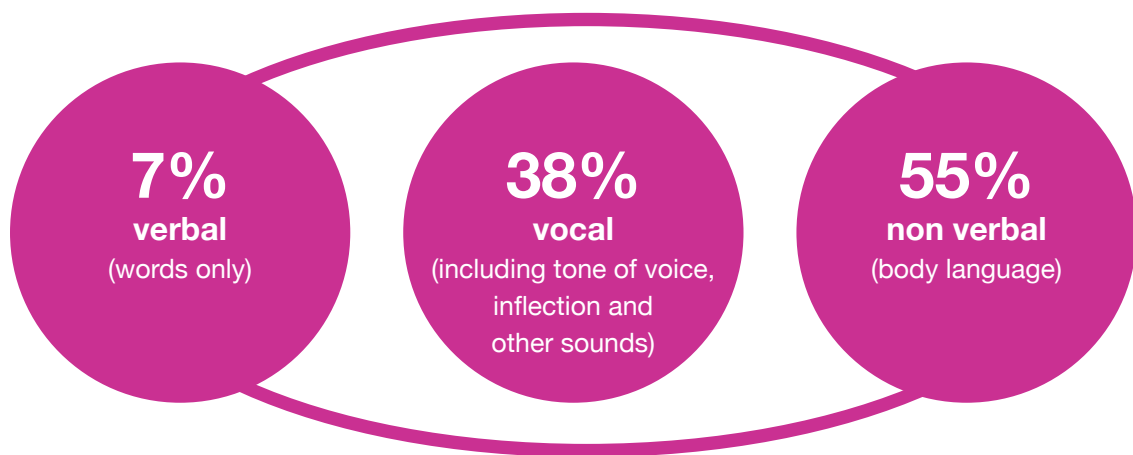


Figure 2: Albert Mehrabian's Communications Model

Communication is made up of 7% verbal communication (what we say), 38% vocal communication (how we say it), and 55% non-verbal communication (body language). When a person has a disability, it can impact significantly on how they communicate. This could include, for example, someone with impaired speech or hearing, someone with limited or no language, or someone whose communication is impaired because of dementia or brain injury.

Failure to make appropriate provision for a person's communication difficulty may result in avoidable serious risks and errors for both the patient and health care provider.

This section provides guidance on communication under the following headings:

- Communication skills
- Communicating with a person who has a disability
- Communication aids and appliances

Remember communication should be non-judgmental, unbiased and respectful. Treat an adult with a disability as you would any other adult.

COMMUNICATION SKILLS

4.2 Establish how the person prefers to communicate

Establish the person's preferred method of communication. This can be done when contact is first made with the service.

A person with a significant disability may have a family member, carer or support person who can provide guidance on the appropriate methods of communication in situations where the person cannot do so themselves. This might include information on a specific communication aid and device which makes communication with the person possible.

In cases where English is not the person's primary language, it may be necessary to arrange for a professionally trained interpreter. It may be helpful if the interpreter has an understanding of how the chosen method of communication works or if necessary to take time to understand.

4.3 Notify relevant staff of the preferred method of communication

Information on a person's preferred method of communication should be passed on to relevant staff so that people do not have to repeat their requirements at each stage of the service user journey. This information should be included in the patient's chart or (with the person's consent) in a sign at their hospital bed.

4.4 Communicating with the person

Active Listening

- Communication is a two-way process. Where possible, always communicate directly with the individual, rather than their carer, support person or interpreter. Be aware of individual differences and diverse needs
- It is important to not only listen, but to hear the message
- Give communication the time needed so that staff and the patient / service user can communicate and understand what is being communicated by the other. A person who is unable to speak or to hear, who has difficulty processing or retaining information, or who cannot read may require more time. As with all interactions with patients and service users, more time may also need to be factored in to communicate bad news in a sensitive way

Verbal communication

- Speak clearly, concisely and slowly
- Use plain language that is easy to understand. If you must use a medical term, explain what it means first
- Give accurate information

Effective questioning

- Ask one question at a time (avoid bombardment)
- Give the person time to respond without unnecessary interruption
- Give the person time to ask questions
- Do not be afraid to ask the same question twice. Repeat what you have said when a person is having difficulty understanding, and verify that they have understood
- Phrasing questions in a way that a person can give a simple “yes” or “no” answer can be helpful in some situation

Non-verbal communication - positive body language

- Face the person you are communicating with
- Maintain eye contact (although this may not be possible or comfortable for some patients / service users)
- Non-verbal communication, such as gestures, facial expressions and appropriate touch, can be important when communicating with people who are experiencing communications difficulties
- Gestures and facial expressions can be used to express an emotion. For example, a thumbs-up can be an acceptable way of reassuring a person that things are all right

Use visual aids

- Drawings, diagrams or photographs are a useful tool in communicating information. They can be particularly useful in communicating with someone who is Deaf or hard of hearing, or someone with an intellectual disability or a brain injury

Give information to take away

- People with disabilities can find it useful to have the information you have communicated to them orally given to them in a format they can review later; for example, a person with a cognitive impairment may need written information to help them remember any instructions they received. This is particularly important for information about follow-up care, exercise or medication

- Write down what you have said in plain English clearly, concisely and accurately
- Avoid using jargon and technical medical language
- Always explain any abbreviations
- Remember typed information is easier to read than handwriting
- Where possible, provide information in an accessible format suitable to the individual's needs. This could be in large print (change the font size), by e-mail, by text message or where practicable in audio format

COMMUNICATING WITH A PERSON WHO HAS A DISABILITY

4.5 Communicating with a person who is unable to stand or who uses a wheelchair

Position yourself at eye level by sitting beside the person. If this is not possible, stand a step back so that the person does not have to strain their neck to see you, or crouch down if appropriate.

4.6 Communicating with a person with speech difficulties

Talk to the person as you would talk anyone else, and listen attentively.

Ask the person to help you to communicate with her or him.

If the person uses a communication device, such as a manual or electronic communication board, ask the person how best to use it. These devices can provide visual information that makes language accessible for people with speech impairments.

Allow time to get used to a person's speech pattern.

Allow time to reply as it may take the person a while to answer. Wait for the person to finish, rather than correcting or speaking for the person.

Ask short questions that require brief answers, or a nod "yes" or "no".

Never pretend to understand if you are having difficulty doing so. If you do not understand what the person is saying to you, let them know this. Ask the person to repeat the message, tell you in a different way, or write it down if possible.

Repeat what you have understood and allow the person to respond. The response will guide your understanding.

Make eye contact with the patient or service user even when someone else is interpreting for them.

4.7 Communicating with a person who has a visual impairment

Be punctual. Lack of punctuality can cause a person with sight loss unnecessary stress.

Remember also that the person may not be able to see whether you have arrived.

- Always let a person with sight loss know when you are approaching. A sudden voice at close range when they did not hear anyone approach can be very startling
- Speak first from a little distance away and again as you draw closer. Say their name so that they know you are speaking to them
- Greet a person by saying your name and what your role is. Do not assume they know who you are, even if they know you

Talk directly to the person, by name, rather than through a third party.

Do try to speak clearly, facing the person with sight loss while you do so.

Do not assume what help they need. Before giving assistance, always ask the person first if they would like help and, if they do, ask what assistance is needed.

A person with a visual impairment may request 'sighted guide' assistance so that the person can find her / his way around the emergency department or to the toilet. If a person with sight loss says that they would like to be guided:

- Offer them your elbow
- Keep your arm by your side, and the person with sight loss can walk a little behind you, holding your arm just above the elbow
- When assisting, it is helpful to give commentary on what is around the person; for example, "the chair is to your right"
- If you have been guiding a blind person and have to leave them, bring them to some reference point that they can feel, like a wall, table or chair. To be left in an open space can be disorientating for a person with no vision

- Ensure that they know what is around them. Describe what is in the room, including equipment, and describe the room from left to right. Give clear instructions about the location of toilets, drinks machines, any steps or other features, such as changes in floor surfaces

Do not assume that a person using a white cane or guide dog is totally blind. Many people with some remaining vision use these.

Do not assume that, because a person can see one thing, they can see everything. If necessary, ask the person if they can see a particular landmark or object.

Never distract a guide dog when in harness.

Do not point if you are giving directions. Give clear verbal directions; for example, “the door is to your left”.

If you have been talking to a person with sight loss, tell them when you are leaving, so that they are not left talking to themselves.

Explain procedures to someone who cannot see what you are doing.

- Clearly explain all the procedures and what will be done step-by-step
- If a person is asked to lie on an examination couch, give clear verbal instructions about what will happen, where the couch is and what the person should do
- Tell the person what parts of their body you will examine and where you will touch
- If you are giving an injection or a needle prick, explain where you will put the needle and what will happen (for example, drawing blood, inserting a drip or giving sedation)
- If a person is having an MRI scan or x-ray, explain all procedures clearly and let the person know when you move behind a screen or into another room

When serving food, staff should:

- Tell people that the meal has arrived and has been placed in front of them
- Identify the food on the plate using the clock system, if a person has a visual impairment; for example, “the meat is at six o’clock, beans at three o’clock and potato at nine o’clock”

Helpful hints

- If food is served on a tray that has a good edge, anything spilled will stay on the tray
- A good colour contrast between a drink and its container is useful to avoid accidents - brightly coloured cups may be seen more easily. For example, a glass of water may not be easily seen; tea in a white mug is easier to see than in a brown mug

The National Council for the Blind of Ireland has developed specific information resources for healthcare professionals, which can be accessed at <http://www.ncbi.ie/information-for/health-professionals>. The topics covered include:

For All Health Professionals

- Guiding a Person With a Vision Impairment
- Getting in Touch With our Services

Nursing Staff

- Assisting Adults With Sight Loss in Hospital
- Assisting Children With Sight Loss in Hospital and at the Doctor's Surgery

Care Staff

- Practical Tips for Care Staff
- Leisure Activities for Day Centres

Public Health Nurses

- Older People With Sight Loss – Living at Home
- Practical Tips for Care Staff

Occupational Therapists

- Older People With Sight Loss – Living at Home
- Practical Advice for Everyday Living
- Changes in Your Own Home

4.8 Communicating with a person who is hard of hearing or Deaf

A person's hearing may be affected at any stage of their life, from the time of birth or in their later years. Loss of hearing may be an invisible disability.

People who have grown up with hearing loss may have Irish Sign Language (ISL) as their primary means of communication, and these are termed the Deaf community. As English is considered their

second language, some have difficulty with written English. It is important to use plain English, and to provide information in simple, concrete terms. Visual aids are also helpful.

People who experience hearing loss as they grow older may rely on hearing aids, on lip-reading or on written information. They generally will not have learned Irish Sign Language.

Learning a few basic signs of Irish Sign Language can help Deaf people feel at home and welcome. **The Irish Deaf Society** has produced a DVD called “**Everyday signed vocabulary in medical settings for service user care**”, and a booklet of “**Basic Medical Signs for Irish medical institutions on common medical sign language for service user care**”. You can find basic signs and information about Irish Sign Language classes on www.IrishDeafSociety.ie

In the Palliative Care setting, the type of information that needs to be conveyed can be difficult. Many patients wish to know about their diagnosis or prognosis; however, others may prefer to negotiate a gradual disclosure of information. Much of palliative care practice is about symptom management, requiring accurate history taking. This can be more difficult when a service user is Deaf. In this regard, it is important to ensure that an ISL Interpreter is available to interpret.

It is thought that, when a person is dying, the person may still be able to hear despite being very weak and mainly sleeping, and many healthcare professionals continue to speak with the person to provide them with reassurance and support. When a person is Deaf, it is important to be mindful that other forms of communication, such as touch, may convey emotional support. However, it can be helpful to check with the person or their family in advance as to whether or not they would be comfortable with touch.

General points

- Ask if someone can hear you clearly; do not assume that they can
- Ask the person with a hearing difficulty how they want to communicate. This could be spoken English, written English, Irish Sign Language or communication appropriate to someone who is deafblind
- You may need to tap the person’s arm gently to get their attention. If touch is not appropriate, you may need to use another approach; for example, in the case of a burn victim you might wave your hand in their line of sight or switch a light on and off

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- Where possible:
 - provide induction loop systems for hearing aid users or a portable listening device for hard of hearing service users, and test them regularly
 - provide written versions of any audio notices and communications
 - support the information given in conversation with written handouts
 - and provide diagrams or pictures which may be useful in supporting text.
 - Make sure that only one person speaks at a time
 - Use gestures, body language and facial expressions to emphasise the sense of what you are trying to communicate; for example, nod rather than saying “hmmm” to show you are listening. Take care that these do not appear over-exaggerated or patronising

4.9 Communicating with a person who lip reads

Get and keep the person's attention

- Gain the person's attention; for example, tap the person's arm gently to get their attention, wave your hand in their line of sight or switch a light on and off
- Talk directly to the person

Position yourself well

- Position yourself three to six feet from the person and at the same level as them
- Make sure your face is in good light while you speak. Do not stand with a light or a window behind you as shadows may make it difficult to read your lips
- Check with the person that they can see you clearly
- Minimise any background noise

Assist the person to see your face and lips

- Make sure they have a clear view of your face and lips
- Do not cover your mouth or have anything in or covering your mouth; for example, chewing gum, pen, paper, hands
- Keep your head still where possible
- Stop talking when looking down or away

Speak clearly

- Let the person know the topic of conversation and signal any change in topic by pausing
- Speak at a moderate pace and maintain a normal rhythm of speech

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- Do not shout because this can distort your lip patterns
 - Do not over-emphasise mouth movements as this will distort your lip patterns
 - Sentences or phrases are easier to understand than single words
 - If a word or phrase is not understood, use different words with the same meaning

Assist the person to understand

- Know that lip reading is tiring
- Allow time for the person to take in what you have said
- Use natural body language and facial expression but avoid exaggerated gestures
- Check with the Deaf or hard of hearing person regularly to ensure they understand. Some health care providers make the common mistake of presuming Deaf or hard of hearing people can lip read. This is not always the case. Even if the person can lip read, accuracy in lip reading is estimated at 30%, resulting in disproportionately high rates of miscommunication and misunderstanding. This may have very serious implications for medication management or in the follow up care of a condition
- Some of what you say may be missed – supplement what you say with written information, notes and diagrams. When you write something down, use plain English

4.10 Communicating in writing with a Deaf or hard of hearing person

- Ask the person how they would prefer to communicate
- Pen and paper, text messaging, e-mail, speed text and written handouts of information provided are useful ways to communicate with someone who is Deaf or hard of hearing
- If using e-mail or text messages to arrange an appointment, ensure any e-mail system or text message service can receive replies (rather than a no-reply number or e-mail account) so that people can respond and can discuss access requirements for an upcoming appointment. If not, make alternative arrangements to enable a reply
- Always follow clear print guidelines. (See the www.ncbi.ie for further information)
- If the person wants to communicate by note-writing:
 - Be patient, it may take longer
 - Always use plain English
 - Ensure your handwriting is clear and legible
 - Allow the person to keep ownership of the notes
 - Ask the person's permission if you want to use the notes as part of their treatment plan; and
 - Treat all handwritten communications as you would a private conversation

4.11 Communicating with a person who uses Irish Sign Language

Some Deaf or hard of hearing patients and service users use Irish Sign Language (ISL) as their first language and preferred method of communication. Not everyone who signs will use ISL; for example, someone from England who is on holiday will use British Sign Language (BSL), an American will use American Sign Language (ASL), and they are all very different.

Patients and service users are entitled to request and be provided with a qualified sign language interpreter. While the onus is on the service user to request an interpreter, it is the responsibility of staff to make the arrangements. Staff should routinely let service users know that:

- they have the right to an interpreter to assist in communication
- there is no cost to the service user; and
- staff will arrange for the interpreter

It is considered good practice for services to arrange an interpreter without being prompted in cases where repeat visits are necessary or where it is known in advance that the service user needs one.

Not providing a qualified sign language interpreter when delivering care to a patient or service user places the health or social care provider in a precarious situation:

- information may be misinterpreted or misunderstood which may lead to a potential adverse outcome for the patient or service user; or
- the lack of provision of a qualified sign language interpreter may result in invalid consent for invasive medical or surgical procedures

An interpreter may also be necessary if the primary carer or advocate of a patient / service user is Deaf; for example, Deaf parents with a child who can hear.

The HSE guidance document on using language interpreters, '**On Speaking Terms**', is available on www.hse.ie

If it is not possible to get an Irish Sign Language interpreter in an emergency or on short notice, it can be helpful to have a standard pre-prepared list of written questions, pictures and symbols that you can use to communicate with a person who is Deaf. The questions or pictures should reflect the usual questions you ask when someone is admitted to hospital, such as "where does it hurt?", "do you have previous health conditions that we should know about?", or "are you on any

medication?” Make sure that the questions are written clearly and in plain English.

To book an ISL interpreter, see www.slis.ie or e-mail bookings@slis.ie. You may need to book an interpreter up to two weeks in advance.

4.12 Irish Sign language interpreters

Sign language interpreters are there to translate between Irish Sign Language and English. They interpret for both the Deaf person and health and social care staff.

Professional Irish Sign language interpreters:

- Work to a Code of Ethics and Professional Conduct where confidentiality is a core value
- Translate not only the words but also the cultural meanings; and
- Are trained to be impartial. Do not expect them to give a personal opinion of a patient

The interpreter is not a caseworker or an advocate. They may intervene, for example, to ask someone to sign or speak more slowly, to clarify understanding or to ask that information be repeated.

With the consent of the Deaf person and where possible, provide the interpreter with background notes and information in advance. This will enable the interpreter to carry out higher quality interpretation.

Allow extra time when working through an interpreter especially in medical settings where terms may not be easily understood.

Make sure that the interpreter sits next to you and that the Deaf person can see both of you clearly.

Direct what you say and make eye contact directly with the Deaf person, not with the interpreter.

Give the interpreter sufficient time to translate what is communicated. Remember that an interpreter has to interpret everything that both a Deaf person and a hearing person say during the course of an interpreting session.

4.13 Deaf interpreters

Deaf interpreters are Deaf or hard of hearing people who have been professionally recognised as accredited interpreters. Contact via bookings@slis.ie.

- They have fluency in Irish Sign Language and work in tandem with Irish Sign Language interpreters or Deaf advocates
- They are skilled in techniques of interpretation and translating meaning between languages and cultures
- They have in-depth knowledge of the Deaf community and can interpret for Deaf foreign nationals, for vulnerable Deaf individuals, in mental health settings and for Deaf individuals with an intellectual disability
- They work to the same guidelines, ethics and standards as Irish Sign Language interpreters

4.14 Irish Remote Interpreting Service (IRIS)

The Irish Remote Interpreting Service (IRIS) uses a web-based programme to connect to a central internet server where an interpreter acts on behalf of the practitioner and the Deaf person.

- This is on-screen video interpretation over an internet connection
- The web based programme does not replace face to face interpretation and should only be used for generic appointments; for example, booking an appointment, checking times or details with the Deaf person
- If an appointment becomes more serious or requires more in-depth discussions, a face to face meeting should be booked
- A service provider or service user will need access to broadband, a microphone, speakers and a camera / video facility on their PC or laptop
- Contact www.slis.ie

4.15 Deaf Peer Advocates

Deaf Peer Advocates can assist in breaking down, understanding and making sense of information received.

- They are not social workers, carers or sign language interpreters
- Their role is to ensure the patient or service user's rights are upheld. They are impartial and work for the best for the client.

4.16 Communicating with a person who is deafblind

A person who is deafblind has combined sight and hearing loss.

- A white cane with a red band signifies that someone is deafblind
- A person who is deafblind needs a specialised interpreter. This person works in tandem with the deafblind peer advocate to ensure the person is understood and understands what is being said
- A peer advocate is a person whose touch and communication style is known to the person who is deafblind and who can relay information to the healthcare worker
- How to communicate with a person who is deafblind is an individual matter. The practitioner adjusts their strategy to the person's need for support
- The deafblind alphabet is a system to fingerspell words on to the hand of a person who is deafblind

4.17 Communicating with a person with an intellectual disability

People with an intellectual disability may have difficulty understanding language that is complex, contains abstract concepts or technical jargon. It is therefore important when talking with someone with an intellectual disability to:

Speak directly to the person concerned.

- If it is necessary to obtain the information from a carer or family member, maintain the focus on the person with the disability through eye contact and body language

Speak clearly and more slowly using simple plain English and short sentences.

- Address the person and use a tone of voice consistent with their age – so speak to an adult as another adult
- Pause frequently to enable the person to process what you are saying
- Choose a quiet place with few distractions if possible
- Give only one piece of information at a time, in short sentences
- Check you have both understood
- Don't pretend to have understood when you haven't
- Use words and phrases familiar to all
- Make it clear if you are changing the subject
- Don't ignore the person or walk away if you don't understand. Tell them you don't understand so you are going to find help

Some people with an intellectual disability may have trouble expressing their thoughts or feelings so it is important to provide enough time for the person to reply, comment and formulate their questions or answers.

- Ask one question at a time and provide adequate time for the person to formulate and give their reply
- Use visual cues – such as objects, pictures or diagrams – and facial expression and body language to convey information, and to try and understand what someone is trying to say
- If the person uses a communication device, then ensure they have access to it, read the directions (usually on or in the device or book) and use it with them

Some people with an intellectual disability can find it hard to recognise and communicate their symptoms, pain or discomfort. As a result, health and social care staff may rely on family members or support workers to bring health problems to the attention of healthcare staff and to provide a good medical history.

- It is important to remember, however, that support workers may also be unaware of symptoms and, with a turnover in support staff, may not always know the person well

Recognise that difficult behaviour may be because the person is in pain, anxious, confused.

There may be times when you do not understand what the person is saying. In this situation, it may be helpful:

- To ask the person to repeat what they have just said
- If you could ask an accompanying support worker / family member to help you understand or to show you how the person says “yes” and “no”, and then ask yes / no questions to identify what it is they are saying; or
- If you still can not understand, show respect for the person and acknowledge the importance of their message by apologising for failing to understand them¹¹

Physical examination may also take longer due to a combination of difficulties with communication, with accurate history-taking or with physical examination due to anxiety or challenging behaviours, and this means that lengthier assessments should be planned for.

4.18 Other communication challenges

Patients and service users may have a number of difficulties which impact on their communication skills; for example:

- Problems and difficulties with social interaction, such as a lack of understanding and awareness of other people's emotions and feelings
- Impaired language and communication skills, such as delayed language development and an inability to start conversations or take part in them properly
- Unusual patterns of thought and physical behaviour. This includes making repetitive physical movements, such as hand tapping or twisting. A service user can become upset if the set routines of behaviour are broken or disturbed
- The current stage of a person's wellness may impact communication. Challenges experienced may reference the individual's desire and capacity to engage in a recovery focussed process. When a person is well the same challenges may not exist
- Years of institutional care within mental health or intellectual disability services, whereby people may have been dependent on others by necessity or by choice, may have an impact on how a person engages with staff. They may need additional support in a staged and appropriate way for a period to initiate greater participation and enable them to assume responsibility for directing and / or managing their own care to the greatest extent possible

Patients and service users may also have a disability which results in adverse reactions to noise, crowds, waiting, food, and smells among others. This may cause difficulty when accessing health or social care services. Recognise that people will have different levels of comprehension, dependent on the individual and circumstances. In view of this, the following are general guidelines may be helpful.

- Consider using visual aids to help; for example, pictures, pointing, pictorial timetables
- Explain what is going to happen before starting
- De-clutter communication – be aware of background noise and not having over stimulation
- Use clear simple language with short sentences
- Use few words instead of many and use as little abstract language as possible
- Make your language concrete and avoid using idioms, irony, metaphors and words with double meanings; for example, "It's raining cats and dogs out there". This could cause the person to look outside for cats and dogs. Some patients and service users may interpret language literally which can cause confusion

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- Give direct requests - such as “Please stand up” rather than “Can you stand up?” - as this may result in the person staying seated or answering “yes”, as the person may not understand what you are asking them to do
 - Give one command at a time and check that the person has understood what you have said – some people may speak clearly but can lack full understanding
 - Do not over depend on using non-verbal communication – be as concrete as possible
 - Allow for extra processing time – some people need ten seconds or more to process what they are being asked or told
 - If necessary, you may need to restate the message in another way and emphasise the most important aspects of the message
 - Do not insist on eye contact. Lack of eye contact does not necessarily mean that the person is not listening to what you are saying
 - Remember that when a person is quite stressed, he or she may not listen or process your words until he or she is calm
 - Do not be personally offended if the person does not appear to engage with you.
 - A person with significant communication challenges may benefit from a home visit or a pre-visit to the health and social care setting prior to a scheduled appointment where possible

The following table provides a list of questions that staff can ask to help them identify a services users communication needs.

Ask yourself:

1. How much language can the person understand?
2. How well does he or she understand the nonverbal aspects of communication?
3. Does the person need more time to process information; for example, will you need to slow your rate of speech, shorten sentences, or allow time for the person to absorb information?
4. Does it help to word your message in a particular fashion or deliver it in a specific style?
Will the person “tune-out” people who use a particular communication style (for example, assertive and loud, soft-spoken etc.)?
5. What is the best way of getting and keeping his or her attention other than eye contact?
(For some individuals, eye contact is difficult).
6. Will background noise, other stimuli (such as people, food, movement, etc.) impact on the person’s ability to process a message?

7. Is the person able to process a message when upset? How do you know the person is upset and what can you do in this case?
8. Will gestures, visual aids or text to aid in the comprehension of messages?
9. Does the person have personal space boundaries that should not be violated? This may mean no touching or not standing too close.
10. Does the person find it hard to understand subtle references or hidden meanings?
11. Has the person been in institutional care within a mental health or intellectual disability setting for an extended period of time? If so, they may be more dependent on others by necessity and sometimes choice.

COMMUNICATION AIDS AND DEVICES

4.19 Communication boards

Manual or computerised communication boards provide visual information that makes language accessible for people with speech impairments. They display written words, photographs and symbols. A symbol showing a cup communicates “**I want a drink**”, or letters can be spelt out using a finger, hand or foot. They are portable. They can be fitted to a lap tray for use by a wheelchair user.

4.20 Communication passports

Communication passports are sometimes used by people with an intellectual disability or people who have difficulty in speaking to record their views, preferences and communication requirements.

- They can often help staff to understand the person with a disability and promote successful communications. Communication passports are a way of making sense of formal assessment information and recording the important things about a person, in an accessible and person-centred way, in order to support a person’s transitions between services
- They aim to describe the person’s most effective means of communication, and how others can best communicate with and support the person
- They can draw together information from past and present and from different contexts to help staff and others understand the person in order to have successful interactions

For further information and templates for communication passports, refer to:

<http://www.communicationpassports.org.uk/Home/>

4.21 Lámh signs

Provision of Lámh signs can be used to support communications with people who have an intellectual or communications disability. Lámh is a manual sign system used by children and adults with intellectual disability and communication needs in Ireland. Lámh signs are based on Irish Sign Language (ISL) and speech is always used with Lámh signs. For further information, refer to **www.lamh.org**

4.22 Induction loops

Hearing induction loop systems for hearing aid users are devices that can be provided in a fixed location or worn around a person's neck as a portable device.

4.23 Communication aids as part of communication strategy

It can be helpful to use communication aids as part of an overall strategy for communicating with people with specific disabilities. For example, Lámh signs can be used alongside communication passports and other visual supports, such as pictures and symbols, to assist communications with people with an intellectual disability. Assistive technology, audio and large print documents can be used to complement information provided verbally for people with impaired vision.

4.24 Provide information about communication aids available

Let people know how to access communication aids and adaptive technology.

- Provide information about the communication aids you provide on your section of the web site and in your patient or service user information booklets or leaflets, where possible
- Provide signs indicating where a hearing aid user can use an induction loop
- Place a notice at reception about how and who to contact in the health and social care service so that the staff member may book an Irish Sign Language interpreter in advance

5. Guideline Five

Accessible information

5.1 Why provide information in an accessible format?

Public bodies are obliged by the legislation to ensure, as far as practicable, that information provided to people with a hearing impairment, a visual impairment or who have an intellectual disability is provided in a form that is accessible to the person concerned.

It is important to provide information in an accessible format which is clear and easy to understand.

It enables and empowers people to:

- Find the services they need
- Make informed choices and decisions
- Understand medical procedures, treatments and after-care; and
- Avoid medication errors

5.2 Information about accessibility of premises and services

Information about accessibility of your premises and your services should be readily available and in a range of formats on request (where practicable).

Provide information in accessible formats - for example, in your patient information booklet or on your section of the website - about your health and social care facility. The following information is helpful:

- Details of the location of your premises, public transport access, car park, set-down and pick-up arrangements, and of where the entrance is
- The location of specific services and facilities, including reception and waiting areas, and accessible toilets and zones which have an audio loop system (for hearing aid users)
- Details of opening hours
- Details of how to make contact or appointments, and of any accessibility arrangements, such as, the facility to make appointments via text message; and
- Information about who to contact for specific assistance and how to contact them

5.3 Providing information in different formats

Ask the person with a disability how she / he would like information to be provided. Some people may need information to be transmitted in an accessible format; for example, via e-mail or a text message in the case of a blind person who cannot read letters sent via post.

In cases where the patient or service user will have regular contact with the service, a record is kept of the preferred method for information provision.

When preparing printed information, such as a leaflet, or posting information to your website, consider also how this can be provided in ways that are accessible to people with disabilities. This could include large print, information on your website that is accessible, Easy to Read, audio, video or Braille or on coloured paper.

5.4 Some tips on written information

Get your key messages across with written information that is clear, concise and simple.

Ask yourself: Who is your audience? What is your key message to them?

The following guidance will help also:

- Write simply and clearly in plain English
- Keep anything you write accurate
- Avoid using jargon and technical medical language
- Always explain any abbreviations
- Using a minimum of 12-point font in documents (or as advised in the HSE National templates for Policies, Procedures and Guidelines)
- Provide a larger-print version for those who need this
- Align text to the left (this is important as the spacing of justified text can cause difficulties for people with dyslexia who are trying to assimilate the information)
- Provide clear headings
- Highlight important words in bold. Avoid using all capitals, italics or underlining, as this makes it harder for people with sight difficulties to make out the shape of the word
- Keep sentences short. Keep one point to each sentence
- Use short paragraphs. Use bulleted lists
- Have good contrast between the text and background colours. Do not use pale colour print
- Use non-reflective paper (for example, a matt finish); and

- Test the document before you go to print to see if people who use your service can understand it easily

5.5 Large print

People with impaired vision may be more comfortable with documents in large print, from 14 point font and upwards.

- Large print versions of key publications and information can be produced simply by changing the font size in your word processing software
- You can produce large print versions of leaflets, forms, prescriptions, hospital menus or other documents as required
- Ask the person if they require information in large print and if there is a particular font size they require

Ensure that links on the internet site can be accessed by visually impaired people who have a reader on their computer.

5.6 Use pictures and symbols

Pictures and symbols can help people who have intellectual disabilities and people who have difficulty in reading, or in dealing with situations that are difficult to discuss.

Access to pictures to explain symptoms may be helpful in some settings; for example, a mobile phone.

5.7 Easy to Read

'Easy to Read' means providing information through very simple text, with accompanying pictures. This makes it easier for some people with intellectual disabilities and people with literacy difficulties to follow.

5.8 Website

Information on your website should be accessible to people with sight problems who use technology to read to them what is on the screen.

Some simple guidance:

- Make your website easy to navigate (easy to find the information you are looking for)
- Structure your documents using headings styles from your word processing package
- Provide a text description of any images – how you would describe them to someone over the phone
- Make sure people can get all the important information from your videos and audio, even if they cannot see or cannot hear them
- Provide enough colour contrast between written information and its background; and
- It can be helpful to subtitle video clips

The National Disability Authority has detailed advice on how to make a website fully accessible.

<http://www.universaldesign.ie/useandapply/ict> or <http://accessit.nda.ie>. Your webmaster and web developer should be familiar with these standards and this advice.

- Ensure everything on your website meets the recognised accessibility standard which is Level AA conformance with the Web Content Accessibility Guidelines 2.0
- All your content, including word and pdf documents, maps, audio, video and html content, should meet these standards
- It is possible to have the accessibility of your website independently checked

5.9 Video and audio

Keep CDs or DVDs and online videos or audios short so that people can find it easier to absorb and remember the information.

Provide a voice-over (audio description) so someone with impaired vision can follow a video.

Provide subtitles, to help people who are hard of hearing.

A video in Irish Sign Language is a good way to provide information to the Deaf community.

Consider incorporating Lámh signs.

5.10 Braille

Braille is a writing system of raised dots that are read by touch. With newer technologies available, the demand for Braille documents is relatively low. Have an arrangement in place to convert documents into Braille where practicable if this is requested.

5.11 Further information

Further information	Reference
<p>Guidelines on accessible information and accessible formats</p>	<p>Access to Information for All, Citizens Information Board http://www.citizensinformationboard.ie/publications/advocacy/accessibility_index.html</p> <p>National Disability Authority guidance www.accessibility.ie/MakeYourInformationMoreAccessible/</p>
<p>Making health information easier to understand and guidance for using plain English</p>	<p>For information on how to write, prepare and design documents in plain English, see: www.simplyput.ie</p> <p>Make it Easy: a guide to preparing easy to read information has been prepared by the Accessible Information Working Group, who work with adults with intellectual disabilities in Ireland. Available at: www.walk.ie</p> <p>The National Adult Literacy Association has information on making health information easier to follow: www.citizensinformationboard.ie/publications/social/downloads/AccessToInformationForAll.pdf</p>
<p>Accessible information using symbols and pictures</p>	<p>Easy Info has resources to help make accessible information for people with intellectual disabilities, including guidance on how to use symbols and pictures and making documents Easy-to-Read: www.easyinfoforum.org.uk</p>
<p>Accessible information for Deaf or Hard of Hearing people</p>	<p>Organisations that provide symbols include:</p> <ul style="list-style-type: none"> • Change Picture Bank (www.changepeople.co.uk); • Photosymbols (www.photosymbols.co.uk); and • Boardmaker communication symbols (www.mayer-johnson.com)

Further information	Reference
<p>Accessible information for blind people</p>	<p>Contact the National Council for the Blind of Ireland's media centre for further guidance on how to provide alternatives, including Braille and good quality audio, for people with impaired vision: www.ncbi.ie</p>
<p>Accessible information for Deaf or Hard of Hearing people</p>	<p>The Irish Deaf Society has facilities for producing signed videos and DVDs: www.irishdeafociety.ie</p>
<p>Accessible information where English is not a first language and translation is required</p>	<p>www.lenus.ie/hse/bitstream/10147/207010/1/Lostintranslation.pdf</p>

6. Guideline Six

Accessible buildings and facilities

6.1 General information

Public bodies are obliged by the legislation to “...ensure that its public buildings are, as far as practicable, accessible to persons with disabilities”

People with disabilities can face particular challenges getting into, moving around and using the facilities of some buildings.

The challenges may be somewhat different for people who walk with difficulty, those who use walking aids, wheelchair users, people with a visual impairment (people who have difficulty seeing or people who are blind), people with hearing difficulties or people with intellectual disabilities. There are a range of different features that are required if a building is to be fully accessible.

Building managers should ensure that the premises are designed to be accessible and that accessibility is maintained.

Those responsible for commissioning equipment should ensure that the wide range of needs and circumstances is catered for, including people with disabilities.

Ask people about their physical access requirements so that an individual’s requirement can be met where practicable.

Provide information about the physical accessibility of your premises and your service, including accessible aids and equipment, in any patient information material or on your website.

Detailed technical guidance on different aspects of physical accessibility can be found in the National Disability Authority’s Building for Everyone <http://www.universaldesign.ie/buildingforeveryone>

6.2 Providing information about the accessibility of premises and facilities

Information about the accessibility of your premises and your services should be readily available and in a range of formats on request (where practicable).

Provide information in accessible formats; for example, in your patient information booklet, or on your section of the website about your health care facility. The following information is helpful:

1. Details of the location of your premises, public transport access, car park, set-down and pick-up arrangements, and of where the entrance is.
2. The location of specific services and facilities, including reception and waiting areas and accessible toilets and zones which have an audio loop system (for hearing aid users).
3. Details of opening hours.
4. Details of how to make contact or appointments, and of any accessibility arrangements, such as the facility to make appointments via text message.
5. Information about who to contact for specific assistance and how to contact them.

6.3 Points to consider – A checklist for accessible buildings and facilities

The following table is a checklist. It provides a list which services can use to support the provision of accessible buildings and facilities. It should be noted that this is not an exhaustive list and can be added to for each area as required.

The list describes a standard to aspire to. It is written in the knowledge that services may not have financial resources to implement all measures outlined; however, there is an obligation on individuals to ensure that they know what is required of them by law.

Points to consider		Yes	No
A checklist for accessible buildings and facilities			
General points			
1.	Can people with disabilities get into your building easily?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Can people with disabilities move around the building easily, and find their way to where they need to go?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Can you evacuate people with disabilities safely in an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is there a warning system in place for Deaf people who cannot hear any alarms?	<input type="checkbox"/>	<input type="checkbox"/>

A checklist for accessible buildings and facilities		Yes	No
5.	Are there accessible WCs where people need them?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Is your furniture and equipment suitable for people with disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you systems in place to ensure accessibility of your premises and facilities is maintained?	<input type="checkbox"/>	<input type="checkbox"/>
Entrance and approach			
8.	Is there a set-down and pick-up point that is clearly sign-posted close to the entrance to the building?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Are there accessible parking bays close to the entrance?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Is there one or more parking meter or payment machine which can be operated when seated?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Is there an unobstructed route from parking or public transport to the entrance?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Is there a non-slip pathway with dished kerbs and with tactile surfaces at crossing points?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Is there a level step-free entrance to the building? Otherwise, there should be both steps and a gentle ramp at the entrance with continuous handrails. A contrast in texture of the paving will let someone with a visual impairment know they are at the entrance.	<input type="checkbox"/>	<input type="checkbox"/>
14.	Are ramps no steeper than 1:20, and preferably no longer than 10 meters?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Are steps non-slip and marked along the edges? Is there clear, well-lit signage with good colour contrast?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Are the entrance doors easy to open or do they open automatically?	<input type="checkbox"/>	<input type="checkbox"/>
17.	If there is a double set of doors to minimise draughts at an entrance, is there enough space between the outer and inner doors for someone with limited mobility or a wheelchair user to negotiate?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Are door handles visible and easy to use and at a height which a wheelchair user can access?	<input type="checkbox"/>	<input type="checkbox"/>
19.	If the door does not have a self-locking device, are there pull-handles to close the door?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Are there door entry control systems, such as intercoms, where necessary that have features that work for people who have vision or hearing impairments?	<input type="checkbox"/>	<input type="checkbox"/>

A checklist for accessible buildings and facilities

Yes No

- | | | | |
|-----|--|--------------------------|--------------------------|
| 21. | Is there a designated area outside for a guide dog to relieve himself?
Foyer, reception and waiting areas | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | Is there clear signage showing where to find different services and facilities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Is the reception desk close to the entrance and in a location to minimise internal and external noise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Is there a two-tier height reception desk that can serve both those who are standing and those who are seated (including wheelchair users) with adequate knee space? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Is there a chair at the reception desk for the person making inquiries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | Is there a suitable-height surface for signing any forms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. | Is there a loop system at reception desks to facilitate those with hearing aids? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. | Is there a portable loop so that a service user can take a loop from one room to another? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. | Is there good lighting on the receptionist's face to facilitate lip-reading? Avoid lighting behind the receptionist where possible. | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. | Is there adequate space for both manual and powered wheelchairs to enter and turn around? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. | Is there adequate seating in any waiting area? Where possible, provide some with armrests that are easier to stand up from. | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. | Does the layout of the seating enable a wheelchair user to sit beside a companion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. | Are written notices in large print, in a clear typeface, with good colour contrast and on a matt background to reduce glare? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. | Are leaflet display stands accessible to people who are standing or who use wheelchairs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. | Can people with limited dexterity take a leaflet from a leaflet display stand easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. | Is there space for a guide dog close to the seating in waiting areas and a water bowl if required? | <input type="checkbox"/> | <input type="checkbox"/> |

General areas and circulation

- | | | | |
|-----|--|--------------------------|--------------------------|
| 37. | Are there non-slip floor surfaces that are dry, well-maintained and easy to use by someone on crutches, with a walking aid or in a wheelchair? | <input type="checkbox"/> | <input type="checkbox"/> |
|-----|--|--------------------------|--------------------------|

A checklist for accessible buildings and facilities		Yes	No
38.	Are there contrasts in colour and texture for floor coverings to define different areas of the building or to mark a route?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Are doorways, corridors and circulation spaces wide enough for powered or manual wheelchair users to navigate and turn?	<input type="checkbox"/>	<input type="checkbox"/>
40.	Are corridors, waiting rooms or wards free of any obstacles that could restrict mobility or cause injury? Check that trolleys, cleaning equipment or wall-mounted objects like fire extinguishers or other materials do not protrude and / or are not placed where they could be an obstruction or a hazard.	<input type="checkbox"/>	<input type="checkbox"/>
41.	Are there handrails and seating in all waiting areas and along circulation routes to enable a person with a walking difficulty, a person who has balance difficulties or a person experiencing chronic pain to get around the building and take a break if they need it?	<input type="checkbox"/>	<input type="checkbox"/>
42.	Are there handrails where there are changes in floor levels and where there are steps or ramps?	<input type="checkbox"/>	<input type="checkbox"/>
43.	Is there a glazed vision panels on doors so that one can see what is beyond the door?	<input type="checkbox"/>	<input type="checkbox"/>
44.	Are there markings on glass doors so that they can be clearly seen?	<input type="checkbox"/>	<input type="checkbox"/>
45.	Are the edges of any steps marked so that they are visible?	<input type="checkbox"/>	<input type="checkbox"/>
46.	Is there an alternative for those who cannot use steps, such as a lift or a ramp?	<input type="checkbox"/>	<input type="checkbox"/>
47.	Are all controls, such as lift controls, door handles or switches, at a height which people who are seated or standing can use?	<input type="checkbox"/>	<input type="checkbox"/>
48.	Is the lift a talking lift that specifies which floor you are on?	<input type="checkbox"/>	<input type="checkbox"/>
49.	Is there a minimum clear opening of 900mm in the lift?	<input type="checkbox"/>	<input type="checkbox"/>
50.	Are the controls in the lift accessible?	<input type="checkbox"/>	<input type="checkbox"/>
51.	Is there good lighting, without glare?	<input type="checkbox"/>	<input type="checkbox"/>
52.	Can a wheelchair user position themselves alongside any seating to enable a companion to take a rest?	<input type="checkbox"/>	<input type="checkbox"/>
53.	Is there sufficient space for a wheelchair user to access and grab rails in key parts of the building, such as along corridors, alongside ramps and in toilets?	<input type="checkbox"/>	<input type="checkbox"/>

A checklist for accessible buildings and facilities

Yes No

Toilet facilities

- | | | | |
|-----|--|--------------------------|--------------------------|
| 54. | Are toilet facilities accessible? These should be large enough a person using a powered wheelchair to use.
For technical details, see Book 5 (Sanitary Services) in “Building for Everyone”: www.universaldesign.ie/buildingforeveryone | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. | Is there an accessible toilet near the examination room so that a person can give a urine specimen, if required? | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. | Are door handles, wash-hand basins, taps and the toilet fully accessible?
Door handles and taps should be usable by people with restricted dexterity. | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. | Are there appropriately placed grab rails and accessible handles for entry and exit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. | Are accessible toilets maintained and repaired promptly if out of order?
Accessible toilets should be maintained free of obstruction and not used as a storage area for cleaning or other materials. | <input type="checkbox"/> | <input type="checkbox"/> |

Consulting and treatment rooms

- | | | | |
|-----|--|--------------------------|--------------------------|
| 59. | In designing and building treatment rooms, have the relevant professionals taken account of the acoustic properties of rooms where consultations take place?
Choose materials that dampen sound. Avoid noisy ventilation or air conditioning systems that can make it difficult for a person to hear. | <input type="checkbox"/> | <input type="checkbox"/> |
| 60. | Are treatment rooms of a sufficient size to enable a manual or powered wheelchair user to turn? | <input type="checkbox"/> | <input type="checkbox"/> |
| 61. | Can the treatment room accommodate a lifting hoist to enable a person to transfer safely and comfortably onto an examination or treatment table or chair? | <input type="checkbox"/> | <input type="checkbox"/> |
| 62. | Are examination couches centrally located with access from both sides (or can they be moved easily so that they are)? Are they height-adjustable so that a person can be examined in a range of positions - lying, standing or seated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 63. | Is diagnostic equipment, such as a mammography machine, capable of being accessed by a person in a seated position? | <input type="checkbox"/> | <input type="checkbox"/> |
| 64. | Are handgrips provided to help people with mobility or vision impairments to have support when standing beside a diagnostic machine or on weighing scales? | <input type="checkbox"/> | <input type="checkbox"/> |

A checklist for accessible buildings and facilities		Yes	No
65.	Are there accessible weighing machines so that people who are not able to stand on the weighing scale can be weighed safely and comfortably? For example, there should also be accessible weighing scales that allow individuals to be weighed in a wheelchair.	<input type="checkbox"/>	<input type="checkbox"/>
66.	Is at least one dressing room accessible to manual and powered wheelchair users and people with limited mobility? Are there hand grips and seating in the dressing room and a call bell if a person requires assistance?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
67.	At least one consultation or treatment room should have a hearing loop system available for a person who is a hearing aid user. Provision should also be made for a portable loop system to be available if a person is required to move between consultation or treatment rooms.	<input type="checkbox"/>	<input type="checkbox"/>
Hospital wards			
68.	Are there accessible and automatic height-adjustable beds available if a service user needs one?	<input type="checkbox"/>	<input type="checkbox"/>
69.	Are hoists and monkey poles available to enable people be lifted or to lift themselves, in particular to enable transfer between bed and bathroom or into and out of a bedside chair?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
70.	Is there sufficient space around a bed for a manual and powered wheelchair user to turn beside a bed?	<input type="checkbox"/>	<input type="checkbox"/>
71.	Is there a fully accessible toilet and bathroom adjacent to the ward, with a choice of shower or bath facilities and with suitable hoists available as required?	<input type="checkbox"/>	<input type="checkbox"/>
72.	Is there a single room available on all wards, which can help infection control or offer more privacy or quiet for those who require it because of their illness or disability, where possible? Some disabilities may result in a person being uncomfortable or find it difficult to communicate in a noisy or bright environment.	<input type="checkbox"/>	<input type="checkbox"/>
73.	Is there a range of chairs in the day room to suit people with limited mobility and with arm rests to assist them when they go to stand?	<input type="checkbox"/>	<input type="checkbox"/>
74.	Is the environment free of obstacles or hazards?	<input type="checkbox"/>	<input type="checkbox"/>
75.	Is there a television provided? If yes, is the option of subtitles available?	<input type="checkbox"/>	<input type="checkbox"/>

A checklist for accessible buildings and facilities

Yes No

Signs and notices

76.	Is there a clear way-finding system around the building?	<input type="checkbox"/>	<input type="checkbox"/>
77.	Is there clear signage at an appropriate height above floor level?		
78.	Are the signs made from a material that does not reflect light? Glare can make them difficult to read.	<input type="checkbox"/>	<input type="checkbox"/>
79.	Is plain English used in signs and notices?	<input type="checkbox"/>	<input type="checkbox"/>
80.	Do the signs use clear and consistent language and images?	<input type="checkbox"/>	<input type="checkbox"/>
81.	Is there a colour contrast between lettering and background on information notices and signs?	<input type="checkbox"/>	<input type="checkbox"/>
82.	Are picture signs and symbols used that can be readily understood by all; for example, people with literacy difficulties, people with intellectual disabilities and people who do not read English?	<input type="checkbox"/>	<input type="checkbox"/>
83.	Is there a notice where you have a hearing loop?	<input type="checkbox"/>	<input type="checkbox"/>
84.	Are notices in a minimum of 18pt font? Do they use large symbols with a combination of upper and lower case lettering?	<input type="checkbox"/>	<input type="checkbox"/>
85.	Do signs meet the recommended guidelines? See the HSE Signage Policy 2005 for more information.	<input type="checkbox"/>	<input type="checkbox"/>
	<ul style="list-style-type: none"> Internal signs: <ul style="list-style-type: none"> - The recommended size for internal location identification and directional signs is at least 60mm height and viewing distance up to 20 metres (m) - The recommended height of a sign is between 1300-1600 mm above floor level - The height of the signs should be chosen for comfort in reading; that is, as close to eye level as possible for internal signs and external pedestrian signs. In general, eye level is considered to be approximately 1500mm from ground. This is also the recommended height for tactile and Braille signs. (National Council for the Blind of Ireland – Recommendations for Signage) 		

A checklist for accessible buildings and facilities		Yes	No
<ul style="list-style-type: none"> • External signs: <ul style="list-style-type: none"> - External location identification and motorist directional signs should be 90mm high and legible from approximately 45m - Where possible, provide Braille or raised lettering so that people with impaired vision can read them by touch 			
Safe evacuation			
86.	Is there an appropriate plan in place for the safe evacuation of everyone, including people with disabilities, in the case of an emergency?	<input type="checkbox"/>	<input type="checkbox"/>
87.	Is the fire alarm both audible and visible so they can be perceived by people who are Deaf or hard of hearing?	<input type="checkbox"/>	<input type="checkbox"/>

6.4 Further information

Further information	Reference
Compliance with Part M of the Building Regulations	The Department of Environment's Technical Guidance Document: www.environ.ie/en/Publications/DevelopmentandHousing/BuildingStandards/FileDownload,24773,en.pdf
Guidance on accessible buildings	The National Disability Authority's Building for Everyone: www.universaldesign.ie/buildingforeveryone
Guidelines on designing accessible environments	The Irish Wheelchair Association have developed Best Practice Access Guidelines - Designing Accessible Environments, following extensive consultation with their members and external organisations: www.iwa.ie/services/housing/iwa-housing-advocacy/designing-accessible-environments

Further information	Reference
Guidance on safe evacuation	The National Disability Authority Guidance on Safe Evacuation for All. http://nda.ie/Good-practice/Guidelines/Evacuation/Safe-Evacuation-for-All/Safe-Evacuation-for-All/Safe_Evacuation_for_All.pdf

7. Guideline Seven

Consent

“Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him / her to understand the nature, potential risks and benefits of the proposed intervention or service.”

National Consent Policy, HSE, May 2013

Please note, the following section “**Guideline Seven: Consent**” should be read in conjunction with the National Consent Policy, HSE which is available on www.hse.ie. These guidelines are also subject to change pending forthcoming legislation.

7.1 General Principles of Consent

The need for consent extends to all health and social care interventions conducted by or on behalf of health and social care services on patients and service users in all locations (for example, hospitals, community, residential care settings).

It is a basic rule at common law that consent must be obtained for medical examination, treatment, service or investigation. Consent must also be sought for a person to take part in a health and social care service research project.

Therefore, other than in exceptional circumstances, treating service users without their consent is a violation of their legal and constitutional rights and may result in civil or criminal proceedings being taken by the service user.

No other person such as a family member, friend or carer and no organisation can give or refuse consent to a health or social care service on behalf of an adult service user who lacks capacity to consent unless they have specific legal authority to do so.

7.2 What is valid and genuine consent?

Consent is the giving of permission or agreement for an intervention, receipt or use of a service or

participation in research following a process of communication about the proposed intervention. The process of communication begins at the initial contact and continues through to the end of the service user's involvement in the treatment process, provision of social care or research study. Seeking consent is not merely getting a consent form signed; the consent form is just one means of documenting that a process of communication has occurred.

The healthcare worker should aim to maximize the capacity of the service user as far as possible to provide or refuse consent. Getting consent is a process involving effective communication between the service user and healthcare professional. The provision of appropriate and accessible information to the service user will be critical in facilitating and supporting them to make an informed choice. In some situations, involving an appropriate third party to facilitate the exchange of information and communication between the healthcare professional and service user will be necessary (for example, where the service user is non-verbal or requires sign language interpretation).

For the consent to be valid, the service user must:

- Have received sufficient information in a comprehensible and accessible manner (in a way that they can understand) about the nature, purpose, benefits and risks of an intervention / service or research project (for example, proposed treatment, diagnostic procedure)
- Not be acting under duress, and
- Have the capacity to make the particular decision

7.3 Importance of individual circumstances

How much information service users want and require will vary depending on their individual circumstances. Discussions with service users should as much as possible be tailored according to:

- Their needs, wishes and priorities
- Their level of knowledge about, and understanding of, their condition, prognosis and the treatment options
- Their ability to understand the information provided / language used
- The nature of their condition

7.4 Informing the person before getting consent

The amount of information to be provided about an intervention will depend on the urgency, complexity, nature and level of risk associated with the intervention.

It is important to:

- Communicate and provide information at a level and in a format which is appropriate to the needs of each patient or service user. (See **Guideline Four: Communication for guidance** and **Guideline Five: Accessible information for guidance respectively**)
- Invest the time and effort needed to ensure that patients or service users:
 - understand the nature of the procedure or treatment
 - understand the consequences of refusing treatment
 - have enough information to make an informed decision
 - have an opportunity to ask questions about their condition and the procedure or treatment

Information about risk should be given in a balanced way. Service users may understand information about risk differently from those providing health and social care. This is particularly true when using descriptive terms such as ‘often’ or ‘uncommon’. Potential biases related to how risks are ‘framed’ are important: a 1 in a thousand risk of a complication also means that 999 out of a thousand service users will not experience that complication.

In order to best support service users in assessing the risk and benefits of various interventions / course of action consideration should be given to providing the information in an accessible and understandable format using plain language.

7.5 How and when information should be provided

The manner in which the health and social care options are discussed with a service user is as important as the information itself. The following measures are often helpful:

- Discussing treatment options in a place and at a time when the service user is best able to understand and retain the information. Sensitive issues should be discussed in an appropriate location to ensure that the service user’s privacy is protected to the greatest degree possible in the circumstances
- Providing adequate time and support, including, if necessary, repeating information
- Use of simple, clear and concise English and avoidance of medical terminology where possible
- Supplementing written or verbal information with visual depictions, for example, pictures
- Asking the service user if there is anything that would help them remember information, or make it easier to make a decision; such as bringing a relative, partner, friend, carer or advocate to consultations

Service users should be given the time and support they need to maximise their ability to make decisions for themselves. It is particularly important to ensure this is the case for those with limited literacy skills or who may lack capacity due to a condition. However, it should not be automatically assumed that service users with certain type of disabilities (for example, intellectual, cognitive, communication difficulties) lack capacity to understand information or make a decision. A person's capacity can be improved and maximised with appropriate and accessible information and supports so all practicable steps should be taken in this regard.

For those with communication difficulties, speaking to those close to the service user, to an advocate, a personal assistant or to other health and social care staff about the best ways of communicating with the service user, taking account of confidentiality issues, may be helpful. For example, additional measures may be required for people with limited English proficiency, people who are deaf and hard of hearing and blind and visually impaired service users.

7.6 How should consent be documented?

It is essential for those who provide health and social care, to document clearly a record of both the service users' agreement to the intervention and the discussions that led up to that agreement if:

- The intervention is invasive, complex or involves significant risks
- There may be significant consequences for the service user's employment, or social or personal life
- Providing clinical care is not the primary purpose of the intervention, for example, clinical photographs or video clip to be used for teaching purposes or blood testing following needle stick injury to staff
- The intervention is innovative or experimental, or
- In any other situation that the service provider considers appropriate

This may be done either through the use of a consent form or through documenting in the service user's notes that they have given verbal and / or non verbal consent.

If a consent form is used and the service user is unable to write, a mark on the form to indicate consent is sufficient. It is good practice for the mark to be witnessed by a person other than the clinician seeking consent and for the fact that the service user has chosen to make their mark in this way to be recorded in the healthcare record.

Written consent forms should be clear and easy to understand.

7.7 Capacity to consent

Has the service user the capacity to make the decision?

Best practice and international human rights standards operate from the presumption that all adult service users have capacity when making decisions unless the contrary is shown and all adult service users shall not be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help the person to do so.¹²

Where the decision-making capacity of the service user may be in doubt, best practice favours a ‘functional’ or issue-specific approach to defining decision-making capacity. According to this, the service user’s capacity is to be judged in relation to a particular decision to be made, at the time it is to be made - in other words, it should be issue specific and time specific – and depends upon the ability of an individual to understand, retain and to use or weigh that information as part of the process of making the decision. The service user must also be able to communicate the decision by any means (for example, using sign language, assistive technology) to the healthcare professional.

Duty to maximise capacity

Best practice and international human rights standards favour “supported decision-making” where possible. This requires that all practicable steps must be taken to maximise the service user’s decision making capacity to allow them to make their own decisions where possible.

Most service users will be able to make some decisions, but may find it difficult to make other decisions which may, for example, be more complex and involve choosing between a number of options. Fluctuations in a person’s condition such as confusion, panic, shock, fatigue, pain or medication may temporarily affect the person’s decision making capacity so as far as possible, seeking consent should be delayed until the person has regained capacity to do so.

It is important to give those who may have difficulty making decisions the time and support they need to maximise their ability to make decisions for themselves.

For further information on assessing capacity see the National Consent Policy and forthcoming legislation.

¹² See Assisted Decision Making (Capacity) Bill 2013

7.8 Emergency situations with service users who lack capacity

In an emergency situation where a service user is assessed to lack capacity, the health and social care professional may treat the service user provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition and that there is no valid advance refusal of treatment. The treatment provided should be the least restrictive of the service user's future choices

While it is good practice to inform those close to the service user – and they may be able to provide insight into the service user's will and preferences - nobody else can consent on behalf of the service user in this situation.

For further information see the **National Consent Policy**.

7.9 Consent, Children and Young People

Best practice and international human rights standards favour an approach which provides that a child's or young person's wishes are taken into account and, as the child grows towards maturity, given more weight accordingly. Where children are unable to give a valid consent for themselves owing to the legal age of consent, they should nonetheless be as involved as much as possible in decision-making as children may have opinions about their healthcare and have the right to have their views taken into consideration by giving their assent to the proposed treatment or service.

For more detailed information see the **National Consent Policy** which also addresses the issue of when it may be necessary to obtain the consent of both parents / guardians and / or when the consent of one is sufficient.

8. Guideline Eight

Role of family members and support persons

8.1 Role of family members and support persons

Family members and other support persons often play a critical role in enabling access to health and social care for people with disabilities, navigating the health and social care system with them and supporting them while in hospital or in other health and social care facilities.

If a person with a disability does not want to be accompanied by a carer or family member, this should be respected.

The family member, carer or support person will generally understand the person's disability and can provide information and insights into a person's accessibility requirements. This is important where people with disabilities are unable to communicate their requirements easily. Staff should be aware of their important role and facilitate it.

An interpreter may be necessary if the primary carer or advocate of a patient / service user is Deaf; for example, Deaf parents with a child who can hear. While the onus is on the service user to request an interpreter, it is the responsibility of staff to make the arrangements. It is considered good practice for services to arrange an interpreter without being prompted in cases where repeat visits are necessary or where it is known in advance that the service user needs one.

Collaboration between family carers or other support persons and health and social care staff can help to ensure that the basic needs and accessibility or communication requirements of a patient with a disability are met.

Family or other care support persons may be able to provide assistance with activities of daily living (such as assisting the person to eat or drink, dress or undress, move around, or use the toilet) where this is required and is what a person with disability wishes. However, family carers and other support persons should never be used to replace general nursing or medical care staff.

8.2 Right to privacy

People with disabilities have the same right to privacy and confidentiality as any other person. **The National Healthcare Charter, You and Your Health Service** states that everyone has the right to have their privacy respected and that, as staff, “We will do our best to ensure that you have adequate personal space and privacy when you use our health services. We maintain strict confidentiality of personal information”.

8.3 Discharge

See “**Guideline Three: Accessible services - general advice, Section 3.14, Integrated Discharge Planning**”, for more information on discharge planning. Also see “Integrated care guidance: A practical guide to discharge and transfer from hospital”.

Make a plan for continuity of care and support after discharge. On discharge from hospital, those playing a significant caring and support role to the person with a disability, including the GP, should also be informed about and understand the person’s medical and drug regime, any specific issues of care management, and under what conditions the person may need to return to the hospital. Where appropriate, make time to discuss a diagnosis and treatment plan with family members, carer or support person.

8.4 Carer needs

Family carers may themselves be elderly or frail and may have difficulties in providing physical assistance. Health care staff should be alert for signs of distress in the carer and limits on assistance they would be able to provide to the patient. Staff may be able to advise the person or their family about important sources of support and where further information is available.

Health care staff in policy and management positions can give consideration on supports which might be offered to relatives who need to visit hospitals or health centres frequently.

8.5 Advocacy

An independent advocate can represent the interests of vulnerable people and play a role in assisting people them to access services, rights and entitlements. An advocate can help them to identify and articulate accessibility requirements and assist them in making choices. Where this support is indicated, health staff should facilitate a person with a disability to access an independent advocate.

Any form of advocacy used must be agreeable to both the service user and the health and social care service.

Part Two

Guidelines for specific services

The guidelines describe a standard which we can aspire to. They are written in the knowledge that services may not have financial resources to implement all measures outlined; however, there is an obligation on individuals to ensure that they know what is required of them by law. They also serve as a resource for health and social care professionals who may be planning services in the future.

Many of the key initiatives you can take to make services more accessible are cost neutral. Consideration, compassion and open communication are free. Time spent identifying a person's needs is an investment in safe, effective care which can prevent unnecessary risks to the individual and the staff member.

9. Guideline Nine

Accessible GP surgeries, health care centres and primary care centres

The following section should be read in conjunction with Part One:

Guideline Three: Accessible services - general advice

Guideline Four: Communication

Guideline Five: Accessible information

Guideline Six: Accessible buildings and facilities

Guideline Seven: Consent

Guideline Eight: Role of family members and support persons

9.1 Plan services for all

People with disabilities are more likely to draw on primary care support as while they enjoy general good health; on average, they have poorer health than the population at large.

Primary care plays a critical role in supporting people with disabilities and chronic conditions to manage their condition, recover after an illness and stay well.

It is essential that primary care services are planned and delivered so that they are accessible to all patients and service users.

The uptake of preventative screening programmes is often very poor by patients and service users with a mental health illness or disability. Research also shows that people with intellectual disabilities who are living in the community are less likely to access primary care than other members of the population.

The following table includes a General Points Checklist to help staff and services identify if their services are accessible.

When reading the tables in the following sections, please note that the guidelines describe a standard which we can aspire to. They are written in the knowledge that services may not have financial resources to implement all measures outlined; however, there is an obligation on individuals to ensure that they know what is required of them by law. They also serve as a resource for health and social care professionals who may be planning services in the future.

General points		Yes	No
1.	Are the premises and equipment accessible to people with disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Is information and communication tailored to particular requirements people with disabilities may have?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are investigations, treatments and prescribed exercises tailored to meet the needs of people with disabilities?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Is a person with a disability treated on the basis of the clinical condition they present with? There can be a risk that symptoms of an illness are attributed to the person's disability rather than to another condition.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do people with intellectual disabilities in your community access primary care?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Are people with disabilities actively included in preventive and screening programmes?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Would it be helpful to keep a register of patients with disabilities to enable audit of their care?	<input type="checkbox"/>	<input type="checkbox"/>

Top Tips

- A positive measure introduced in the UK has been an automatic annual check-up for patients with an intellectual disability – this is considered good practice.
- Ensure preventive and screening programmes are designed to be accessible to and inclusive of people with disabilities where appropriate; for example, mammograms, cervical smears, flu vaccinations etc.

9.2 Your premises

The following table is a checklist which will help staff identify if their premises are accessible. It should be noted that this is not an exhaustive list and can be added to as required. More information is available in **Guideline Six: Accessible buildings and facilities**.

Points to consider

A checklist for your premises

Yes No

General points

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is your premises physically accessible to people with disabilities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there an alternative for patients who have difficulties in negotiating stairs; for example, that they can be seen in a downstairs consulting room? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there accessible parking close to the entrance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a pathway from the entrance to the parking area? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the main road free from obstructions or steps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there clear external and internal signage with large well-lit signs so that people can find their way easily to the building and around the building? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. If you have an intercom system at the entrance to the GP surgery or health centre, is it usable by someone seated in a wheelchair, by someone who has a visual impairment and by someone who is hard of hearing or Deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is there a ramp if the entrance is not level? Wheelchair users cannot negotiate steps, whereas people who walk but with some difficulty generally prefer a small number of steps to a ramp. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is there a handrail to assist people who are not steady on their feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there a hearing loop? If so, are people who use hearing aids routinely informed that it is available? Alternatively, consider a portable hearing loop or listening device that can be taken from one treatment room to another. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Is there an accessible toilet located at the entrance level and signposted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is the receptionist desk at a height where someone who is seated can transact their business? <ul style="list-style-type: none">• Is it possible to put a chair at the reception desk for someone who has a walking difficulty to sit down, if needed?• When a person is seated, do they have an unblocked view of the receptionist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is there sufficient space in the waiting room for a wheelchair user to turn around, and also so that the person can sit in the main waiting area next to a seated companion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. If your premises is not physically accessible to someone, are you prepared to arrange an appropriate alternative; for example, provide a home visit? | <input type="checkbox"/> | <input type="checkbox"/> |

A checklist for your premises		Yes	No
15.	In the case of an emergency, is there an appropriate plan in place for the safe evacuation of everyone? Has consideration been given to safe evacuation of those with disabilities; for example, people who are Deaf, blind, hard of hearing or who have mobility issues?	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

Top Tips

- If there is no fixed ramp, services might consider if it is possible to provide a mobile ramp or provide the option of both steps and a ramp
- If there is a loop system or a portable listening device, check that it is tested regularly and that staff know how to use it

9.3 Appointments, opening hours, waiting rooms

See **Guideline Three: Accessible services - general advice for more information on making appointments.**

Please note that the following section does not mean that preferential treatment will be given to people with disabilities, but rather that services should exercise consideration for the circumstances of a case where appropriate.

- Where possible, be flexible in making appointments, taking into consideration that some people with disabilities have difficulties with early morning appointments because of medication or the additional time needed to get ready
- Where possible, be flexible about surgery/ health centre opening hours to enable a family member, personal assistant or support person to accompany people with disabilities to attend an appointment
- Some people with disabilities may get agitated (for example, in an unfamiliar environment) or find it difficult to remain in one place for long. For these patients, consider appointment times that may minimise waiting times; for example, the first appointment after lunch
- If appointments can be made by text message or email, ensure there is a two-way process so that a person can respond to a text message or email, and cancel or change an appointment if

necessary. It is important that reception staff respond to text messages and emails in a timely way. Let people know of alternative methods of communication; for example, include a number to text on publicity material and headed paper

- People with disabilities may require more time than the standard consulting appointment (for example, to allow for additional time to interpret sign language) and consideration should be given to booking a longer appointment or double appointment
- It can be helpful to schedule appointments with an interpreter so that waiting times and cost of interpretive services are minimised

9.4 Waiting to be seen

For more information, see **Guideline Three: Accessible services - general advice.**

Visual Display Units in waiting rooms and public areas can inform people of appointments, directions, information or queuing information. A visual system could be a ticket machine, a visual display or a white board.

If possible, have both an audible and visual system for letting people know their turn. This is to ensure that people with impaired vision and people who are hard of hearing or Deaf are aware that they are being called for their turn.

If you use a ticket system for the queue, ensure that the ticket machine is at a height where a wheelchair user or a person of short stature can reach it (and that there is an alternative for people who are blind).

Inform people of how they will be called and of the location of the visual display units so that they can sit where they can see or hear when they are called.

In the absence of a visual display unit in the waiting room, make sure that people with impaired vision or those who are Deaf or hard of hearing are informed when it is their turn to be seen.

If you have a leaflet stand, make sure it can be reached from a wheelchair.

If your reception desk is not at an accessible height, be prepared to meet a wheelchair user away from the reception desk, in a place which will enable them to discuss their requirements with the same degree of privacy afforded to others.

A person with a walking difficulty or balance problems may need assistance sitting or standing. People with impaired vision may need assistance in finding a seat in the waiting room or a consultation/treatment room.

Offer to guide someone to the treatment room if this is needed; for example, someone with impaired vision or who is unsteady on their feet.

Some people with disabilities may find it difficult to wait in a crowded reception or waiting area without becoming agitated or anxious. Where possible, provide a quiet place for people who are distressed or anxious to sit, away from bright lights and noise.

9.5 Filling forms

It may be helpful to make large print forms available that are accessible to people with impaired vision.

It may be helpful to provide the option for the form to be accessed and completed on-line in advance of an appointment, if possible.

Ask if the person needs assistance filling in a form and provide that assistance if necessary. Approximately 25% of adults in Ireland have literacy difficulties. They are sometimes embarrassed by this, and can be very adept at covering up their problem. All staff should be particularly mindful of this group.

If the receptionist's counter is too high (for example, for a wheelchair user), you may need to step around it to complete your business with the patient / service user. Ensure there is a private area where people can give personal and medical details without being overheard.

A clipboard can be helpful for people unable to reach the counter when filling out forms or signing documents.

9.6 Examination and treatment

It is important to liaise with the specialist services that are treating any underlying disability or chronic condition, and ensure that any appropriate treatment protocols are followed in the primary care setting. For example, someone with a spinal injury may need to keep a particular posture, and this should be factored in to any examination or primary care treatment.

Ensure that your treatment and diagnostic facilities are accessible to wheelchair users and people who are unable to stand for long periods of time; for example, it may be helpful to:

- Equip your premises with an examination couch that can be raised or lowered, and with a hoist or monkey bars that can assist someone with mobility problems to safely transfer on and off
- Provide wheelchair weighing scales; and
- Provide handgrips to help people with mobility or vision impairments to have support when standing, for example, on weighing scales

If the patient is not able to transfer to an examination couch with assistance, conduct the examination in the person's chair or wheelchair if appropriate.

9.7 Consent

You should seek the consent of the person with a disability as with any other patient. See **Guideline Seven: Consent**.

Always ask for consent to share confidential information about an individual's accessibility requirements.

9.8 Communication with patients and service users

See **Guideline Four: Communication for more information on communicating with a patient or service user in a way that meets their needs**.

Communicate directly with the person, rather than their family member, carer or interpreter.

If you have a patient with a disability, ask what their preferred method of communication is to enable two-way communication with the service; for example, orally, in writing, by e-mail or otherwise. Text and email may be appropriate for making appointments / administrative tasks; however, they should never substitute for a face to face clinical or professional consultation. It is relatively easy to have an email relationship with a patient with a disability, but this can be a source of error and poor clinical management if it is the sole means of communication.

Ensure that communication is appropriate to the person's needs so that the person can receive and understand communication around appointments or referrals, a diagnosis, prescribing medications, exercises etc.

Record their preferred method of communication on their file and ensure that:

- Relevant staff, such as receptionists who make appointments, are aware of it and
- A system is in place to alert other relevant staff who may have contact with the patient or service user as part of their care plan

Where the person has a significant disability, family members or carers may be able to offer guidance on how best to communicate.

Where possible, use the person's preferred form of communication, for example, texting or e-mailing, in relation to appointments.

Give the patient or service user relevant information to take away, clearly typed and in plain English. A service may take steps to translate the information into other languages where necessary; however, this should also be written in a style which is easy to understand.

It may be necessary to provide additional time or communication support to enable a person to understand the treatment and possible outcomes and to ask questions. A service may take steps to translate the information into other languages where necessary; however, this should also be written in a style which is easy to understand.

General principles of good communication include:

- Face the person you are communicating with
- Maintain eye contact
- Never carry out another task when listening to someone
- Speak clearly, concisely and slowly
- Use straightforward language
- Ask one question at a time and do not interrupt unless necessary
- Give the person time to respond and ask questions
- Repeat what you have said when a person is having difficulty understanding and verify that they have understood; and
- Phrase questions in a way that a person can give a simple 'yes' or 'no' answer

Explain the procedures you will undertake, step by step.

For a patient who is unable to see, go through each procedure or test before you do it. Tell them what parts of their body you will examine and where you will touch. If you are giving an injection or a needle prick, explain where you will put the needle or, if you are taking blood pressure or using a stethoscope, explain the procedure.

Some patients or service users may need extra time to understand what is being said to them and to ask questions (for example, a person who is unable to speak or to hear, who has difficulty processing or retaining information or who cannot read, or a person who has an intellectual disability, an acquired brain injury or dementia). Use very simple language. As they may have difficulties processing or remembering information, take it slowly, step by step.

Do not overload the patient or service user with information. Where appropriate, use pictures, signs and symbols.

If someone has difficulty in hearing, face them directly and make sure your face is in the light, to enable them lip-read. Speak clearly, do not exaggerate your mouth movements and do not cover your mouth. Use gestures and diagrams and provide information in writing to reinforce what you are saying.

If you have difficulty understanding what a person is saying, tell them in a respectful way. The person maybe able to respond with a gesture to questions that require just a “yes “or “no” answer.

If requested by a Deaf person, book an Irish Sign Language interpreter in advance of an appointment. Take all reasonable steps to ensure that a Deaf person can access a qualified Irish Sign Language interpreter of their choice. The absence of a professional interpreter can result in misdiagnosis, clinical risk and compromise safety. Where there is an unplanned visit or an emergency, you may be able to communicate through a remote sign language interpreter via video link. This requires a wifi-enabled computer with a camera, microphone and speakers, as found on modern laptops.

Be sensitive to the stress it may cause if someone has difficulty in communicating clearly or in understanding information. Facilitate them in giving it extra time and in explaining as clearly as you can, using gestures and diagrams to supplement the spoken word.

9.9 Information

For further information see **Guideline Five: Accessible information**.

Provide information on accessibility features of your premises and services. Include this information on your communication materials; for example, on a website, information leaflets, booklets etc.

Provide take-home information to supplement what you say to your patients or service users. People may not be able to absorb everything you say during a consultation or treatment session. Information should be written in plain English and typed in clear print. Use simple language to explain medical terms. Provide appropriate diagrams, for example, for physical exercises.

Provide information to your patients on other relevant community support services and entitlements; for example, if a patient has recently developed a disability, you may be able to refer them to the appropriate support group for that condition. The Citizens Information Board publishes information on entitlements for people with disabilities.

Provide service user/patient information forms, information about after-care, prescriptions, medical certificates and other information leaflets in a large print format when required.

Some people with an intellectual disability may require information in Easy to Read format, which consists of short simple text and illustrations. There are a number of resources you can draw on, such as picture banks and picture books that are used by some people with an intellectual disability in health settings. Use pictures and symbols to explain treatments or health conditions

Do not presume that a person can read or understand the written information you provide. Always verbally explain any written information about medication, treatment or after-care, for example. Check that the service user understands what you have said and written down. If this is not clear repeat the information and be patient.

9.10 Continuity of care

It will help some people with disabilities to see the same GP or other relevant professional each time they visit. For example, a person with an acquired brain injury or a person with an intellectual disability may experience less distress if they are dealing with a member of staff that they know.

Ensure that every member of staff is trained so that they may recognise the accessibility and communication needs of patients and service users and, in turn, communicate with and assist them as needed.

9.11 Home visits

Some patients may find it physically difficult to get to a GP surgery or primary care centre. Others, such as a person with an intellectual disability or dementia, may be less disorientated or anxious if they are seen at home by a GP or other member of the primary care team. Where possible, arrange home visits in these circumstances

If you are visiting a person with impaired vision in their own home, let them know if you move something and let them know if you replace the item so that she/he can find it when you leave.

9.12 Family members and carers

Family members, carers and support persons play a key role, particularly for people with significant levels of disability. They are often an invaluable source of expertise about a person's disability, health and well-being. They can help achieve better outcomes in communication, understanding and decision-making. With the consent of the person with a disability, involve their family, members, carers and support persons in care plans.

Primary communication must be with the patient and not with their family member or personal assistant.

Where the person so consents, give family members, carers and support persons information that is easy to follow about the treatment, diagnosis, medication and follow-up appointments, to enable them to provide appropriate care and support.

Public health nurses, social workers and other members of primary care teams can play a key role in supporting family carers and in giving them information on the help and the entitlements open to them. The Citizens Information Board website is also a useful source on information on entitlements and supports.

9.13 Referral and sharing of information

It is essential that patients and service users experience integrated care in primary care, specialist care, rehabilitation and hospital care services which is centred on the individual and their needs. Where appropriate, teams can share their knowledge and experience so that person centred care becomes the norm.

The multidisciplinary team in primary care can meet different aspects of an individual's needs; for example, the public health nurse, physiotherapist, occupational therapist, social worker or speech and language therapist.

The primary care team plays an important role in supporting an individual with a disability who is awaiting a rehabilitation service or has been discharged from rehabilitation back to the community.

The individual's family, carers or disability support service also have a key role. The primary care team may need to liaise with others involved in the person's care, including hospital specialists or the community mental health care team, where appropriate.

It is important to have good communication between different individuals and teams which are looking after different aspects of a person's medical, care and support needs so that these are addressed in a co-ordinated way.

It is also important to ensure that particular accessibility requirements, for example, preferred forms of communication, are shared between different professionals and services involved in the person's care, so that these do not need to be negotiated again every time.

Ask for the person's consent for their accessibility requirements being noted in their file and passed on to other practitioners

Include the person and their family (with the person's consent where appropriate) in any multi-disciplinary case conference.

Primary care team services and specialist disability support services may be necessary after the onset of a disability; for example, if a person acquires a brain injury from an accident. Often there is a waiting list for rehabilitation, which means that there is a key role for community support and information for the person during this interim period.

10. Guideline Ten

Accessible Hospital Services, including Out-Patient Departments

The following section should be read in conjunction with Part One:

Guideline Three: Accessible services - general advice

Guideline Four: Communication

Guideline Five: Accessible information

Guideline Six: Accessible buildings and facilities

Guideline Seven: Consent

Guideline Eight: Role of family members and support persons

10.1 Ask, Listen, Learn, Plan, Do

People with disabilities are often experts in what they need. See **Guideline One: Developing accessible health and social care services** for more information on Ask, Listen, Learn, Plan and Do.

Ask

- Ask all patients: Do you have any specific requirements that must be accommodated? Is there anything we can do to assist you? Remember many disabilities are not visible
- With the consent of the person with a disability, family members, carers or support workers may also be able to guide on any specific needs.

Listen

- Listen attentively to what their requirements are and how they can be addressed.

Learn

- Use booking visits or pre-admission clinics to identify any accessibility needs before a person attends for elective or pre-planned treatment
- If accessibility requirements have not been determined at pre-admission stage, make a plan when the person first visits the hospital

Plan

- Plan the support required for:
 1. Admission
 2. Hospital stay
 3. Discharge

Do

- Put the plan into action

The following sections will give you more information on planning the support for each of these stages.

10.2 Who to talk to when developing the care plan?

Discuss any options with the individual.

Involve, with the consent of the person with a disability, their family, members, carers and support persons in the drawing up of care plans.

- Family members, carers and support persons can play a key role in supporting and caring for people with disabilities and are an invaluable source of expertise about a person's disability, health and well-being
- In so far as possible, facilitate a person with a disability, where they so wish, to receive care and support from family members, carers or personal assistants while in hospital. However, family carers and other support persons should never be used to replace general nursing or medical care staff

-
- Family members or other carers may need to be given information about diagnosis, medication, treatment, exercises, care and any outpatients' appointments, in order to provide effective support after discharge from hospital

Organise a multi-disciplinary case conference where this is required; for example, where the person has complex conditions or high support needs. Cross-disciplinary support may be invaluable in treating someone with dementia, with intellectual disability, with mental health difficulties, with spinal injuries or other complex needs.

- Liaise with other medical teams involved in the person's care and treatment as appropriate
- Draw on the expertise of staff from across the hospital, such as physiotherapists, social workers and speech and language therapists, who will assist with planning services and information for people with disabilities prior to admission and on discharge
- Liaise as required with disability service providers, the person's key worker or clinical specialists in disability. This should also assist when co-ordinating care and planning between the hospital and the community
- Liaise as required with older people's specialists in the hospital and with specialist services, primary care teams, voluntary organisations and key workers in the community

10.3 Identify existing care protocols

Identify if there are any care protocols associated with the person's primary disability or pre-existing condition. For example:

- People with spinal injuries may have particular requirements around posture, toileting, and avoidance of pressure sores
- People may need help with their toileting and bathing requirements, eating and drinking, regular turning to prevent pressure sores or in providing accessible communication

10.4 Prepare in advance

Book any equipment or arrange assistance or adaptations before the person is admitted to hospital. For example, a lifting hoist may be needed in a treatment room in order for someone to move safely from their wheelchair onto an examination.

Place an accessibility checklist in the person's file so that all accessibility requirements can be noted. (See **Appendix 1** for a sample checklist. An online checklist may suit some people). Use the list at follow-up appointments or when referred to other diagnostic or treatment services in

the hospital, or to community based services. Check if any requirements have changed at each subsequent visit.

Enable access to an independent advocate; provide the person with contact details for independent advocacy services to help the person avail of their entitlements.

Arrange where possible for continuity of care so that someone with a disability can benefit from seeing same health practitioner each time they attend an outpatient appointment. Factor this into the scheduling of appointments. For example, someone with an acquired brain injury or a person with an intellectual disability is likely to experience less distress if the person they see is known to them.

10.5 In the hospital

Admission - In reception

- Where a low reception desk is available, make sure that the low space is kept clear and is not blocked with office equipment, to allow face-to-face contact with a manual or powered wheelchair user and people of short stature
- People with mental health difficulties or an intellectual disability may prefer to sit and wait in a quiet area if available

Informing people of their turn to be seen

- Be sensitive about how you call a person; do not shout or compromise the person's privacy. If there is not a dual spoken and visual announcement of someone's turn, people may require a receptionist to alert them when their appointment is called. For example:
 - People with impaired vision can be alerted by a gentle tap on their shoulder or arm
 - People who are Deaf or hard of hearing can be alerted visually by a hand movement, such as a discreet wave or by tapping the person gently on their shoulder or arm

Getting to the appointment / ward

- People with walking difficulties or balance problems may need assistance in getting to an outpatient clinic or ward. For example:
 - Porters should be available to assist a person if requested, for example, to sit down or stand from a seated position, and/or provide a wheelchair and accompany a person with a mobility difficulty

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- If the outpatient clinic, consulting or treatment room is in a part of the hospital which the patient cannot access (for example, up stairs), arrange to see the person in an alternative location that is accessible to the patient. Put in place a plan so that this will be rectified in the future
 - A person with impaired vision may request a 'sighted guide'. Again, porters, receptionists and other staff can all learn how to accompany and guide people with impaired vision appropriately when requested

In the ward

- Accommodate the requirements of a person with a disability when they are admitted to a ward. For example:
 - allocate a bed close to an accessible toilet and washing facilities
 - ensure that there is a facility for people who are Deaf or hard of hearing to access subtitles, if there is a television in the room
- Where possible, a person may prefer to be in a quiet part of the ward or in a single room; for example:
 - a person with mental health difficulties may prefer to be located in a quiet part of the ward or in a single room, if possible, away from loud noises and bright lights. A single room may be important for someone who needs to get a good night's sleep to manage a particular condition (for example, bipolar disorder)
 - a person who is hard of hearing may find it easier to communicate more effectively in a quiet part of the ward or a single room. Where possible, position their bed so that they can see when someone comes into the room
 - a person with impaired vision may find it easier to communicate in a quiet part of the ward or in a single room
 - a person with an intellectual disability or cognitive impairment may be less anxious if they are in a familiar and quiet environment
 - a person with dementia or other cognitive impairment may benefit from being in a quiet part of the ward or in a single room. This may help to reduce confusion and anxiety. Avoid moving people with dementia from one room to another where possible, as that can give rise to distress

Meal times

- When serving a meal, catering staff should tell a person with impaired vision that the meal has arrived and has been placed in front of him/her
- Adapted cutlery and drinking aids should be made available to those who need them
- Serve food on a tray that has a good edge – anything spilled will stay on the tray
- Help the person identify where the food is on a dinner plate by using a clock system. For example, “the meat is at 12 o’clock, the peas are at 3 o’clock and the potatoes are at 6 o’clock”
- For someone with low vision, providing good colour contrast between a drink and its container can avoid accidents. For example, water in a clear glass may not be easily seen; instead place the water in a brightly coloured cup. Another example is to pour tea into a white mug where it is easier to see than in a brown mug
- Sometimes a personal assistant or support person is able to assist with feeding; for example, where the person has swallowing difficulties. This should only be carried out with the consent of the person with a disability, and should never replace general care provided by hospital staff
- Make special provision for people with disabilities who do not have a carer or support person to assist them. It is very important to provide assistance with meals and hydration

Care from family or carer

- Where possible, provide flexibility in visiting times so that people with disabilities can receive support from their family member, carer, support person or personal assistant, if requested. This is important for people with significant disabilities
- Make special provision for people with disabilities who do not have a carer or support person to assist them. It is very important to provide assistance with meals and hydration, using the toilet and washing
- Care from family or a carer should never replace general care provided by hospital staff

Disability-specific care needs

- Be aware of specific disability-related health support needs. Being aware of the need for specific care can avoid the onset of more complicated health problems. For example:
 - A person may require regular turning to avoid the risk of the build-up of pressure sores
 - A person may require the use of a hoist, wheelchair or other specialised equipment
 - A person with a spinal cord injury or paralysis may require timely and respectful bowel care procedures to be implemented at specified times.

Where people cannot articulate their needs

- It is particularly important that hospital staff be aware that some people with disabilities, such as people with an intellectual disability or people with an acquired brain injury, may not be able to articulate their requirements clearly; for example, asking for water or using the toilet
- This is also important because a person may not be able to articulate changes in their symptoms or pain levels. The following may be helpful:
 - a higher level of clinical observation and the building of a good relationship and communications
 - sensitivity and good communications to assist the person in communicating pain and discomfort; and
 - the use of pictures and symbols or asking a person to touch the part of their body that hurts

Familiar objects

- Encourage people with intellectual disabilities and people with dementia to bring some familiar objects such as photographs of family members on their bedside table

Television

- Ensure that the facility for subtitles is switched on as this will mean that the television is accessible for people who are Deaf or hard of hearing
- Many people with sight loss enjoy television, so don't be embarrassed to ask the person if they would like the television switched on

Hearing loop / Listening Devices

- Where possible, provide a facility for a person who is a hearing aid user to have a portable induction loop so that they can communicate with staff or visitors during their stay in hospital. Listening devices that amplify sound can help improve communication with people who are hard of hearing

Explain medical procedures clearly and accessibly

- If a person is undergoing an operation or any procedure, it is important that what is going to happen is clearly explained in advance
- It is particularly important to let someone who is blind or has low vision know what is happening verbally, as they will not be able to see it. Explain clearly and step-by-step what is happening at each stage. For example:

- If an anaesthetist is going to apply an oxygen mask, this should be explained in advance
- If a person is having an MRI scan, mammogram or x-ray, explain all procedures clearly and let the person know when you move behind a screen or into another room
- If diagnostic equipment is being used, such as an echocardiogram, describe clearly what is on the screen, as this may not be seen by a person with impaired vision or understood by people with cognitive impairments
- If people with impaired vision are asked to wear a halter monitor or blood pressure monitor, point out where the monitor will be located before it is put on
- Always ask people with disabilities, “Is there anything we can do to assist you?”

10.6 Discharge from hospital - integrated discharge planning

“To ensure service users are discharged or transferred safely and on time requires full assessment of their individual healthcare needs, planning and co-operation of many health and social care professionals.”¹³

Make a plan for continuity of care and support after discharge in accordance with the “Integrated care guidance: A practical guide to discharge and transfer from hospital”.

See section 3.14 for an extract from the “**Discharge and transfer from hospital - The nine steps quick reference guide**” and some helpful guidance.

- **Step one:** Begin planning for discharge before or on admission
- **Step two:** Identify whether the service user has simple or complex needs
- **Step three:** Develop a treatment plan within 24 hours of admission
- **Step four:** Work together to provide comprehensive service user assessment and treatment
- **Step five:** Set a predicted date of discharge / transfer within 24 – 48 hours of admission
- **Step six:** Involve service users and carers so they make informed decisions and choices
- **Step seven:** Review the treatment plan on a daily basis with the service user
- **Step eight:** Use a discharge checklist 24 – 48 hours before discharge
- **Step nine:** Make decisions to discharge / transfer service users each day

11. Guideline Eleven

Accessible Emergency Departments

The following section should be read in conjunction with Part One:

Guideline Three: Accessible services - general advice

Guideline Four: Communication

Guideline Five: Accessible information

Guideline Six: Accessible buildings and facilities

Guideline Seven: Consent

Guideline Eight: Role of family members and support persons

Staff should also refer to **The National Emergency Medicine Programme – A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland** which is referenced throughout the section below.

Emergency Sign Language Interpretative Service

Once Emergency Department staff identify that a person is Deaf and uses Irish Sign Language (ISL) as their primary language, they should follow the local policy in place to arrange an interpreter. The emergency contact number for the Sign Language Interpretative Services is 087 672 5179.

Emergency Multilingual Aids (EMA)

EMAs are available to assist staff and patients in an emergency where English is not their first language. These are available on: <http://www.hse.ie/eng/services/Publications/SocialInclusion/EMA.html>

11.1 On arrival

Extract from the **National Emergency Medicine Programme (EMP) Strategy: Section 16.8.2.10**

Vulnerable adults:

Adults with a physical or intellectual disability, cognitive impairment or mental ill-health diagnoses may require additional social supports during and following their Emergency Department (ED) presentation.

The National Emergency Medicine Programme (EMP) – A strategy to improve safety, quality, access and value in Emergency Medicine (EM) in Ireland (referred to as the **National EMP Strategy** in the following section) notes that some people have additional or particular care needs when they present to emergency services. The strategy makes specific reference to patients with complex psycho-social problems, people with an intellectual disability, people with a physical disability, and people with language or communication problems. All of these service users may have accessibility needs. It is, therefore, important to be sensitive to the needs of patients and service users, and to identify as early as possible in the patient / service user experience what needs a person may have so that they can be managed accordingly. For example:

The receptionist may during the check in process identify if the service user or their carer has any obvious accessibility needs and, where appropriate, inform clinical staff. Local procedures should be developed to support staff who identify accessibility needs; for example, how to arrange an interpretative service in an emergency.

While the **National EMP Strategy** identifies the most important component of Emergency Medicine work as the “prioritised evaluation and treatment of patients with time-critical healthcare needs”, it may take additional time to assess a person’s immediate communication or other support requirements where they have accessibility needs.

Assigned nurses or doctors may routinely identify any accessibility need when asking about the past history of note or at the end of a triage process, when asking “Is there anything else you need to tell us?”. However, in order to evaluate and treat some patients, it can be helpful for staff to tailor questions to specifically identify accessibility needs or, alternatively, how to meet them.

Top Tips

- Remember some forms of disability are not visible
- Provide assistance to people to meet their accessibility requirements where possible. However, do not assume that you know best. Just because people have the same disability, it does not mean their needs are the same. Always ask if there are specific requirements to accommodate a person’s disability. A person with a disability is normally an expert in what is required to ensure that their accessibility needs are met
- The triage nurse should document any identified accessibility needs on the front of the Emergency Department card and highlight it in handover. This not only improves the experience

for the patient or their family / carer, but also saves staff critical time

- For some patients, it can be helpful to have the same staff member involved in their care throughout the Emergency Department journey; however, this is not always possible

11.2 Communication

Extract from **National EMP Strategy, Section 21.7 People with Language or Communication Problems**

Excellent communication is essential to the successful interaction with all patients and their families attending Emergency Care Networks (ECN)¹⁴ units. Clear information is required on access routes to the hospital; therefore, effective road and hospital signage detailing the type of ECN unit is essential.

Communication barriers that can impede successful interaction include:

- Literacy difficulties
- Not speaking the same language
- Communication barriers in the environment, including poor signage and a noisy environment
- The inability to access and/or use services or equipment
- Physical disability restricting communication, such as difficulties with writing
- A visual or hearing impairment; and
- A lack of ability to concentrate and focus on communication

Patients may present to the ECN with one or a variety of the above barriers to effective communication. Resources to assist with removing and reducing language and communication barriers are listed in the References and Resources section of the National EMP Strategy. Speech and Language Therapists can also provide assistance with reducing communication barriers as outlined in Chapter 16 of the strategy. Where a patient doesn't have adequate English skills, the HSE recommends the use of professional interpreting services for clinical examinations or obtaining consent to ensure patient confidentiality.

¹⁴ Emergency Care Networks (ECN's) will include:

- 24/7 Emergency Departments (ED's);
- Local Injury Units (LIU's) where patients with non-life threatening injuries can receive care;
- The potential role of Local Emergency Units (LEU's) providing daytime only emergency services may be considered on a limited number of sites.

Effective communication is essential to take a good case history and identify symptoms. Difficulties in communication can increase the risk that health conditions or symptoms pass undetected.

Provide for accessible communication and information at every stage of the patient's journey. Establish if there are any specific communication aids that the person wants to use and their preferred form of communication so that their accessibility needs are met. For example:

- Some people with an intellectual disability have a communication passport; some people with speech impairments use a communications board. Communication aids will normally contain information about the person's disability, communication needs, medication or health.¹⁵ The patient passport, where possible, should be used to inform the Acute Needs Assessment
- If funding becomes available, it may be helpful to procure a portable induction loop for hearing aid users or a portable listening device for hard of hearing service users

Building trust is essential to good communication.

Always communicate with the person with a disability in the first instance. If this is not possible, involve the person's carer or support person.

You may need to allow additional time to communicate with service users depending on their needs. Providing the time may be important in detecting a health problem that is not obvious, making a correct diagnosis and explaining this and follow up treatment. A person with an intellectual disability, for example, may need more time in order to understand the diagnosis and the treatment.

For more details see **Guideline Four: Communication and Guideline Seven: Consent**

11.3 Accessibility requirements

As attendance in an emergency department is not planned, people with disabilities will not have let the hospital know in advance of any support needs.

“The infrastructure of each facility in the ECN (Emergency Care Network) must meet the needs of patients with a physical disability, thus ensuring they are cared for in a safe environment. Emergency Department infrastructure should also accommodate patients' family members, carers, Emergency Department staff and other hospital staff who have physical disability.”¹⁶ In addition to an accessible treatment space, equipment can also be helpful. Examples include a height-

¹⁵ See The National Emergency Medicine Programme – A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland - Section 21.5.1.1, Patient Passport and Section 21.5.1.2, Acute needs assessment.

¹⁶ See The National Emergency Medicine Programme – A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland - Section 21.6 People with Physical Disability

adjustable trolley or examination couch, and hoists to assist a wheelchair user to safely move onto an adjustable trolley / examination couch from their wheelchair.

It is part of essential care to ensure that patients are hydrated, that basic comfort needs are met and that any additional interventions are undertaken to prevent the risk of build-up of pressure sores, particularly if they have to wait on a trolley for more than two hours.

A person with a disability may have specific support needs around basic activities, such as eating, drinking, turning to prevent pressure sores or going to the bathroom. For example, if a person is in the emergency department for long periods of time on a trolley, they may need to be turned regularly to prevent the risk of pressure sores, or they may need assistance with any feeding and hydration required.

This support is especially important if the person does not have a family member, personal assistant or care worker with them. However, even if they are available and may wish to assist in the process, family carers and other support persons should never be used to replace general nursing or medical care staff.

While many of the support needs around basic activities will be routinely met as part of the professional standards adhered to by staff providing essential care, staff may need to be made aware of specific needs during handover processes, and other disciplines of staff may need guidance on their role. In a busy emergency department, it is important to ensure that specific requirements of someone with a disability are not overlooked.

- Ensure that relevant staff have received appropriate training to assist
- Handover between staff in different disciplines should routinely include a briefing on specific accessibility needs
- Where necessary, develop an agreed approach to ensure that specific care needs are managed at appropriate intervals as required

The emergency department staff may need to liaise with appropriate services to identify specific needs. This might include the person's GP or specialist (for example, the psychiatric team or community mental health team) or their disability support service. See Section 16 of the **National EMP Strategy** for information on the roles of therapy professionals and medical social workers in emergency care including physiotherapists, occupational therapists, orthoptists, speech and language therapists, dieticians, podiatrists and medical social workers.

See **Guideline 4: Communication for more information on communicating with patients and service users with specific disabilities.**

If admitted to hospital, it is essential that a person's accessibility requirements are passed on to all relevant staff, including receptionists, porters and catering staff. Inform the person with a disability of any information that is being passed onto other staff or service providers.

11.4 Waiting to be seen

“Emergency Department clinicians and hospitals have a duty of care to patients who may need to be accommodated in a waiting room area.” See **Section 19.9.2. Recommendations for Patient Care in Emergency Department Waiting Rooms of the National EMP Strategy.**

Use this time as an opportunity to find out if there are any specific requirements while the person is waiting.

The triage process will identify the priority in the treatment of patients, based on the severity of their condition which can lead to delays for other patients.

Some patients and service users may experience significant distress or anxiety in unfamiliar, crowded or noisy environments; for example, a person with a mental health difficulty, an acquired brain injury, an intellectual disability or a person with dementia. If the Emergency Department has the space and/or capacity, the following measures may be helpful for service users in this situation. However, it should be noted that these suggestions are not to provide a person with a disability a preferential service over any other patient or service user, but rather to ensure that compassion is shown in a situation where a person's disability directly leads to significant distress or anxiety which could be alleviated. Please note, the following suggestions are dependent on local resources:

- Ask a person if they would prefer to wait in a quiet room / elsewhere and call them when their turn is near
- Inform a person if there is to be a long wait and how long it will be, if this is known. This may allow them an opportunity to go away and get a cup of tea or a meal. Send a text message or call them on their mobile phone if they are near the top of the queue

Make sure that systems are in place to ensure that people are informed appropriately when it is their turn to be seen if they have impaired vision or are Deaf, hard of hearing or deafblind.

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- Where possible, plan to have both spoken and visual announcements
 - If this is not possible, people with impaired vision can be alerted by a gentle tap on their shoulder or arm
 - People who are Deaf or hard of hearing can be alerted visually by a hand movement, such as a discreet wave, or by tapping the person gently on their shoulder or arm

If there is a television in the emergency department waiting room, make sure that it displays subtitles and can be accessed by people who are Deaf or hard of hearing.

11.5 Family or carer support

A person with a disability may need support while waiting to be seen, as well as in communicating their medical history, making informed decisions and giving consent to care. In an accident or emergency setting, family members, carers or personal assistants can assist the person with a disability and be an invaluable source of expertise about a person's disability, health and well-being.

Facilitate the person with a disability to be supported by a family member, carer, personal assistant or advocate, where they so wish. The triage nurse may be the person who makes this decision, which should be communicated to other staff

11.6 Assigned staff

It may be helpful to assign a key member of staff to assist a person with a disability to ensure that her/his requirements are met. This can be very important for a person who has significant disabilities or someone who has no accompanying person to support them. However, it is recognised that it is not possible to facilitate this in every setting.

11.7 Explain medical procedures clearly and accessibly

If a person is undergoing any procedure, it is important to explain what is going to happen clearly and in advance.

It is particularly important to let someone who is blind or has impaired vision know what is happening as they will not be able to see it. Tell them about any procedure you are going to do, such as taking blood or giving an injection, and where the needle site will be.

If performing a physical examination, explain in advance where you plan to examine (i.e., touch).

Explain clearly and step-by-step what is happening at each stage.

Explain all diagnostic procedures clearly, such as an ultrasound, rectal examination, electrocardiogram, an x-ray or MRI scan. Let the person know when you move behind a screen or into another room.

If performing an intimate examination as part of standard protocol, ensure a chaperone is present.

11.8 Integrated Discharge Planning from the Emergency Department

Health and social care professionals should refer to:

- **Guideline Three: Accessible services** - general advice, Section 3.14, Integrated Discharge Planning
- **Guideline Ten: Accessible Hospital Services**, Section 10.6, Discharge from hospital - integrated discharge planning
- **Integrated Care Guidance: A practical guide to discharge and transfer from hospital**
- **Chapter 19. The Emergency Medicine Patient Pathway, The National Emergency Medicine Programme – A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland**

Extract from the National Emergency Medicine Programme Strategy, Section 19.17.4 Recommendations for Patient Discharge and Departure

- All patients should have an appropriate brief discharge summary sent to their GP
- The Emergency Medicine Programme will develop a template for Emergency Department discharge summaries in collaboration with the Directorate of Clinical Strategy and Programmes Primary Care Programme
- The time of Emergency Medical discharge and the time of Emergency Department departure should be recorded for all patients
- Follow-up care arrangements for all patients should be recorded in the patient's Emergency Department records/Emergency Department Information Systems
- Standard National Emergency Care Systems datasets will include follow-up arrangements for ED patients
- Patients should be provided with self-care information as part of the discharge process (for example, head injury advice)

Where appropriate to the Emergency Department, make a plan for continuing care and support after discharge.

Safe discharge may mean that staff will liaise with other disciplines, such as the Public Health Nurse, their GP, the specialist treating their primary disability or other condition or their disability support service. “Multidisciplinary assessment is particularly valuable in supporting the safe discharge of patients with complex care needs.”: Section 19.19.4, Patient Discharge, **National EMP Strategy.**

All GPs should be informed following a service user’s attendance at the Emergency Department as part of standard processes. Where this post exists, this may be the task of a GP liaison nurse.

Assess if any additional supports are needed when the person goes home, following their Emergency Department visit.

When a person is discharged from hospital, explain all follow-up procedures, medication, after-care or when further appointments are needed. Print this information off in clear print so the person has it to keep.

It is important that family members, carers or support persons also understand the medication regime. While it is important to respect the person’s privacy, it is also important for their safety that those assisting them know which medication should be taken. Carers also need to be told when and under what conditions the person needs to return to the hospital.

Signpost a person towards relevant disability organisations for support and information if appropriate.

12. Guideline Twelve

Accessible maternity services

The following section should be read in conjunction with Part One:

Guideline Three: Accessible services - general advice

Guideline Four: Communication

Guideline Five: Accessible information

Guideline Six: Accessible buildings and facilities

Guideline Seven: Consent

Guideline Eight: Role of family members and support persons

12.1 Introduction

The guidelines are written in the knowledge that services may not have financial resources to implement all measures outlined. However, many of the guidelines are cost neutral, and they also serve as a resource for health and social care professionals who may be planning services in the future.

These guidelines are for all health and social care staff and should be read in conjunction with the relevant **Code of Professional Conduct** and with the existing guidelines for staff, including the **Clinical Guidelines of the Institute of Obstetricians and Gynaecologists** at the **Royal College of Physicians in Ireland and Midwifery Practice Standards (2010)** from **An Bord Altranais agus Cnaimhseachais**.

An Bord Altranais midwifery practice standards state that health professionals should enhance their knowledge of services and supports available to women with disabilities, in line with the Royal College of Nursing's (2007) guidelines. The Royal College of Nursing guidelines, entitled **Pregnancy and Disability: RCN Guidance for Midwives and Nurses**, can be accessed at <http://www.rcn.org.uk/>.

More detail is available on accessible services in **Guideline Three: Accessible services - general advice; Guideline Four: Communication; Guideline Five: Accessible information; Guideline Six: Accessible buildings and facilities and Guideline Seven: Consent**.

Clinical staff need to be knowledgeable about particular needs and issues connected with disability and to have corresponding clinical skills. For example, relevant clinicians should know about epidural anaesthesia for someone with spina bifida or spinal cord injury.

It should be noted that this section is primarily about accessible maternity services from the woman's perspective. However, patients and service users may wish to have a partner, family member, friend or an advocate accompany them, who may have an accessibility requirement. In this regard, services may need to give consideration to their needs also; for example, a blind parent attending the birth of their baby.

12.2 Non-judgmental

In accordance with the **Code of Professional Conduct**, be non-judgmental and professional in caring for women who are pregnant.

- Do not query her decision to get pregnant nor her capacity to care for and nurture her baby
- Do not assume that she has or does not have any specific requirements – ask. People with disabilities may have a lot of expertise around specific needs they have and how they could be met

12.3 Planning for specific requirements

Birth or Care plan

A birth or care plan should take account of any specific needs a service user may have, and this includes accessibility requirements associated with a woman's disability. Ideally an assessment of these needs should be conducted at the first antenatal booking visit.

Participation in care is important. Actively involve the woman in the assessment and birth or care plan. Enable her make informed choices at every step – about antenatal care and classes, about the birth of her child, about baby feeding, about support with parenting skills etc.

Where appropriate, further information may need to be sought from the person's GP, other health professionals or specialist services. Where care requirements are more complex (for example, a woman with multiple disabilities, intellectual disability or significant mental health difficulties), involving a multi-disciplinary team can address different aspects of care. It may be necessary to hold a case conference to help formulate a comprehensive birth or care plan.

Ensure that relevant staff are aware of any requirements in relation to care or treatment that are associated with the underlying impairment; for example, the need to maintain a particular posture for someone with a spinal injury.

Plan ahead. For example:

- Book accessible aids and equipment, such as a height-adjustable examination couch or a hoist for a woman with a physical disability
- Ensure the delivery suite is accessible

Some women with disabilities will benefit from seeing the same health practitioner each time they attend an antenatal clinic. Where possible, factor this into the scheduling of appointments.

Appoint a staff member to a key worker role in situations where it is required; for example:

- Where a woman has significant disabilities or
- A woman with disabilities who does not have the support of a partner available. This key worker should have received appropriate training

Share relevant information with the care team and other staff

It is essential that relevant information is shared with staff involved in the woman's care at different stages of the care journey; for example, in antenatal care, during birth and during postnatal care. This can minimise the need for a woman with a disability to negotiate the same issues at different stages of her care or when she meets different health personnel.

- Include relevant information; for example, communication preferences on her chart and an IT system for booking questionnaires, where available
- Clinical staff, including medical, nursing and therapy staff, should be informed of specific elements of the birth or care plan
- Information relevant to care and support on discharge should be passed on to relevant staff, such as the woman's GP, public health nurse or social worker
- Relevant staff, such as catering, housekeeping and reception staff in the hospital, should be informed of any individual requirements relevant to their roles; for example, any special requirements around managing meals

Accessible premises

See **Guideline Six: Accessible buildings and facilities** for more information.

Ensure that buildings are easy to access and get around:

- Provide handrails and seating where people have to walk some distance between departments
- Provide clear signage in plain English to enable people find their way

Provide open accessible toilets to serve waiting areas, the delivery suite and the wards. Maintain in good working order.

Provide accessible shower and bath facilities on the wards. See National Disability Authority's **Building for Everyone www.universaldesign.ie/buildingforeveryone**, Sanitary Services for the appropriate technical standards.

Ensure that the bed layout in the delivery suite and the maternity ward facilitates a woman who uses a manual or powered wheelchair or a woman who has impaired vision to move around easily.

Provide good lighting everywhere: in reception, the antenatal clinic, the delivery suite and on the postnatal ward. This benefits everyone, including those who are partially sighted.

Ensure that waiting rooms, corridors, consultation rooms and wards are free of obstacles that could impede mobility or be a hazard for someone who cannot see. For example:

- Do not store equipment in a corridor where it could block circulation or present a hazard
- Do not store cleaning materials in an accessible bathroom and
- Ensure that leads and wires from equipment or vacuum cleaners are not left trailing on the floor where they are a hazard and may trip someone

Accessible equipment

Ensure that equipment is accessible or that an appropriate alternative is offered. For example:

- Provide height-adjustable examination couches or beds, with a hoist available, so that a woman can transfer safely on and off
- Provide weighing scales that are suitable for a wheelchair user
- Provide height-adjustable baby cots incubators and baby bathing facilities so that women with physical disabilities can feed, lift, hold and bathe their babies; and

- Ensure that appropriate equipment and aids can be used whether the woman is standing, seated or lying down

Appointments and waiting room

See **Guideline Three: Accessible services – general advice** for information on appointments and waiting rooms.

Communicate about appointments in the way that is accessible for the individual; for example, by e-mail or text message for someone who is Deaf or hard of hearing, or by phone or e-mail for someone who is blind or vision impaired. Ask the individual what their communication needs are.

Let people know approximately how long they have to wait and where they have to go when they are called.

Have a system which enables women who have difficulty seeing or women who have difficulty hearing to know when they are being called. Ticketing systems with visual electronic displays are accessible to someone who is Deaf. However, there needs to be an audio component for someone who cannot see. If this is not possible, someone who has a vision or hearing impairment could be informed that it is their turn by a gentle tap on the shoulder.

If you have a television in the waiting room for antenatal appointments or on the maternity ward, make sure that it has a facility for subtitles and is accessible to people who are hard of hearing or Deaf.

It can be helpful to schedule appointments with an interpreter so that waiting times and cost of interpretive services are minimised.

Information

Provide information about the accessibility of your premises and services; for example, in an information booklet or on your website. This could cover information about accessible parking, accessibility features of your building and any communication aids or other supports available.

Provide information on what to do and who to contact if complications emerge or in case of emergency.

Your information for mothers should cover issues around pregnancy and mental health, including post-natal depression.

- Encourage women to disclose if they have mental health issues or are on medication so that they can get appropriate support both around their pregnancy and their mental health
- Provide information on counselling supports available, support that can be received by telephone, and provide information for new mothers about post-natal depression support groups and counselling services

Ensure that information on the maternity services, childbirth and infant care can be provided in different formats on request and where practicable. You may be asked to provide information in large print, on audio, by e-mail, through your website or in Braille.

All information should be in plain English. A service may take steps to translate the information into other languages where necessary; however, this should also be written in a style which is easy to understand.

Ensure there is a text description of any pictures or diagrams, that can explain them to someone who cannot see: this is essential where a document on-line is being read using screen-reader technology.

Make use of Easy-to-Read health leaflets on specific procedures that are available. Easy to Read is the term for very simplified text with pictures, which is important for people with literacy problems or limited English.

Ante-natal classes can use visual teaching aids with subtitles to communicate with women who are hard of hearing or Deaf.

Video clips, audio clips and DVDs can enhance the accessibility of information to women with disabilities. Keep information in audio and video short as it can be difficult to retain a lot of information from such sources. Women who have difficulty retaining information can go over these again and again.

For more see **Guideline Five: Accessible information.**

Consent

Please read **Guideline Seven: Consent** and the **National Consent Policy** for further information on consent.

To enable a woman to give informed consent to any procedure, appropriate information needs to be given and communicated in a way that meets the accessibility needs of the woman. Staff should explain in a clear and accessible way what will happen if a woman needs an intervention of any type. Some service users may need additional time and support, including, if necessary, repeating information to help them understand.

It must not be assumed that a service user lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, mental condition (including intellectual disability, mental illness, dementia or scores on test of cognitive function), their beliefs, their apparent inability to communicate, or the fact that they make a decision that seems unwise to the health or social care professional. You should presume that all women have the capacity to consent to a particular procedure or intervention, unless there is an adequate trigger indicating otherwise.

All service users may experience temporary lack of capacity due to severe illness, loss of consciousness or other similar circumstances.

Always get consent to pass on any confidential information about accessibility requirements or to pass on information to other medical or support staff or the woman's family.

Flexibility

Services may need to be flexible so that they can meet the needs of a service user with a disability.

When making appointment times, take into consideration that a woman with a disability:

- May find early morning appointments difficult to attend due to medication, additional time needed to prepare etc; and
- May need extra time to get to an antenatal or outpatient appointment

Be open to provide one-to-one support to enable a woman with a disability to participate in antenatal training and to support baby feeding and development of parenting skills.

Where possible, be flexible about offering home visits as an alternative to coming to the hospital or baby clinic where a woman's disability would make that particularly challenging. This might include providing antenatal visits at home, teaching and supporting a woman with parenting skills at home, or having the baby weighed at home rather than in the baby clinic. This may not be feasible in some settings.

Allow flexibility in visiting times so that the woman's partner or carer support person can assist and support her with her activities of daily living and with baby care.

12.4 Antenatal services

Antenatal care

Factor in longer appointments where necessary. It may take longer to communicate with someone with a speech or hearing disability or someone with an intellectual disability. There should be sufficient time given to hear any concerns, to explain what is happening and to ensure the woman understands what is being said.

Where antenatal care is shared between the GP and the hospital, it is essential to ensure there is good communication about any aspect of the woman's requirements that may be associated with her disability.

Explain the steps involved in any procedure or test in advance, in clear and simple language. These procedures can include blood tests, urine tests, blood pressure and weight checks or ultra sound examinations. For someone with a hearing difficulty or mental health impairment, using diagrams is a good way to explain. Explain in advance what is happening to someone who cannot see.

A woman with a mobility disability may need to sit down or lie down during an x-ray or other diagnostic examination. If this is not possible, discuss with the woman and take any guidance she may have on how to proceed into consideration when examining alternative options.

Provide a safe and supportive environment for women with mental health difficulties to disclose and discuss their concerns. Where needed, make a referral to the mental health team or to the mental health support midwife if there is one available.

Antenatal classes

Antenatal classes should be held in places that are physically accessible.

Where possible, ante-natal classes should be designed to be inclusive, where class content, information and presentation methods are accessible to everyone including mothers with disabilities.

Exercises and techniques should be adapted as appropriate where a woman has a physical disability.

- A woman who cannot see will need diagrams or exercises explained orally
- A woman who is hard of hearing or Deaf may need to sit close to the facilitator so that she can hear or lip read
- Information to take away should be available in a range of accessible formats to suit the needs of individuals

Antenatal tutors should be able to tell women with physical disabilities about adaptive techniques or aids. It may also be helpful for them to liaise with staff in the delivery suite where appropriate, to ensure that they also have this information.

It is not always possible to cater for a woman with a disability in a mainstream ante-natal class, and one-to-one sessions may be required in particular cases.

Women with intellectual disabilities may also benefit from one-to-one antenatal sessions where material can be explained in a simple way at an appropriate pace. For example, if a woman with an intellectual disability is undergoing a planned caesarean, the procedure should be carefully explained in simple language.

12.5 Giving birth

It is important at this stage to spend extra time with a woman with a disability to listen and respond to any concerns she may have.

Ensure that the midwife and clinical team are familiar with the specific requirements of a woman in relation to accessible care and / or any special communication issues they may have.

Ensure that the team have devised ways to communicate with the service user appropriately.

For example:

- A woman with a hearing impairment or an intellectual disability may find diagrams and gestures a useful aid to communication
- A woman who is Deaf or hard of hearing can agree some signs or gestures which can act as alternatives if she is unable to lip read during labour
- A woman who is visually impaired or who has an intellectual disability may need verbal explanations to understand what is happening
- A woman with an intellectual disability may need a midwife or midwifery assistant to stay with her and give reassurance to reduce anxiety or fear. Keep information short and simple, not too much to take in
- A woman with a physical disability may need to have assistance to move safely and change her position during labour, and may require an additional member of staff to assist

Explain clearly and step-by-step what is happening at each stage during an examination, and then what will happen depending on the findings; for example, if the woman's cervix is dilated, if her waters have broken, if she is being referred for an emergency caesarean section or if she needs a forceps delivery.

Explain information about choices in pain control clearly and then what is happening when pain control is instituted. Explain that using gas and air may make someone feel disorientated.

During labour, ask 'What can we do for you?' and 'How can I make the pain easier for you?'.

12.6 Care in the ward

If it is possible, it may be helpful for a woman with a disability to have a private room. This does not mean that a person with disabilities receives preferential treatment above other service users, but rather that their specific needs are taken into consideration as part of the provision of their care.

For example:

- Providing quiet can be important for a woman with mental health difficulties or a woman with hearing difficulties
- Someone with a vision impairment may find it easier to orient themselves in a single room than on a busy ward

For a woman with hearing difficulties, if possible, the bed should face the door so that the woman can see when a catering assistant or nurse enters the room. If this is not possible, the staff member should make their presence known to the woman.

Where a woman with a disability is sharing a ward, try to ensure her bed is placed close to the washing and toilet facilities.

Help orientate women to the layout and facilities. Show them the location of light switches, toilets and showers, other facilities on the ward for the baby and how they can summon help. While this should be done for all patients and service users, it is particularly important for service users who have a visual impairment or an intellectual disability.

Provide height-adjustable cots for women who require this to enable them care for their baby as independently as possible.

12.7 Post-natal care and after discharge

Communicate information to assist women with disabilities in their recovery from birth and in developing the practical skills of parenting and self-care. Communicate in a way that is accessible to the service user. This may take additional time depending on the needs of the woman. See **Guideline Four: Communication** for more information.

Provide information in a suitable format to take away. For example, this could be in large print, by e-mail, on audio or in pictorial Easy to Read format, as required in the particular case. See **Guideline Five: Accessible information** for more information.

Give adequate instructions on postnatal exercises and recovery after birth to women with disabilities. A physiotherapist may be able to assist women with physical disabilities about appropriate pelvic floor or other exercises that are recommended for recovery.

Provide support, assistance and guidance on the practical aspects of baby care. For example, the physiotherapist can assist the woman with techniques for lifting and holding her baby, provide advice on useful aids etc.

Communicate sensitively and in ways the woman can receive and understand, on any areas of difficulty or distress, such as if it is a crisis pregnancy, if the baby is ill or has a disability or on the death of the baby. Ensure there is counselling available that is capable of communicating with the woman and her partner in ways they can receive and understand.

Many women who are Deaf see deafness not as a disability but as an intrinsic part of their identity. Respect this perspective when informing her about the results of any hearing tests on her baby.

12.8 Discharge and follow-up

It is important to plan for a woman's accessibility requirements and her medical and support needs on discharge. Preparation for discharge may need to include a case conference between the maternity staff in the hospital and public health nurse, occupational therapist, social worker and GPs to ensure the needs of mother and child are supported when she returns home. With the woman's consent, ensure that the details of a woman's accessibility requirements are included in a plan for postnatal care and follow-up appointments.

Explain clearly when and where follow-up appointments will take place, and when she will see the public health nurse and attend the baby clinic to get the baby weighed. Provide this information on appointments in an accessible format to take away, such as large print, by e-mail, in audio or text format, as required.

Additional supports may be required depending on the circumstances of this case. Ensure that the woman is fully involved and informed about plans. For example:

- It may be necessary to organise additional parenting support at home, such as a home help or a personal assistant
- Specific support may need to be organised from a public health nurse in breastfeeding at home
- Specific support may be needed for postnatal depression

Public health nurses can have a very important role to play in the provision of advice, information and support during the postnatal period. It is important that follow-up visits are put into their schedule so that the new mothers receive this support.

12.9 Post-natal depression

Ensure there is a plan for the prevention, early detection and management of perinatal mental health problems and postnatal depression. Identify women at risk, facilitate appropriate support and access a range of supports for them.

Explain clearly and in non-judgmental ways how to address postnatal depression.

Provide accessible written information about postnatal depression and available health and support services for women experiencing postnatal depression.

12.10 Good practice guidelines for women with specific disabilities

A woman with physical disabilities

Discuss with a woman with a physical disability additional support that can be provided by a physiotherapist in carrying out exercises and breathing as her pregnancy develops and in preparing for childbirth. A physiotherapist may also assist the woman in developing techniques for lifting and carrying her baby.

Plan ahead for an occupational therapist to visit a woman at home prior to the birth to see if there is any equipment or adjustments to the woman's home that need to be made in advance of bringing a baby home. This could include accessible baby baths or changing areas.

Women with physical disabilities may experience difficulties in their mobility as a result of weight gain during pregnancy. A pregnant woman who is a wheelchair user may need a larger wheelchair, or a woman with a walking disability may need to avail of a mobility aid.

A height-adjustable baby cot or table to change a baby's nappy can help a new mother to be independent.

Put plans in place to provide support at home where appropriate and possible.

- A new mother may need home help / an assistant to assist her in the care of her baby, such as in nappy changing, lifting her baby from the cot or bathing the baby
- Home visits may also be required if it is difficult for a woman with a physical disability to attend a baby clinic

A woman with mental health difficulties

Staff involved in maternity care should provide a safe and supportive environment where a mother can disclose and discuss any mental health issues and be referred to sources of support and care in relation to any mental health issues.

If available, offer a woman with mental health difficulties access to a specialist mental health service or mental health support midwife in the hospital.

Liaison between staff, such as maternity staff, physiotherapists, occupational therapists etc., and a community mental health team or mental health nurse should take place where appropriate, with the woman's consent.

Midwives and doctors involved in maternity care should become familiar with a woman's medication and mental health history where appropriate. Discuss with a pregnant woman the use or withdrawal of medications during her pregnancy and birth, particularly if medication that she is taking could be harmful to the foetus or a baby who is breastfed.

If a woman is transferred from a psychiatric hospital or ward, she will need to be supported by a mental health nurse and any medication managed appropriately.

Women with mental health difficulties often experience anxiety attending an appointment.

- Take time to listen to the concerns or anxieties expressed by women with mental health difficulties
- Take time to explain what will happen during an examination and at different stages of the birth process
- Give reassurance and support where this is needed
- To alleviate significant anxiety, if appropriate and where possible, try and ensure that the woman can wait in a quiet place and that she does not have to wait too long for the appointment

If the woman has given birth before, ask her if she had experienced anxiety or difficulty and find out what helped her and what did not help. Ask her what would help her during her current pregnancy and forthcoming birth.

It is important to plan with the woman the support that can be provided by the woman's GP, the public health nurse, and the community mental health team after she is discharged from hospital.

Provide information on advocacy services, support groups and services for post-natal depression.

A woman with a vision impairment

When you talk to a woman with a vision impairment, give your name and explain your role. Let her know when someone else enters or leaves the room.

Allow a guide dog to accompany a woman to the hospital for antenatal appointments and classes, and discuss with her what the options are regarding bringing a guide dog with her when she is an inpatient and during the birth.

Explain all examinations and procedures in advance, step by step, to someone who cannot see what you are doing.

Provide written information in an accessible format which the service user can access; for example, large print, e-mail or Braille.

Explain the layout of the relevant parts of the hospital, such as the reception, waiting room and toilet facilities. In the birthing suite or in the ward, explain where the different facilities are, including the location of the toilet and shower and the call bell for assistance.

Offer to guide a woman with impaired vision to where she is going; for example, to a seat in the waiting room.

Provide a private space where she can give oral answers to fill in any form, without being overheard.

Ensure a woman with a vision impairment is let know orally when it is her turn to be called. Offer her assistance to go to the examination or treatment room.

If a woman with impaired vision is having a foetal ultrasound or examination, explain clearly and step-by-step what is happening on the screen. Facilitate a woman to hear her baby's heart beat through vibration.

It is important to explain clearly any complications where repeated scans take place. Where possible, arrange for the ultrasound to be printed in large print format and arrange for it to be emailed to the woman if requested.

Explain procedures clearly and step by step during the birth.

Provide clear guidance on how to care for her baby taking her visual impairment into consideration. For example, give guidance on how to express milk or to make up formula feeds.

A woman who is Deaf or hard of hearing

A hearing loop enhances hearing for someone who uses a hearing aid. A portable loop system can enhance communication at different locations; for example, in the waiting room, the birthing suite and the ward.

- Let service users know if you have one available
- Check the loop system regularly to see that it is working

Some people who are Deaf or hard of hearing lip-read.

- Position yourself face-to-face in front of the woman when speaking and with good light on your face
- Do not speak when walking away or from behind a theatre mask
- Speak clearly and make eye contact
- Remember that she may not fully catch or understand what you are saying, so use diagrams, gestures and provide written information as well. For example, if there is a test being conducted on the mother or baby, a thumbs-up can signal that all is well

If a Deaf woman has requested an Irish Sign Language interpreter, put a plan in place for this to be provided at subsequent visits and when she comes into hospital to give birth. Plans may also need to be put in place in advance of an unplanned or emergency admission.

Where partners are attending antenatal classes or at the birth, make arrangements for access to Irish Sign Language Interpretation where the partner is Deaf.

Unless the woman requests it or in an emergency when there is no alternative, avoid relying on the woman's partner to act as the interpreter. If he is needed by her to support her through labour pain or childbirth, it is difficult to also act as interpreter. In addition to this, Irish Sign Language Interpreters are qualified to interpret all of the information. A partner, family member or friend may not do so for a number of reasons; for example, in an effort to protect a service user from worry, etc.

During labour, it may be difficult for a woman to lip read. If this is the case, an additional member of staff may be needed to help with communication. Prior to labour, agree with the woman some visual signs or gestures that staff can use to help communicate.

Provide women who are hard of hearing or Deaf with baby alarms that vibrate when the baby cries. It is best if she is located in a single room on the ward as the alarm may pick up the cries of other babies.

A woman with an intellectual or cognitive disability

A woman with an intellectual or cognitive disability will need information explained to her in very simple language and simple terms that she can follow. Use of diagrams can be helpful. Remember the level of understanding may vary for each service user.

A woman who has other communication difficulties, other medical difficulties or another concurrent disability (for example, mobility, visual impairment, or mental health difficulties, etc.) will need additional support during pregnancy, childbirth and afterwards.

A woman with an intellectual or cognitive disability may require additional support from a physiotherapist to support her breathing during pregnancy or birth.

A woman with an intellectual or cognitive disability may experience difficulties in communicating pain during labour. It is important to anticipate this and to ensure she has assistance in communicating and managing pain; for example, being accompanied by a family member or carer during labour may provide additional reassurance for her.

It is important to explain simply and clearly in advance about any procedures to be undertaken, such as vaginal examinations.

The choices and possible complications of different ways of giving birth (natural birth or caesarean section) or use of epidural pain relief should be explained simply and clearly to enable informed consent to be obtained. See **Section Fifteen: Consent** for more information.

Information may need to be repeated several times, as a woman with an intellectual disability may not understand the first time she is given information. Check that what has been said is understood.

Information may not be well retained from one visit to the next, so ensure it is repeated.

Maternity services should liaise with the woman's support network, including her family and service provider, where appropriate, to ensure that her needs are understood and met.

A multi-disciplinary case conference may need to be organised when a woman with an intellectual disability becomes pregnant to plan appropriate care and support for her during pregnancy, during the birth and on discharge.

Good coordination is required to provide appropriate care and support after discharge including support in caring for the baby.

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Additional Useful Resources

Specialist disability organisations

There are a number of disability services, service providers, advocacy services and carer support organisations available to support service users. The Citizens Information Board, Disability Managers in the HSE and other umbrella bodies will be able to guide you in the right direction.

Specialist disability organisations can have a wealth of practical information on matters like communication, accessibility, and day-to-day management and living with a particular condition.

While it is not possible to list every disability organisation in this guidance, the Citizens Information Board publishes a list of national voluntary organisations, including disability organisations. www.citizensinformationboard.ie/publications/voluntary_sector/downloads/directory_of_volunteers2008.pdf

For a list of voluntary mental health organisations, see www.citizensinformation.ie

Many organisations working with people with specific conditions can be found via one of the relevant umbrella bodies.

Further information	Reference
General guidance	The National Disability Authority's accessibility toolkit www.accessibility.ie provides general information on how to make services, buildings, information, and websites more accessible to people with disabilities. This website is updated regularly. Guidance on accessible buildings and places
Guidance on accessible buildings and places	The Department of the Environment, Heritage and Local Government: Building Regulations 2010. Technical Guidance Document M Access and Use

Further information	Reference
<p>Guidance on accessible buildings and places</p>	<p>www.environ.ie/en/Publications/DevelopmentandHousing/BuildingStandards/FileDownload,24773,en.pdf</p> <p>The National Disability Authority's Building for Everyone: www.universaldesign.ie/buildingforeveryone.</p> <p>The Irish Wheelchair Association have developed Best Practice Access Guidelines - Designing Accessible Environments, following extensive consultation with their members and external organisations: www.iwa.ie/services/housing/iwa-housing-advocacy/designing-accessible-environments</p>
<p>Guidance on safe evacuation</p>	<p>The National Disability Authority Guidance on Safe Evacuation for All: http://nda.ie/Good-practice/Guidelines/Evacuation/Safe-Evacuation-for-All/Safe-Evacuation-for-All/Safe_Evacuation_for_All.pdf</p>
<p>Guidelines on accessible information and accessible formats</p>	<p>Citizens Information Board, Access to Information for All: http://www.citizensinformationboard.ie/publications/advocacy/accessibility_index.html</p> <p>National Disability Authority guidance: www.accessibility.ie/MakeYourInformationMoreAccessible/</p> <p>Information for all: European standards for making information easy to read and understand – Inclusion Europe</p> <p>Do not write for us without us: Involving people with intellectual disabilities in the writing of texts that are easy to read and understand – Inclusion Europe</p> <p>Both the above available at: http://inclusion-europe.org/en/projects/pathways-ii</p>

Further information	Reference
<p>Making health information easier to understand and guidance for using plain English</p>	<p>For information on how to write, prepare and design documents in plain English, see: www.simplyput.ie/</p> <p>Make it Easy: a guide to preparing easy to read information has been prepared by the Accessible Information Working Group who work with adults with intellectual disabilities in Ireland. It is available at: www.walk.ie</p> <p>The National Adult Literacy Association has information on making health information easier to follow: www.citizensinformationboard.ie/publications/social/downloads/AccessToInformationForAll.pdf</p>
<p>Accessible information using symbols and pictures</p>	<p>Easy Info has resources to help make information accessible information for people with intellectual disabilities, including guidance on how to use symbols and pictures and making documents Easy-to-Read: www.easyinfoforum.org.uk/</p> <p>Organisations that provide symbols include:</p> <ul style="list-style-type: none"> • Change Picture Bank (www.changepeople.co.uk) • Photosymbols (www.photosymbols.co.uk) • Boardmaker communication symbols (www.mayer-johnson.com)
<p>Accessible information for blind people</p>	<p>Contact the National Council for the Blind of Ireland’s media centre for further guidance on how to provide alternatives, including Braille and good quality audio, for people with impaired vision: www.ncbi.ie.</p>
<p>Accessible information for Deaf or Hard of Hearing people</p>	<p>The Irish Deaf Society has facilities for producing signed videos and DVDs: www.irishdeafociety.ie.</p>

Further information	Reference
Accessible information where English is not a first language and translation is required	www.lenus.ie/hse/bitstream/10147/207010/1/Lostintranslation.pdf
Hospital care for people with dementia	http://www.rcn.org.uk/development/practice/dementia/commitment_to_the_care_of_people_with_dementia_in_general_hospitals/commitment_to_dementia

Information on entitlements

Name:	Citizens Information Board
Address:	Ground Floor, George's Quay House, 43 Townsend Street, Dublin 2
Website:	www.citizensinformation.ie
Telephone number:	0761 07 9000
Fax number:	01 605 9099
Service provided:	The Citizens Information Board provides information on public services and entitlements in Ireland.

Sign Language Interpreters

Name:	Sign Language Interpreting Service
Address:	Deaf Village Ireland, Ratoath Road, Cabra, Dublin 7
Website:	www.slis.ie
Email:	bookings@slis.ie
Telephone number:	0761 07 8440 or mobile 087 980 6996
Emergency out of hours:	087 672 5179
Fax number:	01 838 0243
Service provided:	The Sign Language Interpretation Service is the national agency for the provision of sign language interpreters, and provides contact details for anyone wishing to book an interpreter. It also organises a limited remote interpretation service via video link.

If you wish to book a sign language interpreter outside office hours, please call the Sign Language Interpreting Service (SLIS) Emergency Helpline on 087 672 5179. Only a small number of people can interpret medical information, but they will do their best to arrange an interpreter for you.

Umbrella bodies - service providers

Name: Disability Federation of Ireland
Address: Fumbally Court, Fumbally Lane, Dublin 8
Website: www.disability-federation.ie
Email: info@disability-federation.ie
Telephone number: 01 454 7978
Fax number: 01 454 7981
Service provided: This is the national support organisation for voluntary disability organisations in Ireland who provide services to people with disabilities and disabling conditions. It serves as an umbrella body for organisations serving people with physical, sensory or neurological conditions.

Name: Inclusion Ireland
Address: Unit C2, The Steelworks, Foley Street, Dublin 1
Website: www.inclusionireland.ie
Email: info@inclusionireland.ie
Telephone number: 01 855 9891
Fax number: 01 855 9904
Service provided: Inclusion Ireland provides information and advocacy support to people with an intellectual disability, and parents and family members of children with an intellectual disability. The membership of Inclusion Ireland includes individuals with intellectual disabilities, parents and carers and service providers.

Name:	National Federation of Voluntary Bodies
Address:	Oranmore Business Park, Oranmore, Galway
Website:	www.fedvol.ie
Email:	info@fedvol.ie
Telephone number:	091 792 316
Fax number:	091 792 317
Service provided:	This is the umbrella body for intellectual disability service providers.
Name:	Not for Profit Business Association
Address:	Unit G9, Calmount Park, Ballymount, Dublin 12
Website:	www.notforprofit.ie
Email:	info@notforprofit.ie
Telephone number:	01 429 3600
Fax number:	01 460 0919
Service provided:	This is the umbrella body for service providers for people with physical or sensory disabilities.
Name:	The Wheel
Address:	48 Fleet Street, (entrance Parliament Row), Dublin 2
Website:	www.wheel.ie
Email:	info@wheel.ie
Telephone number:	01 454 8727
Fax number:	01 454 8649
Service provided:	The Wheel is a support and representative body connecting community and voluntary organisations and charities across Ireland. Established in 1999, The Wheel has evolved to become a resource centre and forum for the community and voluntary sector.

Appendix 1

Accessibility checklist

The following table is a checklist which staff can use to help them identify if there are any specific requirements relating to a person's disability.

Are there specific requirements relating to the person's disability?		Yes	No
Does the person need:		Yes	No
1.	To make appointments by text message or e-mail?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Help to know when it is their turn to be called?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Support with communication or specific communication aids?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Assistance with mobility?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Consultations to take place on the ground floor?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Specific equipment such as a lifting hoist, a height-adjustable or examination couch or accessible weighing scales?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Adapted diagnostic equipment, such as an MRI or mammogram, adapted to accommodate their impairment?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Specific support or care needs related to a pre-existing condition or primary disability?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Specialist nursing staff, a key worker or social worker to assist with a disability?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Arrangements in place for a family member, carer, support person, personal assistant or independent advocate?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Specific assistance required to give informed consent to care?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Accessibility requirements in relation to follow-up appointments, referrals to other services or services in the community?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Does the person have any other accessibility requirements?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Does the person need an interpreter? If so, what language?	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 2

Core principles of a quality services

The **National Healthcare Charter, You and Your Health Service**, is a Statement of Commitment by the HSE describing what service users can expect when using health services in Ireland, and what they can do to help Irish health services to deliver more effective and safe services. It is based on eight principles which underpin high quality, people-centred care. These principles have been identified through a review of national and international patient charters and through wide consultation with the Irish public.

The National Healthcare Charter aims to inform and empower individuals, families and communities to actively look after their own health and to influence the quality of healthcare in Ireland.

You and Your Health Service - what does it do?

It outlines supporting arrangements for a partnership of care between everyone involved in healthcare: patients/service users, families, carers and healthcare providers.

It supports a healthcare culture that delivers health and social care services in a predictable, preventative, personal and participatory way.

It recognises that there are different roles and responsibilities for both service users and healthcare providers.

It promotes the importance of service users as individuals with diverse needs and not just a medical condition to be treated.

It applies to all public health and social care services, including community care services and acute hospital services.

The following table sets out the core principles of providing a quality service as set out in the **National Healthcare Charter, You and Your Health Service**.

8 Principles	What patients and service users can expect
Access	Our services are organised to ensure equity of access to public health and social care services.
Dignity and Respect	We treat people with dignity, respect and compassion. We respect diversity of culture, beliefs and values in line with clinical decision-making.
Safe and Effective Services	We provide services with competence, skill and care in a safe environment, delivered by trusted professionals.
Communication and Information	We listen carefully and communicate openly and honestly, and provide clear, comprehensive and understandable health information and advice.
Participation	We involve people and their families and carers in shared decision making about their healthcare. We take account of people's preferences and values.
Privacy	We will do our best to ensure that you have adequate personal space and privacy when you use our health services. We maintain strict confidentiality of personal information.
Improving Health	Our services promote health, prevent disease, and support and empower those with chronic conditions to self-manage their condition
Accountability	We welcome your complaints and feedback about care and services. We will investigate your complaints and work to address your concerns.

Extract from **National Healthcare Charter – You and Your Health Service.**

Appendix 3

Disability - the numbers

The Census and the National Disability Survey give an indication of how many people experience different kinds of impairment. This can be useful for service planning.

There are different degrees of disability from total and severe to moderate and mild, and the number of people with disabilities is very sensitive to where the line is drawn, what exact question is asked and how it is asked.

Based on the National Disability Survey 2006, between one in five and one in ten of the population had a long-term disability. In Census 2011, 13% of the population stated they had a long-term disability. In addition, there are people who may be experiencing short-term impairment, because of a broken limb, for example, and older people who have some difficulties in everyday activities, but do not describe themselves as having a disability.

So the data presented in this section is indicative and not precise.

Mobility is the most frequently encountered disability. Of the 160,000 people who had difficulty in walking any distance, 83,000 used walking aids and 31,000 were wheelchair users.

People with a lot of difficulty in seeing (with glasses) greatly exceeded the numbers who were completely blind. So there is likely to be a widespread demand for large print but fewer Braille users.

The figures also suggest that health service staff are likely to encounter people who are hard of hearing more frequently than those without any hearing. Census 2011 showed there were about 2,600 people for whom Irish Sign Language was the language of the home.

People with disabilities by type of impairment and severity: National Disability Survey 2006

This is a table which is based on those people interviewed in the National Disability Survey 2006 who had disclosed a disability both in Census 2006 and in the National Disability Survey. It includes the type of impairment and severity.

	Total	% of population
Seeing	50,600	1.19
- moderate difficulty	27,600	0.65
- a lot of difficulty	20,700	0.49
- cannot see	2,300	0.05
Hearing	57,600	1.36
- moderate difficulty	35,200	0.83
- a lot of difficulty	20,600	0.49
- cannot hear	1,800	0.04
Speech	35,300	0.83
- moderate difficulty	16,800	0.40
- a lot of difficulty	12,200	0.29
- cannot speak	6,400	0.15
Mobility and dexterity	184,000	4.34
- moderate difficulty	57,000	1.34
- a lot of difficulty	62,200	1.47
- cannot do	64,900	1.53
Moving around home	101,200	2.39
- moderate difficulty	50,200	1.18
- a lot of difficulty	38,400	0.91
- cannot do	12,700	0.30
Going outside of home	128,900	3.04
- moderate difficulty	53,700	1.27
- a lot of difficulty	49,900	1.18
- cannot do	25,300	0.60
Walking for about 15 minutes	160,000	3.77
- moderate difficulty	47,200	1.11
- a lot of difficulty	52,900	1.25
- cannot do	60,000	1.42

	Total	% of population
Using hands and fingers	79,000	1.86
- moderate difficulty	33,900	0.80
- a lot of difficulty	30,900	0.73
- cannot do	14,300	0.34
Remembering & concentrating	113,000	2.67
- moderate difficulty	54,900	1.29
- a lot of difficulty	43,800	1.03
- cannot do	14,300	0.34
Remembering important things	77,600	1.83
- moderate difficulty	39,100	0.92
- a lot of difficulty	27,600	0.65
- cannot do	10,900	0.26
Forgetting where I put things	85,800	2.02
- moderate difficulty	44,600	1.05
- a lot of difficulty	30,400	0.72
- cannot do	10,800	0.25
Concentrating for 10 minutes	77,900	1.84
- moderate difficulty	35,000	0.83
- a lot of difficulty	29,800	0.70
- cannot do	13,100	0.31
Intellectual functions	27,700	0.65
- a little difficulty	4,000	0.09
- moderate difficulty	9,100	0.21
- a lot of difficulty	10,300	0.24
- cannot do	4,300	0.10

	Total	% of population
Intellectual & learning	71,600	1.69
- a little difficulty	12,000	0.28
- moderate difficulty	25,900	0.61
- a lot of difficulty	24,800	0.58
- cannot do	8,900	0.21
Interpersonal skills	22,300	0.53
- a little difficulty	4,600	0.11
- moderate difficulty	7,200	0.17
- a lot of difficulty	7,200	0.17
- cannot do	3,400	0.08
Learning everyday skills	55,000	1.30
- a little difficulty	10,200	0.24
- moderate difficulty	19,500	0.46
- a lot of difficulty	18,700	0.44
- cannot do	6,700	0.16
Diagnosed with intellectual disability	50,400	1.19
- a little difficulty	14,000	0.33
- moderate difficulty	24,200	0.57
- a lot of difficulty	9,000	0.21
- cannot do	3,200	0.08
Emotional, psychological & mental health	110,600	2.61
- a little difficulty	25,300	0.60
- moderate difficulty	46,300	1.09
- a lot of difficulty	35,100	0.83
- cannot do	8,900	0.21

	Total	% of population
Pain	152,800	3.60
- moderate difficulty	74,900	1.77
- a lot of difficulty	73,100	1.72
- cannot do	4,700	0.11
Breathing	71,500	1.69
- moderate difficulty	45,000	1.06
- a lot of difficulty	25,200	0.59
- cannot do	1,300	0.03
Total persons with a disability	393,785	9.29

Appendix 4

Membership of the HSE Universal Access Steering Committee

The HSE Universal Access Steering Committee was established in 2011 to advise, make recommendations and support the development of a strategic approach to universal access in health and social care services. It is a partnership of key internal and external stakeholders and experts.

Greg Price	Director, National Advocacy Unit, HSE
Cate Hartigan	Assistant National Director, HSE (until July 2013)
Paul Defreine	Chief Architectural Adviser, HSE Estates
Diane Nurse	National Lead for Social Inclusion, HSE
Michael Shemeld	National Disability Unit, HSE
William Reddy	Acute Hospitals Programme, HSE (until June 2012)
Tony Leahy	Mental Health Specialist, HSE
Enda Saul	Communications, HSE
Rosalie Smith Lynch	Area Manager, Consumer Affairs, HSE
Chris Rudland	Area Manager, Consumer Affairs, HSE
Helen Lahert	Citizens Information Board
Elaine Howley	Not for Profit Business Association
John Hannigan	National Federation of Voluntary Bodies
Deirdre Carroll	Inclusion Ireland (until June 2012)
Jim Winters	Inclusion Ireland
Jacqueline Grogan	Disability Federation of Ireland
Shane Hogan	National Disability Authority (until June 2013)
Donie O'Shea	National Disability Authority
Dr. Shari McDaid	Mental Health Reform
Marie Prendergast	Primary Care, HSE
Michele Guerin	Equality Officer, HSE
Marian Murray	Equality Officer, HSE
Sinead Burns	Area Manager, Consumer Affairs, HSE
Deborah Keyes	Area Manager, Consumer Affairs, HSE

Gerry Mulligan	Primary Care Reimbursement Services, HSE
Helen Valentine	Primary Care Reimbursement Services, HSE
Phil Garland	Assistant National Director, Children and Families, HSE (until September 2012)
Caoimhe Gleeson	National Advocacy Unit, HSE
Angela Kennedy	National Advocacy Unit, HSE
Juanita Guidera	National Advocacy Unit, HSE

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