Government of Western Australia
Department of Health

FIONA STANLEY hospital

Focus on Disability:

Improving the patient journey at Fiona Stanley Hospital

Disability Liaison Officer Pilot Project

Phase 3

Final Report – June 2016

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Contents

Abbreviations

ABF	Activity Based Funding
AH	Allied Health
AMU	Acute Medical Unit
CAC	Consumer Advisory Council
CoNEcT	Complex Needs Coordination Team
DAIP	Disability Access and Inclusion Plan
DLO	Disability Liaison Officer
DHN	Disability Health Network
DSC	Disability Services Commission
ED	Emergency Department
EDIS	Emergency Department Information Software
FSH	Fiona Stanley Hospital
NUM	Nurse Unit Manager
PWD	People with Disability
SMHS	South Metropolitan Health Service
WA	Western Australia

Acknowledgements

The project team would like to acknowledge the People with Disability (PWD) Advisory Committee and PWD Working Group for their valuable contribution to this project.

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- Sheryl Little, Carer Representative
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Executive Summary

The Clinical Senate Debate– *Clinicians – Do you see Me?* (2011) highlighted the experiences that People with Disability (PWD) and their carers face within the hospital system. It was highlighted that PWD and their carers felt that they were not listened to while in hospital and that their care seemed to be poorly coordinated. They also noted that they did not feel that their opinions were valued or that the information that they provided was treated with respect.

Following this debate, the mandate was to consider what could be done to improve the acute care experience for PWD admitted to hospitals in Western Australia (WA). As a result, it has become a joint project between WA Health and the Disability Services Commission (DSC) to evaluate and improve the current systems in place.

Pilot projects were carried out in 2014 at nominated South and North metropolitan sites, Sir Charles Gairdner Hospital and Armadale Hospital respectively. Following on from these projects, it was recommended to undertake the pilot project at Fiona Stanley Hospital (FSH).

The primary objectives of Focus on Disability – Improving the Patient Journey at FSH were to:

- Identify and guide systems and process changes required to improve health services provided to PWD and their Carers;
- Strengthen and build capacity at FSH;
- Capture Patient and Carer experiences and feedback at FSH;
- Provide recommendations for improvement on admissions, patient screening mechanisms, support and management and discharge processes for PWD at FSH; and
- Ensure the identified recommendations and improvements were sustainable under an Activity Based Funding (ABF) model with consideration of the changes post project funding.

The activities undertaken during the eight month project incorporated Patient- Carer Interviews, Staff Process Mapping Workshops and a hospital wide Disability Access and Inclusion Survey. Subsequently, a thematic review was undertaken to ascertain the common themes evident in all three activities and identify key recommendations.

A number of recommendations resulted from this project including:

- Review the Emergency Department (ED) Risk Screening process for PWD. to identify care needs
- Develop a pre admission pathway to enable early identification of PWD and complex needs at the point of admission.

- Enhance and encourage staff education and awareness in disability including awareness on the Carers Recognition Act and other relevant WA Health policies.
- Create working relationships between key stakeholders such as the FSH Disability Access and Inclusion Committee and the FSH Consumer Advisory Council (CAC)
- Provide education on the standard operating procedures of referring patients in ED to Allied Health specialties.
- Promote the Customer Feedback service and look at ways to make it more accessible for PWD.
- Investigate ways FSH can better support Carers.
- Review compliance on updating the Journey Board and establish set criteria for the discharge risk rating scale for disability.

1. Project overview

1.1 Background

A debate of the Clinical Senate in 2011 entitled “Clinicians - Do you see me?” explored the fields of health and disability and proposed a number of recommendations for improving the delivery of health services to people with disability. The chief recommendations were the establishment of the Disability Health Network, and the development of “Disability Liaison Officer” (DLO) positions.

Joint funding for DLO positions was secured through the Department of Health (Director General) and Disability Services Commission (DSC) and project scoping (Phase 1) was completed in 2013 by project officers from North and South Metropolitan Health Services.

Whilst the original intent of this project was to introduce a discrete Disability Liaison Officer (DLO) role for a trial period (please refer to Appendix 4.1), it was not felt this was a sustainable model moving into an Activity Based Funding (ABF) environment. Rather it was felt that the current practices and system processes which support PWD and complex needs be reviewed and enhanced.

1.2 Resources

Funding of $110 000 was made available to Fiona Stanley Hospital (FSH) for 15/16 and was managed through the Director of Allied Health. Funding was used for the recruitment of a Senior Project Officer and the relevant capital and operational expenses

1.3 Governance

The project was governed by the PWD Advisory Committee at FSH, chaired by the Director of Allied Health. The committee provided clinical oversight and set the direction of the project. Members included:

- FSH Director Allied Health (Chair)
- Area Allied Health Advisor SMHS
- Senior Project Officer
- FSH Safety Quality and Risk representative
- FSH Culture Innovation and Change representative
- Team Leader CoNeCT SMHS
- Consumer representative
- Carer representative

- DSC Local Area Coordinator (LAC)
- FSH Allied Health representative

The PWD Working Group, chaired by the Senior Project Officer managed the operational tasks of the project. The members of the PWD Working Group included:

- Senior Project Officer
- CoNeCT representative SMHS
- FSH Capacity and Access representative
- FSH Occupational Therapist
- Nurse Unit Managers from Emergency Department (ED), Ward 6B and 6C
- DSC Local Area Coordinator

1.4 Objectives

The objectives of the project were:

- Identify and guide systems and process changes required to improve health services provided to PWD and their Carers;
- Strengthen and build capacity at FSH;
- Capture patient and Carer experiences and feedback at FSH;
- Provide recommendations for improvement on admissions, patient screening mechanisms, support and management and discharge processes for PWD at FSH; and
- Ensure the identified recommendations and improvements were sustainable under an Activity Based Funding (ABF) model with consideration of the changes post project funding.

1.5 Methodology

1.5.1 Patient Cohort

Patients were selected in conjunction with the below criteria in Table 1.

In Scope	Out of Scope
Adults aged 18-64 with a permanent disability	• Children • Transition from child to adult care • Older adults (aged 65 and over)
Inpatients	No identifiable discharge destination due to time risks of project
Outpatients (for patients that have had an inpatient stay or outpatients who have chronic/worsening conditions)	Patients under the governance of the "Long stay younger people program" to avoid duplication
Ambulatory care	Primary Health Care
Mental health if included as part of dual diagnosis	Mental health as primary diagnosis
Disability cohort as defined by the (WHO, ICF)*	Primary diagnoses as per Phase 1 project: • Dementia • Behavioural disorders • Pain disorders • Respiratory disorders
	State Rehabilitation Unit FSH
Emergency Department admissions	Emergency Department presentations

Table 1 Selection criteria for patient cohort

** World Health Organisation International Classification of Functioning, Disability and Health (WHO ICF):*

a) the person has a disability that is attributable to one or more intellectual, cognitive, neurological, sensory or physical impairments or to one or more impairments attributable to a psychiatric condition; and

b) the impairment or impairments are, or are likely to be, permanent; and

c) the impairment or impairments result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following activities:

i) communication;
ii) social interaction;
iii) learning;
iv) mobility;
v) self-care;
vi) self-management; and

d) the impairment or impairments affect the person's capacity for social and economic participation; and

e) the person's support needs in relation to his or her impairment or impairments are likely to continue for the person's lifetime.

1.5.2 Patient - Carer Interviews

A "Patient Journey" study involving in-depth interviews with Patients with Disability, and their Carers commenced in September 2015 and concluded in December 2015. All participants were required to be inpatients between the ages of 18-65 years.

Patients on inpatient wards were identified either through consultation with the Nurse Unit Managers (NUMs), shift coordinators and/or other members of the working group or through the Senior Project Officer identifying relevant patients through the Senior Project Officer identifying patients via Journey Board management.

Patients and Carers were asked to consent to the interview and were provided with an overview of the project. Refer to Appendix 4.2. Patients and Carers then completed a face-to-face interview and either a follow up telephone call or email approximately 2-3 weeks following discharge. Interviews were conducted by the Senior Project Officer at bedside on the ward. All efforts were made to include a wide range of PWD to participate in these interviews. For example, interpreters were provided and patients with hearing impairments or speech and language impairments were able to read the questions and/or respond in writing.

No record of the interviews were made in the patient's health record, however if the Senior Project Officer identified any issues of concern with the NUM or shift coordinator.

1.5.3 Process Mapping Workshops

Two process mapping workshops were conducted on 1st October 2015 with FSH staff, the first with ED staff and the later with ward representatives from 6B and 6C. The workshops were attended by:

- Porter/s;
- Nurse/s;
- Junior Doctor/s;
- Ward Clerk/s;
- Social worker/s; and
- Occupational therapist/s.

At the ED process mapping workshop the patient journey was discussed and analysed from ED presentation to ward admission. At the ward process mapping workshop the patient journey was discussed and analysed from patient arrival on the ward to discharge or inter hospital transfer.

1.5.4 Disability Access and Inclusion Plan Survey

FSH staff were invited to complete a survey to assist the development of the hospital's Disability Access and Inclusion Plan (DAIP) for the next five years. The DAIP sets out the hospital's strategies in supporting PWD through the hospital's services, facilities and employment opportunities. The survey was advertised via the FSH Staff Electronic newsletter (CARE Bulletin) and on the intranet homepage and was open for a period of two weeks. The DAIP survey requested staff feedback on the following seven outcomes:

- People with disability have the same opportunities as other people to access the services of, and any events organised by, the relevant public authority,
- People with disability have the same opportunities as other people to access the buildings and other facilities of the relevant public authority,

- People with disability receive information from the relevant public authority in a format that will enable them to access the information as readily as other people are able to access it,
- People with disability receive the same level and quality of service from the staff of the relevant public authority,
- People with disability have the same opportunities as other people to make complaints to the relevant public authority,
- People with disability have the same opportunities as other people to participate in any public consultation by the relevant public authority, and
- People with disability have the same opportunities as other people to obtain and maintain employment with a public authority.

2. Results

2.1 Patient - Carer Interviews

2.1.1 Patient Demographics

A total (n) of 32 patients were interviewed. Out of the 32 patients, 16 were female and 16 were male.

Approximately 13% (n = 4) of the patient cohort identified as being of Aboriginal or Torres Strait Islander origin.

The largest age demographic was in the 56-65 years category with approximately 47% (n = 15) of the patients surveyed in this age bracket. Please refer to

Figure 1 for an overview of the ages of patients interviewed.

Primary disability was defined as the disability group causing the most difficulty to the person (overall difficulty in daily life, not just within the context of the support offered by the service). The largest cohort, approximately 34% (n = 11) was neurological conditions which included conditions such as epilepsy, spina bifida, multiple sclerosis and cerebral palsy. Please refer to

Figure 2 for a synopsis on the primary disability cohorts of patients.

Patients with mental health illnesses were included in the project scope if it was part of a dual diagnosis. Exactly 50% (n=16) of the cohort had a mental health illness at the time of interview in addition to their primary disability.

The majority of patients (n = 8) were located on ward 6B. Please refer to Table 2 for a breakdown on patient location.

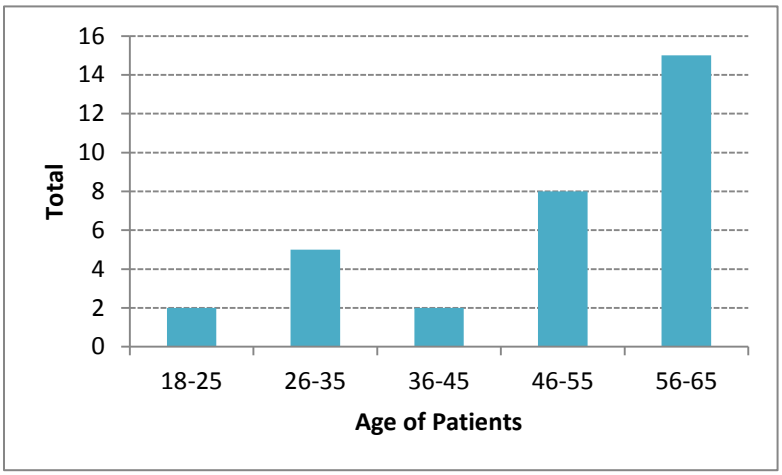


Figure 1 Age of patient cohort

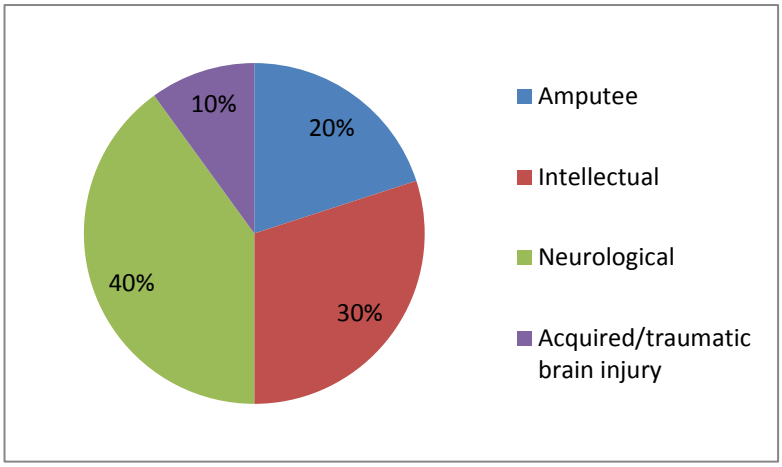


Figure 2 Categories of the primary disability in patients

Ward	Total
3DS	2
4A	2
4B	2
5A	1
5B	2
5D	2
6A	4
6B	8
6C	4
7A	2
7B	1
MHA	1
Transit Lge	1

Ward specialties (general guidelines only)

3DS: Urology	4A: Orthopaedics
4B: Burns	5A: Acute Medical Unit
5D: Respiratory	6A: Ear, Nose & Throat
6B: Neurology	6C: General Medicine
7A: General Surgery	MHA: Mental Health Assessment
Transit Lge: Transit Lounge	

Table 2 Location of patient cohort

2.2.2 Carer Demographics

Nine carers were interviewed, including seven of who were family members. The remaining two were paid support workers. 44% (n= 4) were located on ward 6B.

2.2.3 Patient - Carer stories

Below is a summary of some of the feedback provided by patients and carers.

Key: PT: Patient C: Carer

PT 003: *"The doctors are very consultative/approachable. They ask me how I am and present me with options regarding my treatment. I am treated with autonomy and respect. I like to keep some independence, and the staff are trying to facilitate this by helping me get up and walk around."*

PT 011: *"I have had to repeat my medical information many times and I can see that handovers aren't being done adequately, for example, I'm claustrophobic and it's in my notes that I need certain medication before having scans like MRIs, both times medication wasn't given and so the MRI kept getting re scheduled. Also the nurses come in and say "it's time you had a shower" and then leave, but if they read my notes or got an approproate handover from the other nurse they would know that I can't shower by myself and need assistance."*

PT 013: *"I'd like my care to run more like a project management team, so at least having the opportunity once to have the consultant, nurse, allied health staff and family sit around the table and discuss my treatment and diagnosis, like a think tank."*

PT 016: *"I feel like I am automatically treated differently (by staff) because I have a disability in terms of how staff communicate to me, the lack of integrating me in my care, not understanding or complying with specific needs that I have… but because I am Aboriginal also, I feel like I am ostracised even more in terms of my treatment and management. I have made several requests to see a Social Worker and an Aboriginal Liasion Officer to no avail."*

C 017: *"As a paramedic and carer for my son, I feel that a lot of the issues here at FSH are global, there needs to be better nursing coordination. My son is a quadriplegic and non verbal (uses computer software to communicate), and I've found that the nurses don't shower/clean him so I have to shower him. Once the nurse said she didn't have time time to do his dressings so she handed me the dressings and I did them. I have had to ask staff for pads and gloves as these are not being restocked in his room. I feel like I am getting good communication from medical and nursing staff possibly because I am a paramedic and so I know what to ask... also my son is not getting adequate meals in lieu of his diability even though we have constantly asked for this."*

PT 027: *"Discharge process was a bit unorganised; felt like they wanted the bed urgently so got me out quite quickly. I live in Busselton so my carer couldn't come to the hospital straight away. Getting home was a problem. They put me in a transit lounge for a while and then I got a bus down to Bunbury. Probably would have liked better organised discharge especially when needing a carer to transport me back to a regional area."*

C 030: *"The communication from medical and nursing staff has been great. I cannot fault my wife's treatment or the staff. However as a carer, I think the hospital need to look at how they can better support the carers, especially because sometimes we have been asked to come in by the staff and help facilitate the patient's needs. We are too giving a service, it would be nice if we could get subsidised parking, even if we could use a kitchen to heat our meals or make a cup of coffee."*

2.2.5 Themes identified

The issues identified from the Patient – Carer interviews have been categorised as follows:

Admission

- Lack of early identification of PWD and their requirements during the patients presentation and subsequent admission into ED.

Screening

- Limited or poor mental health screening/assessments were conducted on patients with complex disability. Several patients requested mental health assessments.

- The screening that was done in the identification of the patient's specific needs was not adequately completed or addressed in the nursing admission, as the patient's 'daily' needs, such as specific diet requirements (allergies to food, assistance with eating), sitting positions, turning and showering were not always being recorded or followed.

Support and Management

- Patients require more time intensive, slower paced and a 'holistic' type of service delivery. Multiple patients mentioned that due to their disabilities, they had a long inpatient admission. Patients said that being "cooped up" in the one hospital room was not conducive to their health. When nursing staff brought them outside for some fresh air, they felt that it assisted in their recovery. Family and friends were sometimes not allowed to do this for various reasons (patient requires more than one individual for assistance).

- The hospital should provide accessible information and ways that patients can provide feedback to the hospital. Patients liked the idea of someone coming to them while they are on the wards.

- Carers and patients felt that there is poorly integrated care for patients with complex disability with and psychosocial issues. Particular psychoscoial issues reported to be poorly managed included intellectual disability, cognitive issues, obesity, mental health and socio cultural issues such as unemployment and homelessness.

- Lack of, or poorly managed, integrated mental health care. For example, some patients noted that they felt that physically they were being adequately cared for, but the same level of care was not put into their mental health. Patients specifically requested mental health assessments. Many said they had not seen a Social Worker/Psychologist and felt that the state of their mental health or lack of adequate mental health treatment was not conducive for them having a timely recovery.

- Lack of autonomy in terms of their treatment, management and just general every day activities. Some patients felt like they were being "told" what to do, rather than staff presenting them with options or listening to what they wanted or needed. Patients would like more control over their treatment and would like to be informed of what daily visitations they may be receiving, rather than staff coming to their room with them being completely unaware. Patients often have many consultants from different specialties coming to their room without them being informed that they should be expecting these visitations.

- Patients with cognitive impairments or limited verbal communication felt like staff talked around them and not to them. They also felt that staff did not make the

effort or had the time to converse with them in a way that their treatment and diagnosis is adequately explained to them in ways that they can understand.

- Poorly developed information, resources and handouts in layman terms or alternative formats with regards to their treatment, ongoing management and discharge planning. Particular areas of concern were intellectual and cognitive disabilities.

Discharge

- In terms of discharge planning, no clarity or information was provided to patients or their carers about when they can expect to be discharged.

- 90% of patients found that their discharge was organised, coordinated and the hospital did an excellent job with liaising with external agencies and hospitals. They found the support and outpatient appointments they received from the hospital to be adequate.

Other

- Several patients noted that it is difficult to find permanent employment due to their disability and ongoing medical issues; however they noted that they do have skills and qualifications and would like to use them, even on a casual volunteering basis. Patients suggested that it would be beneficial to them and to the hospital if a Disability Volunteering Group was established where they could do odd jobs around the hospital. Suggestions included weeding and gardening, a welder mentioned being able to fix hospital equipment, simple administration work like posting letters and cleaning the hospital grounds.

- Patients provided some positive feedback with regards to the physical infrastructure and accessibility of FSH which they noted that the size and quality of the rooms were excellent, the space for treatment and equipment was ample and that the hospital had therapeutic gardens and grounds. On the contrary patients felt that the hospital should review the high cost in parking and the transparency and accessibility of maps within and to the hospital.

2.2.6 Patient – Carer Follow up interviews

Approximately 97% (n = 31) of patients and 100% (n = 9) of carers consented to follow up interviews post discharge. Out of the 31 patient consents, 18 follow up interviews were successfully completed. With the nine carer consents, three carers declined at the phone call to discuss the patient's treatment and discharge management.

The follow up interviews primarily sought feedback from patients and carers relating to their discharge management and processes. In addition one of the questions that

patients were asked was to quantify rate on a scale of 1 – 5 if their needs were met with regards to their disability during their time at FSH.

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Approximately 56% (n =10) agreed that their needs were met. Please refer to **Error! Reference source not found.** for an overview of the patient responses.

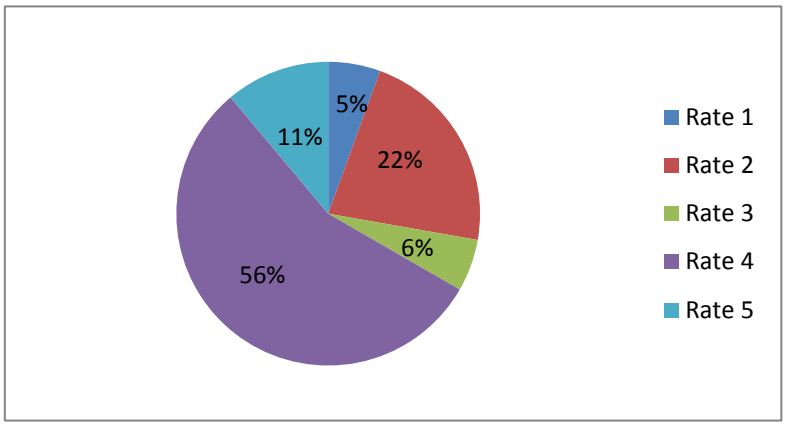


Figure 3 Rating results of 'how were your needs met?'

2.3 Process Mapping

2.3.1 Emergency Department

At the ED process mapping workshop the patient journey was discussed and analysed from ED presentation to ward admission. Each number below in

Figure 4 corresponds to the discussions and/or issues that were discussed during the ED Staff Process Mapping workshop.

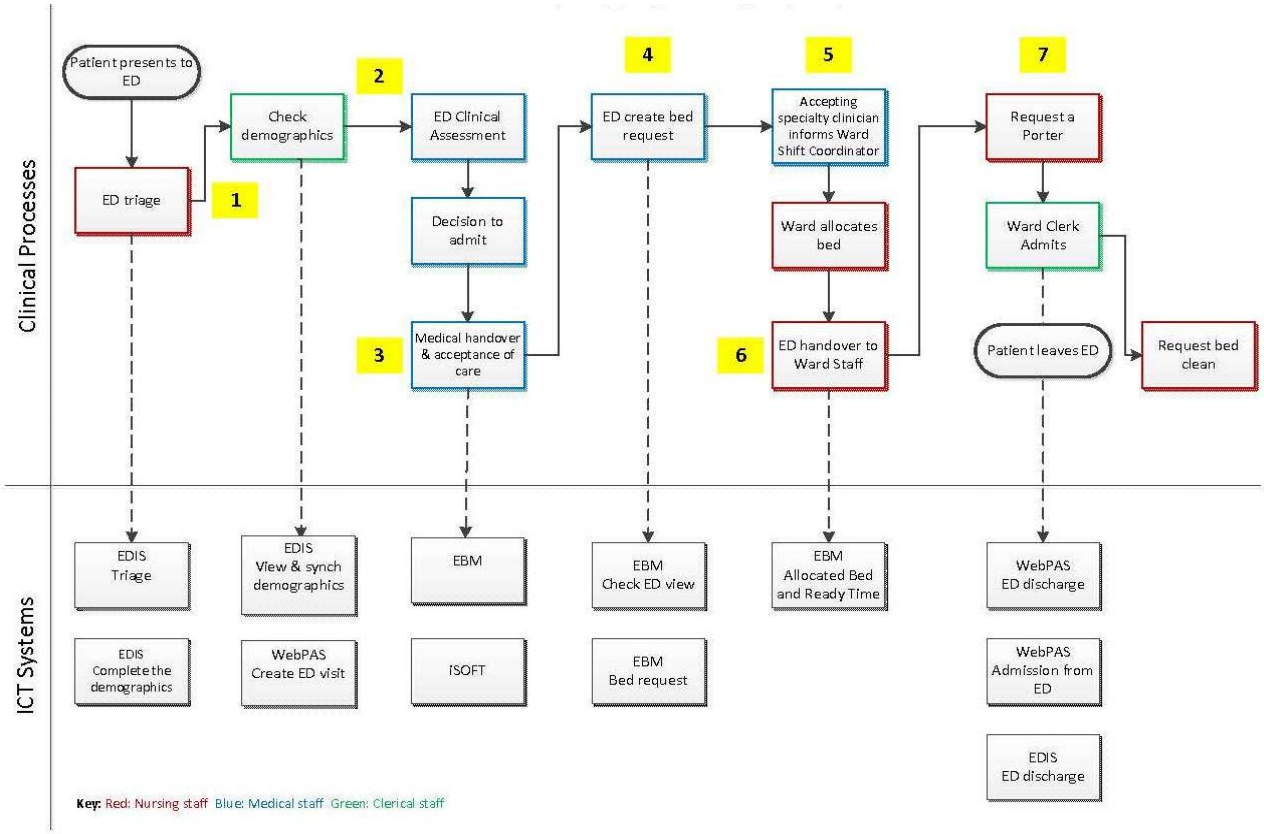


Figure 4 Emergency Department Process Mapping

1. There is no current flagging system or identifier for PWD in the Emergency Department Information Software (EDIS). At present staff can ascertain if a patient has a disability by looking at Next of Kin/guardian details, residential address (i.e. if it is a care facility) or if there is a DSC Local Area Coordinator contact.

2. Referrals to Allied Health (AH) should happen at this stage. The majority of the time AH staff will identify patients based on reading the patient's medical and social information. This is time consuming. Queries were raised why FSH cannot have an automatic AH referral process for specific flags (i.e. patient over 65 years) like other metropolitan hospitals. The current risk assessment form is vague, subject to interpretation and is too 'nurse orientated.' A nurse has to complete the risk assessment form, do any referrals to AH as well as provide medical treatment to the patient.. The risk assessment form is carried right through the patient's journey from ED- ward-discharge and is not reviewed at any point. The risk assessment form is currently being reviewed by staff within ED.

3. There is little or very limited AH input at this stage. AH involvement in the handover process is currently being reviewed by a working group governed by the ED NUM.

4. Nurses can stipulate extra requirements needed for the patient, for example, bariatric patient, requires interpreter etc. Special requirements/information on disability can be provided in three ways, i) through Electronic Bed Management (EBM) ii) verbally iii)

through iSOFT. Currently EBM is not being used to flag special requirements. In addition, with verbal handovers sometimes items are unintentionally not mentioned. These limitations present further problems in step 6.

5. Normally this is done from an Acute Medical Unit (AMU) registrar who informs the shift coordinator. However, AMU registrars often do not provide specific information to the shift coordinator with regards to the patient's complex needs.

6. Refer to step 4. Inefficiences and compliance issues with EBM and verbal handovers present problems.

7. Porters do not receive special instructions about the patient's needs except if the patient requires an escort. Porters noted that they don't believe that they require any additional information to assist them with their duties.

2.3.2 Wards

At the ward process mapping workshop the patient journey was discussed and analysed from patient arrival on the ward to discharge or inter hospital transfer. Each number below in

Figure 4 corresponds to the discussions and/or issues that were discussed during the Ward Staff Process Mapping workshop.

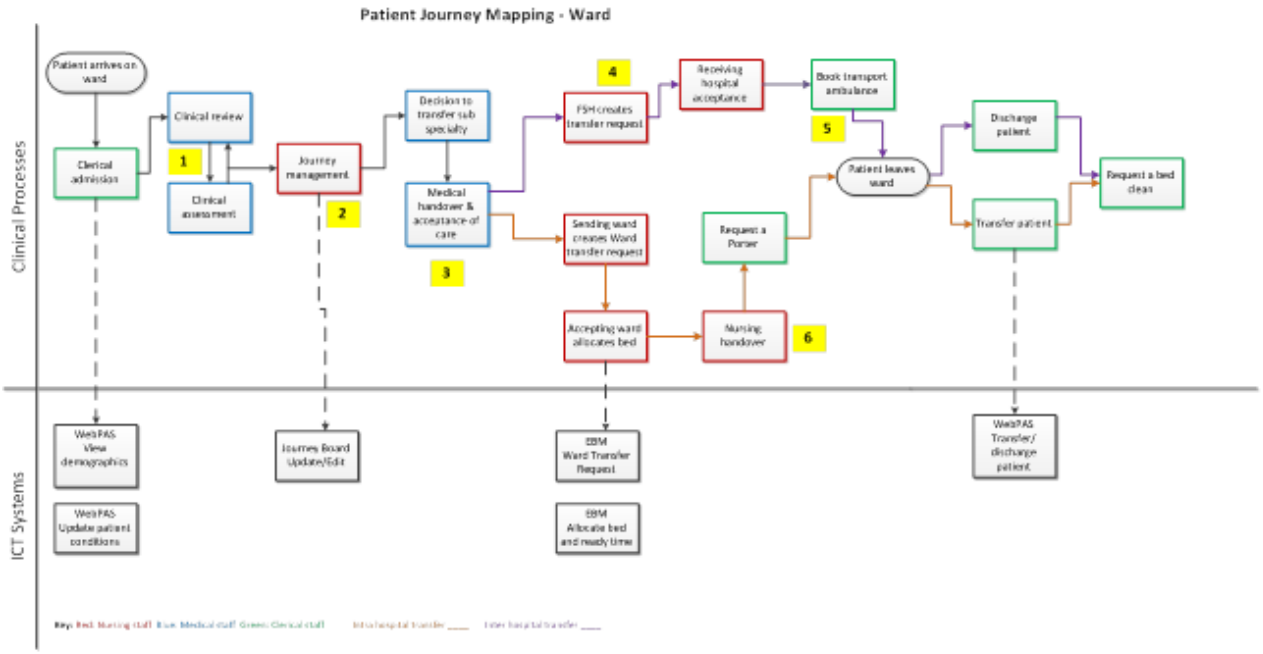


Figure 5 Ward Process Mapping

1. The clinical assessment and clinical review occur concurrently/cyclical. Staff have no specific flagging/identifier for disability except for what is documented in the patient's medical records. AH staff have to read the patient's medical notes to get an overview of the the patient and sometimes have to do a more active follow up and contact staff from ED or AMU for further information. The brief handover provided to ward staff by ED or AMU often does not provide specific information pertaining to the patient's complex needs or disability. Nurses noted that from this stage onwards in the patient's journey, family members or carers need to be part of the patient's ongoing treatment.

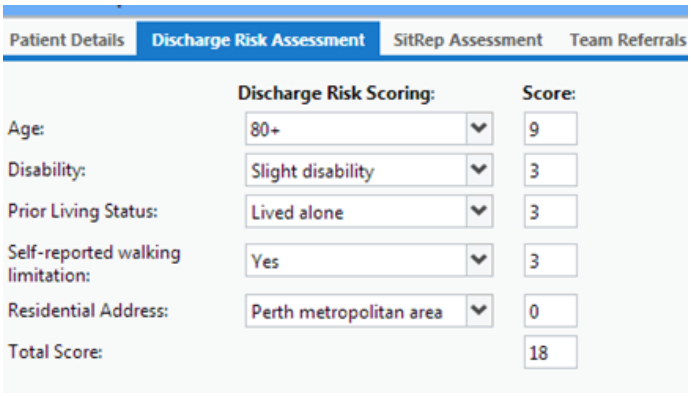
2. There is confusion as it whose job it is to update Journey Board. While there are daily journey management meetings, questions arose as to whose job it is to physcially input data into the Journey Board database. One element of Journey Board is the discharge risk assessment rating (see Figure 2). A score is given to gauge whether there will be compromises to a patient's timely discharge. The higher the score, the higher the risk that the patient will not be discharged on 'time'. In this field there is a tab relating to D. However, there is no set criteria in rating disability as either slight/moderate/major and thus is subjective and open to interpretation. If this field is completed, it can help staff identify patients that have a disability.

Figure 6 Journey Board Discharge Risk Assessment

While completing the discharge risk assessment is mandatory, medical staff noted that any barriers to a prompt discharge are more often than not verbally discussed as opposed to being formally documented.

3. Medical staff noted that AMU doctors provide limited information pertaining to the patients complex needs. They noted that this is likely because of the high patient turnover in AMU and staff working shift work.

4. Doctors complete the discharge letters, nurses complete the and AH can transfer letters letter too. complete a pertaining to Information complex the patient's identified needs can be here.



5. The only special request noted is if the patient is bariatric.

6. Intra hospital transfer: ward staff will complete discharge letters, transfer letters and iSoBAR (iSOFT) but the main way of providing information is verbal. Medical staff noted that they normally just discuss the current complaint and not necessarily mention the patient's complex needs or disability unless the disability is a causal factor for the patient's current complaint.

   If the patient requires an escort, nurses will provide a bedside handover.

2.3.3 Issues identified

The issues identified and corresponding recommendations from the Staff Process Mapping Workshops have been listed below:

Issue 1: There is no flagging or identification mechanism for patients with disability at ED. Ward staff mentioned that they would benefit if a flagging mechanism was created in ED and AMU.

Issue 2: There is currently insufficient and incomplete handover processes from ED/AMU staff to ward staff with regards to the patient's D (EDIS, iSOFT and verbal). Staff also noted that in particular, verbal handovers from AMU staff are not thorough enough.

Issue 3: The risk assessment completed in ED is vague, subject to interpretation, is not always completed.

Issue 4: There is ambiguity and low compliance with who is responsible for updating Journey Board and completing the discharge risk assessment. There is also ambiguity and no set criteria on how to rate D as slight, moderate or major.

Issue 5: There is variability with quality and quantity of information in creating and managing bed requests with regards to providing information on a patient's D on EBM and verbally.

Issue 6: There is too much reliance on verbal handovers and the risks that are associated with this, for example staff forgetting to pass on information related to a patient's disability or function

2.4 DAIP Survey

The FSH DAIP survey was open for consultation between 6th – 20th November 2015 and provided staff with the opportunity to discuss the disability framework currently at FSH. Approximately 216 people completed the survey. The main themes identified in the survey are tabulated below, with the extended results located in Appendix 4.3.

THEMES	ISSUES
Staff Education & awareness	Training/education on diagnosis, treatment & management of PWD is required for staff.
	Current services for PWD need to be promoted hospital wide not only to staff but to visitors and/or patients.

THEMES	ISSUES
	There needs to be more open communication to staff regarding disability services, strategies and processes at the hospital and more opportunity for staff to provide feedback.
Physical Accessibility	Parking distance from car parking bays to the hospital can be an issue for PWD.
	The cost of parking for long stay patients and their carers can end up being substantial.
	There is inadequate signage to and within the hospital.
	Intra hospital transport i.e. buggies should be considered for people with mobility issues.

Table 3 Summary of DAIP results

3. Recommendations

A thematic review was undertaken to collaborate and identify common themes arising from all three activities, namely the Patient – Carer Interviews, Staff Process Mapping Workshop and the hospital wide DAIP survey. The common themes and issues identified in all three activities were tabulated with potential strategies and key responsibility areas identified.

It is anticipated that the FSH DAIP committee will hold overarching governance for these strategies and that they be included in the current draft version of the FSH DAIP 2015-2020.

Please refer to Table for the summary of recommendations.

ISSUE	RECOMMENDATIONS	PRIORITY	RESPONSIBLE
1. Disability Access and Inclusion			
1.1 There is currently no governance related to a coordinated plan of working with PWD.	Commence FSH DAIP Committee. Please refer to Appendix 4.4 for the DAIP Committee's Terms of Reference. Develop working relationships with FSH Consumer Advisory Council and consider their involvement in meetings and working groups.	Medium Low	Director Allied Health. DAIC representative.
1.2 Format of communication for PWD or their carers related to admission, diagnosis, treatment and discharge planning needs to be accessible.	Provide information from the review to the Standard 2 – Partnering with Consumers Committee. Develop a plan to address various aspects of communication issues in collaboration with Standard 2 – Partnering with Consumers Committee. Education to staff to be provided following the implementation of the plan.	High High	DAIC representative. DAIC representative.
1.3 Inconsistent engagement of support workers or carers with PWD.	Determine an education strategy in relation to the Carers Recognition Act.	Medium	DAIC representative.

2. Disability Awareness and Consumer Focused Care			
2.1 Ensuring that the patient's complex needs are being addressed during their review, assessment and treatment.	Enhance hospital wide awareness, through promotional events such as the International Day of People with Disability on 3rd December.	Low	DAIC representative.
3. Identification of Clients in Need			
3.1 Inconsistent early identification, consideration of care requirements on admission and relevant discharge planning requirements of PWD and their complex needs.	Develop a "Pre-admission planning pathway" to enable early identification of the PWD at the point of admission. (Note: Refer to SCGH Pre Admission Pathway). Education to staff to be provided following the implementation of changes.	High	DAIC representative.
3.2 Compliance and quality of risk screening tool in ED.	Member from the DAIC to be involved with ED working group who are reviewing processed within ED. Education to staff to be provided following the implementation of changes.	High	DAIC representative.
3.3 Inconsistency in updating Journey Board including specifically completion of the discharge risk assessment.	Undertake a pilot audit on several wards re the compliance of updating the journey board including completing the discharge risk scale. Establishing criteria on rating disability as slight/moderate/major in the discharge risk rating scale. Education to staff to be	Medium	DAIC representative.

	provided following the update.		
3.4 Low referral number of PWD to Allied Health services.	Provide re-education and training on referral process, but also clearly demonstrate why it is important- saves Allied Health time so that they can spend more time providing clinical care.	Medium	Representative on FSH ED risk screening review working group.
4. Clinical Handover			
4.1 Ensuring that adequate information on patient's complex needs/disability are provided in medical, nursing and Allied Health handovers.	Review current clinical handover audits to determine identified gaps in clinical handover. Provide information from the review to the Standard 6 - Clinical Handover Committee. Develop education plan regarding incorporating the needs of the PWD in clinical handover. (An option may include a current e Learning Package titled 'Disability e-Learning'.)	High	DAIC representative in collaboration with the medical, nursing and AH education Directors.
5. Mental Health and Social Supports			
5.1 PWD report Mental Health is inadequately addressed during their admission.	Collaborate with the Mental Health team at FSH to review this feedback and develop an action plan. Consider the use of volunteers to be used to provide companionship during	Medium	DAIC representative.

	admissions.		
	Explore opportunities with external organisations (i.e. Kalparrin, Serco) in establishing and providing support networks, services and facilities at FSH.	Medium	DAIC representative
6. Carer Recognition and Support			
6.1 Reduced level of support to carers especially related to inpatient admissions.	Develop a Briefing Note to be submitted to the Hospital Executive Committee with options for increasing consistency of support to carers (ideas to consider include subsidised parking, subsidised meals, opportunity to use staff kitchen for heating their own meals, counselling, and access to social workers and pastoral care services).	Medium	DAIC representative
	Explore opportunities with external organisations (i.e. Kalparrin, Serco) in establishing and providing support networks, services and facilities at FSH.	Medium	DAIC representative.
7. Physical Environment			
7.1 Difficulty with access due to distances required to be travelled.	Investigate current transport options within FSH. Develop a plan following a review of options.	Low	DAIC representative in partnership with Director Operations

4. Links and appendices

4.1 Disability Liaison Officer Phase 1 Summary

Background

The Disability Liaison Officer (DLO) Project originated from the Clinical Senate report recommendations of the Health and Disability senate debate in June 2011 titled 'Clinicians – Do you see me?' The mandate for senators was to consider what they could do to improve the acute-care experience for people with a disability who interface with the Western Australian health system.

The key issues that were raised were: no access to one central point of patient information; poor awareness of and attitude towards disability; fragmented and poorly coordinated disability services across NMHS, SMHS and the community; resource limitations which impact on hospital service delivery; lack of disability education and training; and absence of disability service delivery models.

The aim of the DLO project was to scope the needs in NMHS and SMHS adult tertiary and secondary hospitals for people aged 18-65 years with complex disability and how services that support consumers with a disability can be improved, enhanced or newly implemented. Excluded were: adults aged over 65 with disability (i.e. older adult); mental health as the primary diagnosis; children with disability; transition stages (i.e. from child to adult care, adult to older adult); emergency department presentations and primary health care.

Aims of a DLO role

- Improved quality of care for patients and families
- Supporting earlier identification of complex disability patients
- Identifying gaps in knowledge and resources to support service improvement
- Sharing successful strategies and outcomes across clinical areas and wards
- Facilitation of staff education both formal and on an "as needed" basis
- Improved patient satisfaction with the hospital experience
- Reduce complaints
- Improved length of stay and reduced readmissions (improving and supporting complex discharge planning to prevent same-diagnosis readmissions)
- Potential cost savings
- Better partnerships with the disability sector
- Better patient flow across the continuum of care

Suggested DLO personal requirements

- Should be a health professional experienced in both the health & disability sectors

- Understands both hospital and community systems, with links and contacts throughout the disability sector
- Need advanced communication, interpersonal, negotiation skills
- Needs experience in delivering training & education
- Is a limited resource so will need a strong support system
- Needs to be in a 'position of clout' / have credibility / power / authority & recognition.

Deliverables/Outcome Measures suggested for the role

- The DLO consider developing a hardcopy template of a "Profile Summary" (patient passport) as a collation point of patient information, as an interim solution until an electronic options is available. Linking in with current systems and processes will reduce a siloed approach.
- The DLO considers creating a disability checklist (screening) to understand disability patient cohort complexity to better manage inpatient admission (this was identified as a strong need by consumers & clinicians alike).
- The DLO work in partnership with the Disability Health Network to achieve outcome measure(s) 1.
- The DLO will evaluate consumer satisfaction. This may be in the form of satisfaction surveys, interviews, incidence of complaints, receipt of qualitative positive feedback or other. This information will be reported informally bi-monthly and formally bi-annually.
- Develop an early identification "red flag" system in Emergency Department (ED) to flag complex disability.
- Improved holistic health care for the complex disability cohort, including integrated medical and mental health care. This will be achieved by the DLO working in alignment with multidisciplinary teams, mental health and medical teams (i.e. complex health includes complex co-morbidity and the mental health of the patient).
- Develop a pre-admission pathway (quarter 1), discharge planning pathway (quarter 2) and contribute to a multidisciplinary care plan for the disability cohort (quarter 2) of the pilot project in collaboration with other stakeholders.
- The DLO will work collaboratively with DAIP to identify hospital wards with the majority of the disability cohort and work collaboratively with the multidisciplinary team to consider one room on each of these wards is set-up to be as disability-friendly as possible e.g. ceiling hoist, sufficient room for wheelchair/essential equipment (this is a prime DAIP role that the DLO can assist with).
- The DLO will work collaboratively with hospital ward staff to audit the wards with biggest volumes of the disability cohort (see Appendix 3) and prioritise wards with greatest area of need.
- The DLO will aim to provide education and training for health care professionals, consumers and families to raise awareness of people with disability and their special needs in the health care setting – this may include specialist disability education for staff, general disability awareness training, bed-side education for consumers/families, information pamphlets in layman terms & resource packages.

- The DLO will aim to develop a clinical pathway for the complex disability patient cohort within second quarter of DLO pilot project.
- Work in partnership with the Disability Health Network to contribute to developing an overarching “Disability Model of Care” (or overarching framework with principles) and Clinical Governance framework which will help support service delivery in the hospital system.
- Build strong working partnerships with Disability Services Commission (DSC) – particularly Hospital Eligibility Coordinator, My WAY Coordinators, DSC Hospital Eligibility and DSC Nursing. Aim to have bi-monthly or quarterly meetings.
- Build working partnerships with Specialist Disability Agencies and non-government organisations (NGO’s) e.g. TCCP, Nulsen, ILC, PwD WA, DDC, National Disability Services WA, Headwest, Brightwater, Mental Health Advisory Council (see stakeholder list for full complement). Aim to have quarterly service-wide disability sector meetings which include department of health WA.
- Work in collaboration & partnership with the Disability Health Network and Disability Access and Inclusion Plan (DAIP) hospital staff to help the DLO guide strategic direction and service planning requirements (i.e. eliminate siloed & fragmented services), with bi-monthly meetings.
- The DLO will work collaboratively with the hospital CAEP co-coordinator to review DSC CAEP data quarterly to monitor equipment costs and patient need/unmet need for the disability cohort.
- The DLO will support long stay patients with complex disability and support current health service initiatives.
- The DLO should report on LoS monthly for each category of disability in the cohort, the associated ABF revenue & those patients over the high boundary.
- Reduction in LOS for the complex disabled patient.
- The DLO work collaboratively with hospital Executives on a gap regarding transition/step-down unit options to manage the issue when patients are medically stable but stay in hospital due to lack of access to accommodation or community options. Executives have been made aware of this issue.

4.2 Patient - Carer Interviews

Government of Western Australia
Department of Health

FIONA STANLEY hospital

Focus On Disability: Improving the Patient Journey Project

Patient / Carer information handout

Purpose
You have been invited to participate in the research project *Focus on Disability: Improving the Patient Journey Project at Fiona Stanley Hospital* (FSH). The purpose of this project is to review the hospital experience for patients with disabilities (PWD). Our aim is to interview PWD and their Carers to gain further insight into the difficulties experienced both in the hospital and the transitions to and from the community. We will look for common themes and write recommendations to direct future changes in the hospital.

Confidentiality
Consent will be completed prior to your involvement. Confidentiality and privacy of individuals will be maintained. Patient responses will be confidential (not identified by name or by UMRN) and each patient will be given a unique identification number (e.g. PT 001). All files are stored on a secure database and will be retained until the end of the project.

Withdrawal
Participating in this project will not interfere with your hospital treatment. Participation is voluntary and you may withdraw at any time.

If you have any questions or concerns please contact the Senior Project Officer, Natasha Cunningham on 6152 1284.

If you have any concerns regarding the interview process, please contact the Director of Allied Health, Shae Seymour on 6152 3221.

Thank you for your participation in this project.

Government of Western Australia
Department of Health

FIONA STANLEY hospital

Patient ID:

Patient/Carer consent to the release of information

I ..... DOB .....
give permission to the South Metropolitan Health Service to interview me in relation to my admission at FSH.

I understand that the information I have provided is part of a quality process improvement project and will have no negative impact on my treatment at FSH.

I give permission for the Senior Project Officer to contact me for follow up interview questions 2-3 weeks following my discharge. I have been provided with an information handout with contact details of the Senior Project Officer.

I consent to my de-identified information to be used for the Patient Journey Interview Summary, which will be presented as part of the *Focus on Disability: Improving the Patient Journey at FSH* Project.

This consent is valid for a period of twelve (12) months.

Patient
Signed: ..... Date: .....

Print Name: .....

Carer
Signed: ..... Date: .....

Print Name: .....

Relationship to patient: .....

Patient Copy

PATIENT JOURNEY INTERVIEW

Patient ID:					
Ward:	ED	6B	6C (Gen Med)		Other: _
Gender:	Male	Female			
Age:	18-25	26-35	36-45	46-55	56-65
ATSI:	Yes	No			
Date:	/	/ 2015			

1. **Can you tell me why you are in hospital?**

Prompts: what do you understand about your treatment?

_____

_____

2. **Do you see yourself as a person with an impairment or with complex needs? Do you require assistance with day to day activities such as showering, public transportation, household chores? Who helps you? Please tell us about it.**

☐ Yes ☐ No

_____

_____

3. **How did you present to Fiona Stanley Hospital, did you come through the Emergency Department first? *(If not ED proceed to Q6)***

_____

_____

4. **How was your experience in the Emergency Department?**

Prompts: Did you have to wait long to be seen by a Doctor in ED?

Were you happy with the treatment and communication that you received from medical staff?

Did you find the process smooth flowing?

Did you feel like you had the opportunity to ask questions?

What were the most positive/negative aspects of your experience in ED?

***Admission **Screening **Support & Management **Discharge*

_____

_____

5. **Now let's talk about the ward.**
   What have been the best or most positive aspects of your time on this ward?

Prompts: Are you happy with the communication that you are receiving from medical staff with regards to your diagnosis?

Do you feel like you are respected and listened to by staff?

Do you feel like you have the opportunity to ask questions?

***Admission **Screening **Support & Management **Discharge*

_____

_____

6. **What have been the challenging or difficult aspects of your stay on this ward?**

Prompts: What do you think this ward could improve on?

Are you happy with level of care that you are currently receiving?

***Admission **Screening **Support & Management **Discharge*

_____

_____

7. **Did you know that FSH has a Customer Liaison Office where you can provide feedback/complaints to?**

Prompts: If you weren't aware of Customer Liaison Office, would you like a brochure or feedback form?

Have you ever provided feedback to the FSH Customer Liaison Office before?

_____

_____

8. **Do you have any other comments or information that you would like to share?**

*Prompts: **Admission **Screening **Support & Management **Discharge*

_____

_____

9. **Are you happy if I contact you in approximately 2-3 weeks' time to discuss how you are feeling post discharge?**

☐ Yes ☐ No

Phone call follow up Qs – estimate 2 -3 weeks post discharge

1. **What information/leaflets did you receive from the hospital when you were discharged? Did you find this information useful?**

Prompts: Was anything confusing post discharge, i.e. what medication to take and when.

Did you require any specialised equipment post discharge, and was this organised effectively by FSH?

_____

_____

2. **Have you had any follow up appointments or contact with hospital staff since your discharge? (e.g Medical Officer, Disability Services, OT). Tell me about your experience.**

_____

_____

3. **On a scale of 1-5,**

1 Strongly Disagree	**2 Disagree**	**3 Neutral**	**4 Agree**	**5 Strongly Agree**

Do you feel like your needs were met with regards to your Disability at FSH?

1 Strongly Disagree	**2 Disagree**	**3 Neutral**	**4 Agree**	**5 Strongly Agree**

If not, what part of your stay did you feel that they were not met? ED? Ward? Do you have any other information that you would like to share?

_____

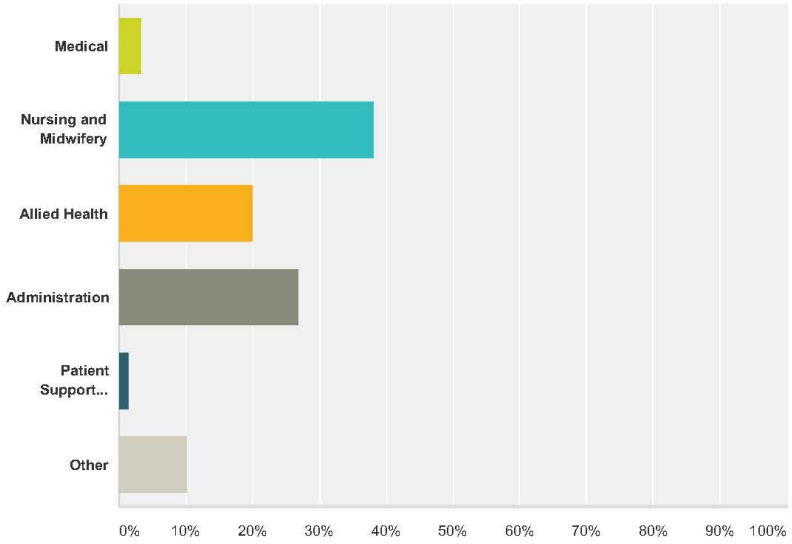
_____

4.3 Disability Access and Inclusion Survey

FSH Disability Action and Inclusion Plan (DAIP) Survey

Q1 What is your position at FSH?

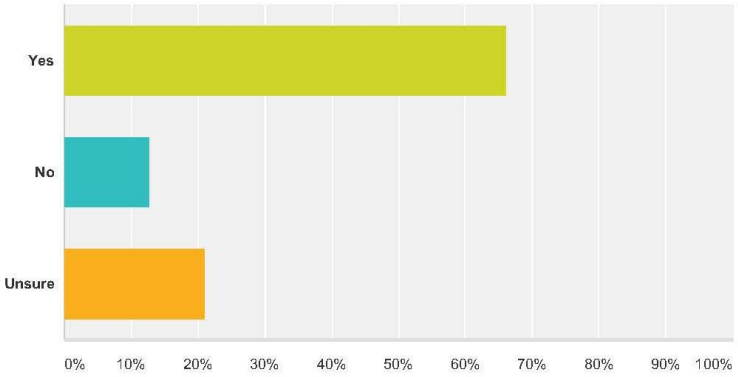
Answered: 215 Skipped: 1



Answer Choices	Responses	
Medical	3.26%	7
Nursing and Midwifery	38.14%	82
Allied Health	20.00%	43
Administration	26.98%	58
Patient Support Services	1.40%	3
Other	10.23%	22
Total		215

Q2 People with disability have the same opportunities to access services at FSH.

Answered: 213 Skipped: 3



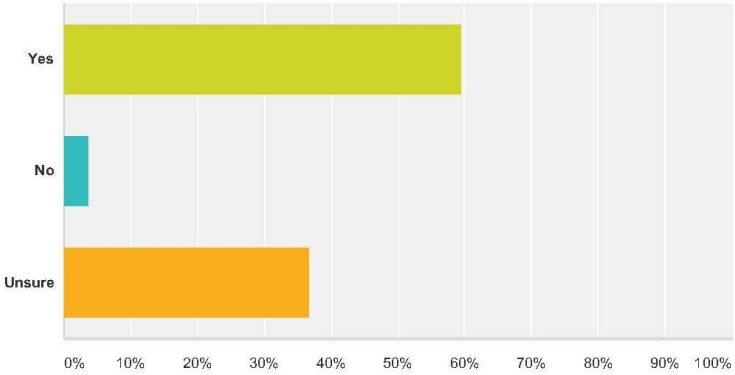
Answer Choices	Responses	
Yes	**66.20%**	141
No	**12.68%**	27
Unsure	**21.13%**	45
Total		**213**

#	Comment	Date
1	Signage is not always at wheelchair user's eye level. I often find people wandering corridors because signage is not easily visualised or directing.	11/19/2015 3:13 PM
2	Many pts who could benefit from The chronic pain STEPS program have difficulty with public transport. The cost of the daily parking ie $21.90 for the two days required is a deterrant as many are already low income earners or on pensions. We suggested discount parking at the same fee staff pay and this request was declined.	11/16/2015 10:08 AM
3	I believe and hope so.	11/12/2015 3:13 PM
4	I'm new to the site so am not yet aware of what services are available	11/12/2015 9:06 AM
5	Signage is poor which affects the ability to find places easily if the person's disability affects their cognition or vision	11/12/2015 8:19 AM
6	parking is limited & expensive	11/11/2015 9:55 AM
7	please see comment to question 4	11/11/2015 7:47 AM
8	The PES does not allow for alternative access - despite this issue being flagged well before the opening of the hospital.	11/10/2015 2:56 PM
9	bed bound patient visiting for outpatients appointment from another hospital had to stay on ambulance trolley as no bed available /organised for appointment. St john ambulance not happy to stay as had another job logged. ?? badly organised or beds need to be available for such patients.	11/10/2015 12:00 PM
10	Limited support for transport, limited signage, distance from carpark	11/10/2015 10:33 AM

11	Patient Parking is very expensive and those of low socioeconomic status simply cannot afford the fees and yet do not get financial assistance when referred to welfare officers Patients with disability who are still in fulltime employment CANNOT get their outpatient appointments coordinated for same day forcing them to take huge amounts of personal leave from work and many losing their jobs. the volunteer driver service at FSH is no where near as comprehensive as Fremantles or RPH: they dont accept clients on oxygen, they dont accept some suburbs that the patients previous tertiary hospital serviced, they dont have enough cars and drivers. for some patients this means they cannot access their appointments patients ringing to reschedule outpatient appointments to meet their needs (often disability related) frequently complain that they cannot get through to the appropriate clinic. As a staff member I also cannot ring these clinics on the patients behalf (the phone lines often just ring out). There simply arent enough clerks to answer the phones as well as manage their other duties. I would recommend someone actually do a random survey and try phoning clinics and see if you can get through (I know for a fact it is very difficult in many of the clinics I deal with on a daily basis, so must be incredibly frustrating for patients)	11/10/2015 8:03 AM
12	No pedestrian crossing - highly likely to be hit by a vehicle traveling at speed.	11/10/2015 7:29 AM
13	It costs me (a member of Serco staff) $90 a fortnight to access acrod parking within 50m of my workplace. Night shift staff get to park in those bays for $3.70 fixed. I have to pay by the hour.	11/9/2015 8:20 PM
14	Do you mean same opportunities as others with a disability or as those without a disability? Im sure those in a wheelchair can, but Im not so sure about the vision impaired or those that are deaf etc.	11/9/2015 2:49 PM
15	People with disabilities who cannot walk far (ie: people with heart problems, prosthetic legs, chronic diseases, the list goes on) find it very difficult to walk from the car park (disabled spots) to any outpatient appointment.. .. this is IF they are lucky enough to know that P1 parking is actually for visitors AS WELL AS for "harry perkins institute & pathology"- The sign does not state "for visitors", therefore people with disabilities will park further away across the road in the above ground car park then have to walk all the way across. -there are no buggies (like at SCGH) or serco staff who are available to pick a patient up from the carpark and take them into the hospital in a wheelchair... a response from a serco staff who was presenting at the FHS induction day in february stated "if someone can drive to the hospital, how come they are unable to walk into the hospital?"; this a very uneducated answer to my question.	11/9/2015 2:20 PM
16	I dont think there are enough parking bays around and close to the entrance of the hospital.	11/9/2015 2:18 PM
17	As long as the facilities and information is written and displayed at a correct level.	11/9/2015 1:35 PM
18	"Disability" is a very broad term. I am sure some people are well supported but I imagine others are not.	11/9/2015 1:30 PM
19	Responding from Rottnest Island Nursing Post (part of FSH) - we have undertaken a Disability Assessment and the pan highlights the adequate access to this department. Some limitations to the front desk for people in wheel chairs - previously considered for upgrade but costs prohibative	11/9/2015 1:25 PM
20	Heavy doors, not much room in places	11/9/2015 1:00 PM
21	People with disabilities should have the same opportunities to access services at FSH. In my current role I am not priviy to information that would identify when there are not opportunities for people with disabilities to access FSH services. I have not received a report from any patient on campus who may report to me in an indirect manner as part of my clinical applications support role. The HSS Clinical Incident Management System (CIMS) has a Feedback module which is designed to capture this type of feedback - it would also be reflected in CIMS incidnets if a patient was adversely affected by inadequate disability services.	11/9/2015 12:59 PM
22	To our services yes. Cannot possibly comment on FSH as a whole.	11/9/2015 12:56 PM
23	They should, but I don't think they do.	11/9/2015 12:48 PM
24	Just through the nature of them being disabled it is much harder for them to manage distances there are only a few disabled bays close to departments. Also the phone syatem is very difficult for them to use to get in contact with appropriate peole going throught the 22222 they get sent on a merry go round of varous people with no comittment to disability. The out patients booking system disadvantages the disabled as they are not seen on a needs basis but only when there is an availble appointment.	11/9/2015 12:47 PM
25	Same opportunities as where?	11/9/2015 12:47 PM
26	Patien ts that are ventilated and admitted to the Spinal Unit for rehabilitation are not able to complete the program successfully as they are being excluded by not allowing a nurse to assist with the community access program, including day leave, overnight leave and weekend leave.	11/9/2015 12:46 PM
27	Transport services are very poor Seating in the cancer center is horid - hard plastic chairs that patients (thin, frail, bony bottomed) need to sit in for hours	11/9/2015 12:35 PM
28	Gettting around alone at FSH is difficult as staff need to log jobs for porters for each leg of the disabled patients journey through the hospital.	11/9/2015 12:34 PM

Q3 People with disability have the same opportunity to attend and participate in events organised by FSH.

Answered: 212 Skipped: 4

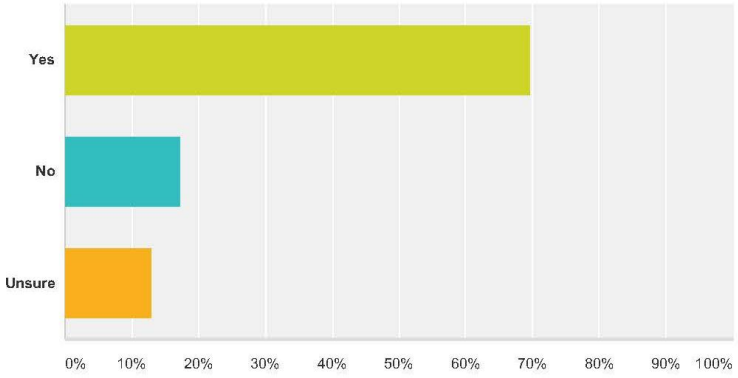


Answer Choices	Responses	
Yes	**59.43%**	126
No	**3.77%**	8
Unsure	**36.79%**	78
Total		**212**

#	Comment	Date
1	Do not see any advertising in general media regarding events organsied by FSH	11/19/2015 3:13 PM
2	As above. This issue was raised when the hospital opened when we tried to get a least subsidised parking for this group of pts who would likley benefit from the program. We were advised the pts would need to be assessed by a social worker on the day of attendence regarding fincancial hardship. The social work department were not able to accomodate this request due to workload.	11/16/2015 10:08 AM
3	I haven't seen anything about many events organised to know	11/14/2015 9:12 AM
4	I assume and hope so, but am unsure	11/12/2015 3:13 PM
5	a/a	11/12/2015 9:06 AM
6	At the risk of losing the sausage sizzles next to the lake, I am not sure that these are easily accessible to people with a disability. I can't think of any other events that FSH have arranged (do Christmas parties off-site count?) I am not sure whether Access and Inclusion has been considered for these.	11/11/2015 10:04 AM
7	some require transport assistance	11/11/2015 9:55 AM
8	Some lecture theatres in the education building provide little wheelchair space/access	11/10/2015 11:03 AM
9	Limited support for transport, limited signage, distance from carpark	11/10/2015 10:33 AM
10	Likely but would be dependent upon disability.	11/10/2015 8:59 AM
11	Unsure on this one.	11/9/2015 8:20 PM
12	As long as the function centre or lecture theatre is accessable. In this day and age it should be.	11/9/2015 1:35 PM
13	"Disability" is a very broad term. I am sure some people are well supported but I imagine others are not.	11/9/2015 1:30 PM
14	From Rottnest Island Nursing Posts perspective - we do not generally hold 'events' However people with disabilities are able to access the department	11/9/2015 1:25 PM
15	Not sure what events have been organised	11/9/2015 1:09 PM
16	If events are held on campus. For example, I imagine they would struggle to access the lake opposite carpark 2 (steps) - but the lake is technically off campus.	11/9/2015 12:59 PM
17	They should, but I don't think they do.	11/9/2015 12:48 PM
18	At times if the ward nursing staff have sufficient time to assist	11/9/2015 12:47 PM
19	I am unaware of any events targeted to people with disabilities conducted by FSH	11/9/2015 12:47 PM
20	Not necessarily, as many patients will be required to take a nurse with them....and nureses are not able to leave the ward for functions	11/9/2015 12:46 PM
21	I am unsure what events are organised by FSH.	11/9/2015 12:34 PM

Q4 People with disability have the same opportunities as other people to access the buildings and other facilities at FSH.

Answered: 208 Skipped: 8



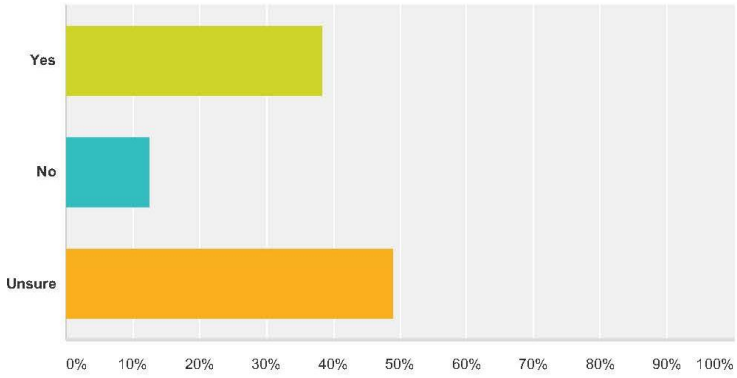
Answer Choices	Responses	
Yes	**69.71%**	145
No	**17.31%**	36
Unsure	**12.98%**	27
Total		**208**

#	Comment	Date
1	It is difficult to cross Robin Warren Dr from the multi story carpark with cars not sticking to the 40km speed limit - I suggest more 40km signs, and also a pedestrian crossing so you can safely get across the street	11/19/2015 4:22 PM
2	See above commnets regarding signange - signange influences accessability. Hvae noted somne peopel with a disability have difficulty pressing the lift buttons	11/19/2015 3:13 PM
3	Parking is too far away from the main hospital.	11/16/2015 11:36 AM
4	I assume and hope so	11/12/2015 3:13 PM
5	a/a	11/12/2015 9:06 AM
6	People for whom walking is difficult may have problems tetting to places on time as the hospital is so spread out. Also signage is poor which affects the ability to find places easily if the person's disability affects their cognition or vision	11/12/2015 8:19 AM
7	The lifts in SRS are not always easy for people to operate but I think they are possibly as good as it gets.	11/11/2015 10:04 AM
8	being in a wheelchair I find the doors are far to heavy and very hard to open and to hold open while entering.	11/11/2015 8:46 AM
9	Some difficulty accessing toilet with a wheelchair. Automatic doors would be beneficial as these doors are often quite heavy and difficult to manouver.	11/11/2015 8:39 AM
10	I have found a visitor who was afraid of lifts stuck on level 2 because the stairs to go further require staff access. I would also suggest the public lifts have some sort of liight to indicate which has arrived at that time. Sound is not enough.	11/11/2015 7:47 AM
11	Difficulty accessing restrooms	11/11/2015 7:00 AM
12	the door to our department is actually a fire door.Some people have to wait for someone else to open it for them.	11/10/2015 11:55 AM

14	Heavy toilet doors to bathrooms in emergency that don't stay open, impossible to use independently and even difficult/falls risk when patient is 1 x assist.	11/10/2015 10:33 AM
15	As much as possible.	11/10/2015 8:59 AM
16	there needs to be a shuttle service around the entirity of FSH linking patients to buildings and carparks. One witha known route and frequency so staff can be assured it can get patients to appointments, bus connections, train connections, car parks etc on time.	11/10/2015 8:03 AM
17	Physical access through the main doors mostly yes. I think all doors to outpatient clinics, entrance/exit areas and disabled toilets should automatically open. It's the distance from carpark to hospital that restricts access. Although there is a drop off area some people still drive themselves. More chairs or wheelchairs should be available at front information desk.	11/10/2015 7:59 AM
18	The distances between buildings is great particularly for someone who requires a wheelchair. Has a patient tramsport system for around the groupnds been considered.	11/10/2015 7:59 AM
19	there is no longer voluntary transport avaialable for outpatient appointments. Most patients cant drive anymore and they need to travel great distances (not just living in the southern suburbs catchment areas) and the criteria are too strict to be eligible	11/10/2015 7:48 AM
20	No pedestrian crossing - highly likely to be hit by a vehicle traveling at speed.	11/10/2015 7:29 AM
21	i find some doors that you open yourself i.e toilet doors are heavy for able bodied people very hard to open for wheelchair people.. revolving door to quick for self propelled chairs and the hand opened doors difficult to open in a chair and go through.	11/9/2015 10:21 PM
22	It costs me (a member of Serco staff) $90 a fortnight to access acrod parking within 50m of my workplace. Night shift staff get to park in those bays for $3.70 fixed. I have to pay by the hour.	11/9/2015 8:20 PM
23	However due to large distances, especially between buildings and carparks would benefit from a 'golf buggy type transport to transfer visitors and patients long distances.	11/9/2015 4:48 PM
24	Parking can be an issure.	11/9/2015 3:19 PM
25	do not work in main hospital	11/9/2015 2:28 PM
26	See above	11/9/2015 2:20 PM
27	The door access to Pathwest specimen collection are in main hospital should be a sliding door that opens by a sensor. The current door is very heavy and hard to open if you have a disability as not all patients with a disability have someone with them to help them to open door.	11/9/2015 2:15 PM
28	People in wheelchairs often require oversized vehicles for transport. The clearance height in the number 5 multi-level car park is too low for such vehicles. Therefore theses vehicles need to be parked in the number 8 carpark which is significantly further away, and requires the patients to negotiate a relatively busy road and steep hill to get to the hospital in a wheelchair. Some of the disabled toilets in the rehabilitation building have very heavy doors, which people with physical deficits, particularly those in wheelchairs are unable to independently open and keep open in order to get through in a wheelchair. Therefore they need assistance to access these toilets, when they would otherwise be independent. Button operated electric doors are needed. People who may be able to drive their own car to the hospital but can only mobilize (walk or wheelchair) short distances (<100m) on their own need assistance to get from the car parks into the hospital itself. The porters at FSH will not go to the car parks to assist these patients - forcing patients who are not able to obtain assistance from friends or family to rely on expensive taxi's, use of voluntary transport which is already in high demand, or use of valuable clinician time instead. A regular shuttle bus, which is wheelchair accessible, from Murdoch train station to the rehab building is required. Ideally this needs to be staffed (perhaps by the FSH volunteers) with someone who can provide assistance to the patients with accessing the shuttle bus.	11/9/2015 2:04 PM
29	Difficulty reaching overhead cupboards in all ward kitchens	11/9/2015 1:37 PM
30	Bankwest ATM is a bit high for a person in a wheelchair. Some reception counters are too high. There is minimal Access between waiting room chairs to a water cooler in some wating rooms.	11/9/2015 1:35 PM
31	some of the entrance doors are not easily accessible to people with disabilities.	11/9/2015 1:31 PM
32	"Disability" is a very broad term. I am sure some people are well supported but I imagine others are not.	11/9/2015 1:30 PM
33	as above	11/9/2015 1:25 PM
34	Many of the access control features preclude use by people with mobility issues - lack of self opening doors in many	11/9/2015 1:20 PM
35	Staff members with movement disability may have trouble negotiating the staff carparks and roadways without footpaths crossing over gardens.	11/9/2015 1:13 PM
36	Unsure as I don't have a disability myself, however everything does seem accessable.	11/9/2015 1:01 PM
37	poor signage, heavy doors, limited room to manoeuvre or park, the door to day Surgery unit is narrow and opens out in to the corridor, Pre Admission Clini (OP Clinic 2) cannot easily take wheelchairs	11/9/2015 1:00 PM
38	No wheelchair sliding door to access Jamaica Blue coffee shop. I imagine spinal patients who currently wheel themselves around campus on trolley beds find it difficult to access Jamaica Blue and the coffee shop outside CD06 - they would need an able bodied assistant to access shop or chest height counter. They can probably access the foodhall the best, but at peak times it is busy and this may deter them from trying due to queues.	11/9/2015 12:59 PM
39	Again our area yes.	11/9/2015 12:56 PM
40	Parking is a bit hard and signage around the place. Not to sure where disabled toilets are for visitors.	11/9/2015 12:49 PM
41	The parking is very difficult if patients have limb mobility deficits, and the distances to be travelled are often too far. A tug system which operated at Shenton Park Campus would assist.	11/9/2015 12:47 PM
42	The high van (wheelchair vans) are not able to access the SRS car park - vans are too high	11/9/2015 12:46 PM
43	I am concerned that people with disabilities have a significant distance to walk, e.g. from the state rehab centre to reception/pharmacy, so wonder if any consideration has been given to a travalator through the main concourse?? I am also concerned that their is a lack of "readable" signage given the amount of times people have asked me where certain depts are	11/9/2015 12:38 PM
44	Gettting around alone as a disabled person at FSH is difficult as staff need to log jobs for porters for each leg of the disabled patients journey through the hospital.	11/9/2015 12:34 PM

Q5 Information provided by FSH is in a format that is readily accessible to all people with disability.

Answered: 208 Skipped: 8

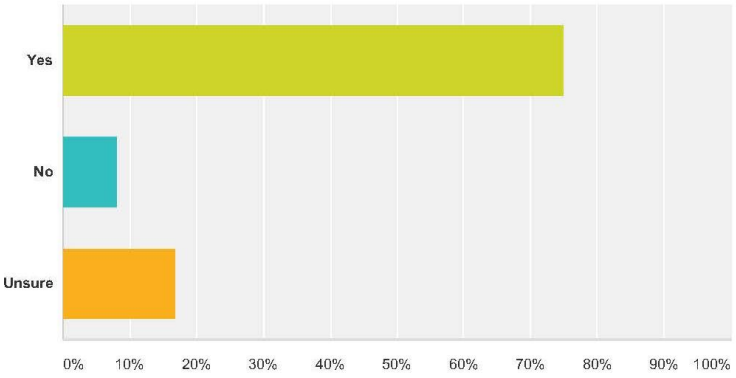


Answer Choices	Responses	
Yes	**38.46%**	80
No	**12.50%**	26
Unsure	**49.04%**	102
Total		**208**

#	Comment	Date
1	again see comments regarding signage	11/19/2015 3:13 PM
2	Consent and Breastfeeding information is only available for those who can read	11/18/2015 3:00 PM
3	I assume and hope so	11/12/2015 3:13 PM
4	I find the signage on site very small and subtle, and therefore difficult to notice. I would think this creates difficulty for elderly and sight impaired patients/visitors	11/12/2015 9:06 AM
5	See comment above re: signage	11/12/2015 8:19 AM
6	I haven't studied the formats (online website information; customer hand-out options) to be able to comment on this.	11/11/2015 10:04 AM
7	Unsure of resources for vision impaired	11/10/2015 10:33 AM
8	the outpatient booking sytem is too confusing for people with cognitive problems eg they get sent out wrong appointment times, webpas system is too rigid and not patient centred eg some patients need OT,PT, SP etc alls scheduled on the same day, but this isnt possible with the rigidity. Also if they phone the hospital to cancel an apontment, the message doesnt get through to the relavant clinician	11/10/2015 7:48 AM
9	It relies heavily on computor and usual written word literacy which could exclude many memebers of the community.	11/9/2015 3:35 PM
10	Does everyone have access to computer and global messages?	11/9/2015 2:13 PM
11	Written material and internet information does not appear to be readily available in audio formats	11/9/2015 2:09 PM
12	Some information is difficult to access, as people don't always provide accessible documents. Some people do not have the knowledge or skills to produce such accessible information. Although disabled people can request alternative formats, that puts them at a disadvantage. A better solution would be to provide all information in html or web format instead of word or pdf.	11/9/2015 1:53 PM
13	Some people are colour blind.	11/9/2015 1:47 PM
14	Menu and games on PES too small and unable to adjust size/complexity for varying abilities.	11/9/2015 1:37 PM
15	Not sure what information you are referring to specificaly. FSH is not well signposted for anyone!	11/9/2015 1:30 PM
16	Have no knowledge of other forms of communication other than visual written electronic.	11/9/2015 1:20 PM
17	iN general yes- soem may be excluded ie brail for the visonally impaired	11/9/2015 1:19 PM
18	I'm unsure whether Department of Health engage with any Disability Employment Services that assist with the support of those that require on the job assistance as required.	11/9/2015 1:01 PM
19	Not always often too verbose and high brow. Needs to be down to earth and is easily read.	11/9/2015 12:47 PM
20	No tactile flooring at lift entrances	11/9/2015 12:47 PM
21	Many pamphlets and information difficult for visually impaired people.	11/9/2015 12:43 PM
22	There is no patient medication information for blind or deaf patients. This is desparately required.	11/9/2015 12:38 PM
23	Not signage	11/9/2015 12:38 PM
24	Need information in languages other than English	11/9/2015 12:37 PM
25	patients with language impairment would have difficulties	11/9/2015 12:35 PM

Q6 People with disability receive the same level and quality of service from the staff at FSH as other people receiving services at the hospital.

Answered: 208 Skipped: 8

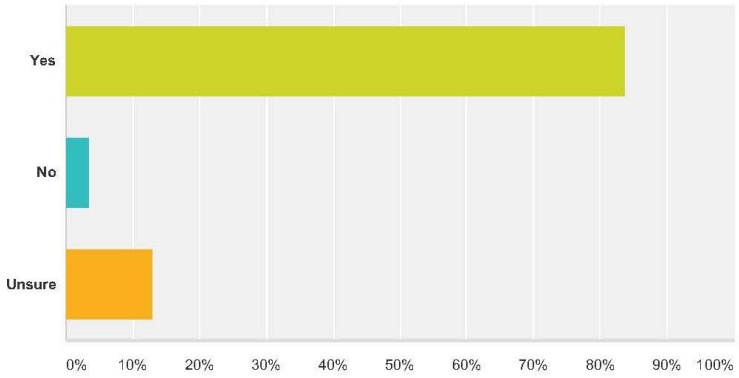


Answer Choices	Responses	
Yes	**75.00%**	156
No	**8.17%**	17
Unsure	**16.83%**	35
Total		**208**

#	Comment	Date
1	Patients often comment how difficult it is to have their phone calls answered by the correct department, or sometimes even to have call answered	11/19/2015 3:13 PM
2	i have notices some times there existing disability prevents further invistigation or rehabilitation	11/19/2015 8:56 AM
3	THEY GET APPROPRIATE CARE	11/14/2015 2:32 PM
4	I assume and hope so. I would always provide the same level and quality of service in my area	11/12/2015 3:13 PM
5	a/a	11/12/2015 9:06 AM
6	I found an elderly lady with a zimmer struggling to get to clinic 3. She didn't know she could ask for wheelchair assistance. I sat her in her zimmer seat and wheeled her to the clinic myself.	11/11/2015 7:47 AM
7	Staff are often not comfortable caring for people with disabilities.	11/9/2015 3:18 PM
8	I would need to ask those with a disability. I dont have one, so Im not sure	11/9/2015 2:49 PM
9	No buggies to support patients to and from carpark to hospital (like SCGH), porters are apparently not allowed to leave the ground of the hospital to collect patients	11/9/2015 2:20 PM
10	Communities Aides & Equipment Program (CAEP) requires the eligiblity criteria to be fullfilled before any provision of equipment is made. This may delay service delivery if the authorisation is required by their service provider. Their service provider quite often prefers to reassess the patient which requires additional travel for the patient to their site.	11/9/2015 1:50 PM
11	I hope so	11/9/2015 1:35 PM
12	Again unsure if changes with different disabilities. Some people will recieve	11/9/2015 1:30 PM
13	True within the area I work, but unsure about all areas of the hospital	11/9/2015 1:20 PM
14	information about parking, access to drop OFF SERVICES IS NOT CLEARLY DETAILED IN OUTPT APPOINTMEnT LETTERS	11/9/2015 1:20 PM
15	Sometimes better	11/9/2015 1:09 PM
16	I hope so, I have not witnessed anything adverse. Some disabilities are not visible, I overhear stigmatised responses to people with mental health conditions in my workplace, this is disappointing and largely driven by ignorance on the part of people who lack understanding of diversity in the human condition.	11/9/2015 12:59 PM
17	Just with all elements of society the disabled are often patronised and looked down upon particularly by out patient clerks. All staff need education regarding the most discriminated section of society.	11/9/2015 12:47 PM
18	Again patients with ventilators have restricitons on what they are able to access - therefore quality of service is reduced.	11/9/2015 12:46 PM
19	Patients with complicated physcial issues expereince more delays in diagnosis and treeatment as different hospital departments do not have easy ways to communicate in a timely fashion. \Patients are often given conflicting information from different specialists with different agendas.	11/9/2015 12:43 PM
20	Medication information is not in an appropriate format for all patients with disabilties.	11/9/2015 12:38 PM
21	Single rooms make communication impaired patients disadvantged if the nurse only pops head in once or twice a shift	11/9/2015 12:35 PM

Q7 People with disability have the same opportunities as other people to make complaints at FSH.

Answered: 202 Skipped: 14

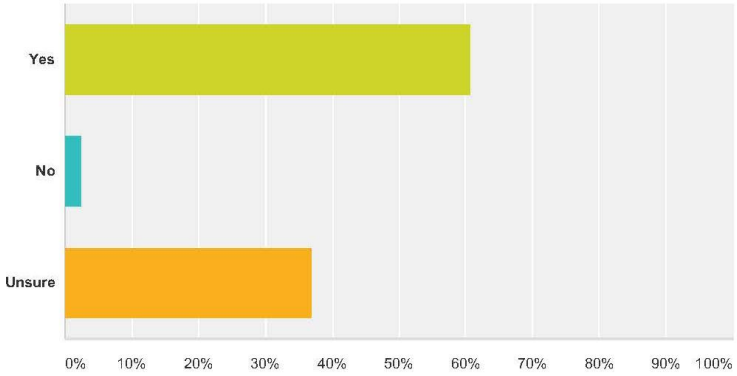


Answer Choices	Responses	
Yes	**83.66%**	169
No	**3.47%**	7
Unsure	**12.87%**	26
Total		**202**

#	Comment	Date
1	Comment forms are not displayed enough in patient areas	11/19/2015 3:13 PM
2	I assume and hope so	11/12/2015 3:13 PM
3	I haven't reviewed the process or documentation options.	11/11/2015 10:04 AM
4	My complaint was not taken seriously. Nor was my osh report (which was actually ignored).	11/9/2015 8:20 PM
5	If it relies on IT skills then no if canbe given verbally or on paper then yes.	11/9/2015 3:35 PM
6	By the sheer nature of their disability, sometimes it makes this difficult or unable to do so.	11/9/2015 3:18 PM
7	Do our complaints forms come in braille?	11/9/2015 2:49 PM
8	A lot of people do not report problem areas as it appears to be left for someone else to report or it is considered normal to have problems.	11/9/2015 2:13 PM
9	Patient satisfaction forms readily available at the Nursing Post on Rottnest Island	11/9/2015 1:25 PM
10	I am aware of patient liaison service, Feedback portal within CIMS, HelpDesk Staff. Staff could refer complaints to Supervisor or HR if desired.	11/9/2015 12:59 PM
11	Unsure in that the only format to make a complaint is either verbal, written or via email and if blind and dumb, with no access to email at home it may be difficult - but accpet this is an extreme case.	11/9/2015 12:55 PM

Q8 People with disability have the same opportunities as other people to participate in any public consultation organised by FSH.

Answered: 206 Skipped: 10

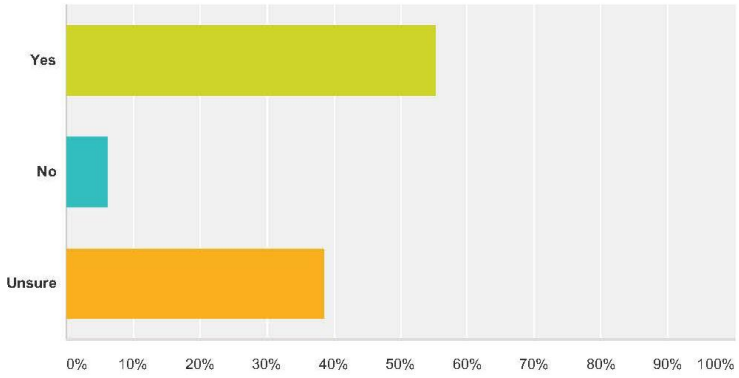


Answer Choices	Responses	
Yes	**60.68%**	125
No	**2.43%**	5
Unsure	**36.89%**	76
Total		**206**

#	Comment	Date
1	As long as this is widely advertised, but some need encourgement to paricipate	11/19/2015 3:13 PM
2	I assume and hope so	11/12/2015 3:13 PM
3	I would hope so.	11/11/2015 10:04 AM
4	Process for organising appointments (especially from Emergency) can be confusing, for people with cognitive impariment they can easily fall through the gap.	11/10/2015 10:33 AM
5	a/a	11/9/2015 3:35 PM
6	They should have opportunity to participate in any public consultation organised.	11/9/2015 12:59 PM
7	Unsure have not seen or recieved any information regarding this point.	11/9/2015 12:47 PM

Q9 People with disability have the same opportunities as other people regarding employment practices (recruitment and retention) at FSH.

Answered: 210 Skipped: 6



Answer Choices	Responses	
Yes	**55.24%**	116
No	**6.19%**	13
Unsure	**38.57%**	81
Total		**210**

#	Comment	Date
1	absolutely not! only certain disabilities are accepted	11/17/2015 8:44 PM
2	I assume and hope so	11/12/2015 3:13 PM
3	From a personal experience with a family member I do not feel that there menatl health situation was dealt with appropriately, certainly so support was offered, which resulted in misssing out on applying for a permanent position in Dec 2014.	11/11/2015 9:07 AM
4	I have to assume the standard inclussion form of application acceptance and job offers made are followed. However, I don't think I've seen a wheelchair bound employee yet.	11/11/2015 7:47 AM
5	As much as possible and dependent upon disabilit.	11/10/2015 8:59 AM
6	I believe that equal opportunities is adhered to here at FSH	11/9/2015 3:16 PM
7	Walking distance- too far for some	11/9/2015 2:20 PM
8	If a person is able to perform the position to the satisfaction of an employer then we all have the same opportunities	11/9/2015 1:35 PM
9	as per Public Sector Standards	11/9/2015 1:25 PM
10	But I would hope they do.	11/9/2015 1:20 PM
11	I think there is a stigma and these people will not be selected if they choose to disclose. Another reason will be given for selecting a different candidate. The costs involved in "reasonable accommodations" for people with disabilities are not considered available by recruiters/selection panels. If we can't retain existing staff levels due to bedgetary restraints, I cannot see a recruiters choosing people with disabilities when contract positions do become available.	11/9/2015 12:59 PM

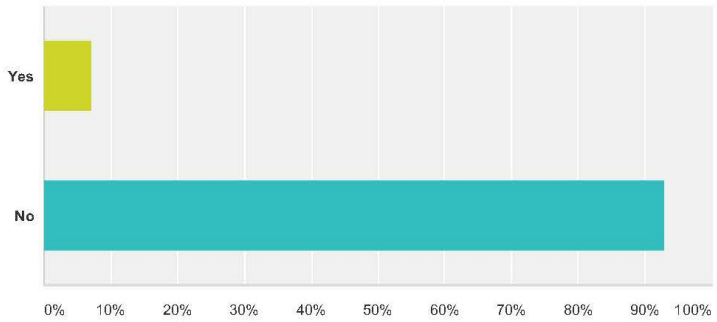
Q10 Any other comments?

Answered: 26 Skipped: 190

#	Responses	Date
1	I think it would be beneficial for FSH Corporate Communications or the relevant area to raise awareness across the hospital of specific services set in place to assist people with disabilities (such as braille pamphlets, TTY Services, etc.) I have made 2 wheel-chair bound patients aware of the "slowing down" button on the hospital turnstyle entry/exit points. I think this sort of information could be regularly noted on the CARE Bulletin as information for new staff and a reminder for existing staff.	11/20/2015 4:46 PM
2	no	11/19/2015 10:06 PM
3	A review of signage from the wheelchair users perespective would be good	11/19/2015 3:13 PM
4	only cleaning isn't opportunity	11/17/2015 8:44 PM
5	I think this consultative process is beneficial for furthering understanding and processes to facilitate all staff, including those with disability who work and are serviced at FSH. Thank-you for the opportunity to participate.	11/12/2015 3:13 PM
6	parking close to the hospital is limited for people with restricted mobility, more acrod spots near Allied health outpatient raes would be helpful.	11/11/2015 9:55 AM
7	parking closer to the dept would help. as I work in the education building parking in the basment car park and just take the lift would help	11/11/2015 8:50 AM
8	Signage for people with poor eyesight in the hospital could be improved. I have difficulty following signage at times as it is very small to certain clinical areas, and my vision is fairly normal.	11/10/2015 11:03 AM
9	Disability Services Commission has a Hospital Liaison Nurse Roz Barker 61409865 who doesn't have a formal contact person at FSH.	11/9/2015 3:18 PM
10	I really dont know how FSH is engaged with those with a disability. Im sure huge efforts have been made but Im unsure of the success.	11/9/2015 2:49 PM
11	no	11/9/2015 2:45 PM
12	Please look at changing the door enterance for Pathology Specimen collection on ground floor in main hospital opposite the Florist.	11/9/2015 2:15 PM
13	My underlying feeling is that FSH does Disability Inclusion and Access quite well, what I feel FSH doesnt do well is Educate its staff and patients on the extra services and things that people with a disability can access while here.	11/9/2015 2:14 PM
14	Fiona Stanley is a well run business. Some people within Fiona Stanley need to take responsibility and work together as a team.	11/9/2015 2:13 PM
15	There are some non-disabled teams that are being bullied. Bullied persons aren't able to thrive in their teams, let alone support disabled team members. Flexibilty is farcicle is some teams - even though there is no reason for such inflexibility, some supervisors believe only they are entitled to it but not the team members. These supervisors wouldn't care less about anyone in their team, let alone disabled persons.	11/9/2015 1:47 PM
16	Patients seem unable to understand what hospital their appointment is in and sometimes the staff don't either. Appointments for F.S.H come here and when told to go to F.S.H the staff there send them back to us. This is very frustrating for the patients not to mention an unfavourable impression of our competency.	11/9/2015 1:38 PM
17	This survey is not detailed enough to assist in making any decision in regards to FSH in how we support people with disability and their carers.	11/9/2015 1:35 PM
18	I think the questions are a little broad to provide yes/no answers. I imagine there is plenty we can do to improve to assist people with disability.	11/9/2015 1:30 PM
19	people with a disability wouldnt be able to do front reception if mentaly they were fine just in a wheelchair as there is no wheelchair access	11/9/2015 1:19 PM
20	Not much is communicated to staff inregards to the Disability Inclusion Strategies, however I have witnessed individuals in the workplace with support people, however belive these are Serco employees.	11/9/2015 1:01 PM
21	A couple of months ago I was contacted as there wasn't any facitliy for a dad to change his disabled teenage son. I wasn't aware of anywhere where he could do this so referred it to SRS. Is there anywhere in the main hospital near Outpatient's to do this?	11/9/2015 1:01 PM
22	This is nonsense. I can only speak for our own area as i am unaware of the situation in other areas.	11/9/2015 12:56 PM
23	NMHS has a Disability Liaison Officer who is/was placed at SCGH - is this service available at FSH?	11/9/2015 12:48 PM
24	All employees require education on access and inclusion for the diabled.	11/9/2015 12:47 PM
25	Would be great if people with disabilities - could avoid smoking within the campus. Seen a lot of State Rehab patients smoking within the hospital and it is a concern for people like me who are pregnant. Would be great if this could be looked at. Thanks.	11/9/2015 12:40 PM
26	nil	11/9/2015 12:38 PM

Q11 Do you have a disability?

Answered: 209 Skipped: 7



Answer Choices	Responses	
Yes	**7.18%**	15
No	**92.82%**	194
Total		**209**

#	Comment	Date
1	Not a permanent one but am currently injured	11/19/2015 4:23 PM
2	Hearing impaired.	11/12/2015 12:20 PM
3	I am not disabled but do have a number of chrinc conditions affecting my ability to work and access the site. I am curnetly appeling a decision where I have been denied site parking and if this is rejected my jouney will significantly impact my health issues - so I feel I have some insight into the dificulties that people with disabilities face	11/12/2015 8:21 AM
4	confined to a wheelchiar	11/11/2015 8:50 AM
5	Spinal cord injury	11/10/2015 2:56 PM
6	I do not have a disability but am aware of State government and hospital policies. As FSH is new clearly services and facilities have been designed appropriately. I also think employment opportunities are provided.	11/10/2015 9:03 AM
7	We have an employee with disabilities working in our office. I have not seen or heard of any occasion where he has been at a disadvantage because of his disability.	11/9/2015 4:32 PM
8	I have worked with the disabled and am heartened to see people with disabilities employed within the Health Depart and by Serco. They should be given the same opportunities as everyone else. They all have something to contribute to the community.	11/9/2015 3:37 PM
9	Hearing	11/9/2015 3:29 PM

4.4 DAIP Committee Terms of Reference

NAME

The Committee shall be known as the Fiona Stanley Hospital (FSH) Disability Access and Inclusion Plan (DAIP) Committee.

ESTABLISHMENT AND PURPOSE

The Committee was established by the FSH Hospital Executive Committee (HEC) on the September 22nd 2015 for the purpose of developing and implementing the FSH component of the SMHS Disability Access and Inclusion Plan in accordance with the Disability Services Act 1993, the WA Health Disability Access and Inclusion Policy OD 0586/15 and Standard 2 of the Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Science (NSWHS) Standards partnering with Consumers.

ACCOUNTABILITY AND REPORTING

The Committee reports directly to the Clinical Governance Committee and is accountable to the HEC via the Chair.

The Committee is required to escalate issues and concerns to the FSH Governance Committee by exception and will provide an annual report to this Committee on key performance areas, achievement against KPI's, Quality Improvement and risk management strategies.

MEMBERSHIP

The Committee will consist of:

- Director of Allied Health (Chair)
- Customer Liaison Manager
- FSH Safety, Quality & Risk Representative
- Director Human Resource Services
- Consumer Representative x 2
- Director – Operations
- Facilities Management Representative
- Medical Representative
- Nursing and Midwifery representative
- Senior Occupational Therapist
- Senior Social Worker

FUNCTIONS AND RESPONSIBILITIES

The functions and responsibilities of the Committee are to:

- Ensure the impact on patient safety and quality of care is considered in all decision making in accordance with FSH vision statement.
- To develop and implement the FSH component of the SMHS DAIP ensuring local strategies address the 7 desired outcomes listed in the WA Disability Services Regulations:
    1. People with disability have the same opportunities as other people to access the services of, and any events organised by, the relevant public authority.
    2. People with disability have the same opportunities as other people to access the buildings and other facilities of the relevant public authority.
    3. People with disability receive information from the relevant public authority in a format that will enable them to access the information as readily as other people are able to access it.
    4. People with disability receive the same level and quality of service from the staff of the relevant public authority.
    5. People with disability have the same opportunities as other people to make complaints to the relevant public authority.
    6. People with disability have the same opportunities as other people to participate in any public consultation by the relevant public authority.
    7. People with disability have the same opportunities as other people to obtain and maintain employment with a public authority.
- To continuously monitor, evaluate and develop service, facilities and programs within FSH to meet the needs of people with disability (including patients, staff and visitors, their families and carers)
- Review policies, procedures and/or guidelines related to Disability Access and Inclusion accordance with related standards an best practice.
- Use the data from relevant management systems and relevant audits to inform quality improvement activities.
- Develop and implement processes for collecting, analysing and reporting feedback from the community and the workforce about the FSH DAIP.
- Provide progress reports and recommendations to FSH HEC and consider appropriate matters referred by the HEC or other clinical governance committees.
- Act as conduit to relevant groups/committees at a South Metropolitan Health Service (SMHS) level or WA health level and ensure compliance with are and state policy, as required.

RELATIONSHIP WITH OTHER COMMITTEES

The following committees have a direct or indirect relationship with the Committees:

- FSH Hospital Executive Committee
- FSH Consumer and Community Advisory Committee
- FSH Clinical Governance Committee
- FSH People with Disabilities Advisory Committee

SUBGROUPS AND WORKING PARTIES

The Committee cannot establish subgroups without the consent of the FSH HEC. Terms of Reference for any subgroups will be subject to endorsement by HEC.

The Committee may create ephemeral working parties at will to complete specific projects by notation within its minutes. At the time of creation the expected time of disbandment of the Working Party shall be specified, as will the deliverables expected of it.

MEETING ATTENDANCE

The Committee may invite non-members to participate in meetings in order to provide information, expert advice or to observe proceedings. This may include consumer representatives, or other external persons. Non-members have no voting rights.

The Committee chairperson will ensure invited persons are aware of their responsibilities and obligations with regards to confidentiality as outlined in the SMHS Confidentiality and Privacy Policy.

Members may nominate a proxy to attend in his/her absence.

CHAIR

The Chair shall be nominated by the Hospital Executive Committee.

When the absence of the Chair is known in advance the Chair may nominate an Acting Chair for the meeting from among members of the Committee. Should the Chair be, or expect to be, absent from meetings for an extended period of time the Committee may elect an Acting Chair for that period.

SECRETARY TO THE COMMITTEE

The Secretary to the Committee shall be the Executive Assistant to the Director of Allied Health.

The Secretary shall:

- issue agendas and supporting material, as far as is possible, three working days in advance of the meeting date
- book venues, prepare minutes and action items for each meeting and circulate these within seven days of a meeting
- keep separate files of:
    - agendas and documents circulated with them
    - minutes and action sheets
    - any documents / correspondence tabled at meetings or circulated other than with Agendas.

The Minute Secretary's files shall remain the property of FSH and must be preserved in accordance with the State Records Act.

OPERATING PROCEDURES

Meetings

- The Committee shall meet monthly according to a date and time schedule that will be agreed and renewed from time to time. The schedule is to be prepared by the Secretary in consultation with the Chair. The Chair may cancel a meeting if there is insufficient business to warrant holding a meeting or an additional meeting may be held at the determination of the Chair.
- Agendas will be compiled and circulated to all members no less than three (3) working days before each meeting.
- Minutes will be taken by secretary and forwarded to the Chair for review and distribution within five (5) working days of the meeting.
- Minutes will be verified at the following meeting and signed by the Chair

Quorum

A quorum consists of the Chair or delegate plus 50% of members (or proxy members). In the absence of a quorum, a meeting may be held but its decisions would be subject to ratification by the succeeding full meeting of the Committee.

Apologies

If a member is to be absent then an apology should be given either through the Committee's Secretary or the Chair.

Voting

Each member of the Committee (or their proxy) has the right to vote. Co-opted members or any other persons in attendance may not vote. The Chair shall not have the casting vote.

Conduct of Meetings

- The decision of the Chair is final in all matters of procedure.
- Members are required to read all agenda items prior to meetings and action/respond to delegated action items within the allocated timeframe.

CONFIDENTIALITY

The proceedings and records of the Committee are confidential to members and the endorsing committees and are only to be used for authorised work related purposes. All paper-based information must be kept secure and placed in appropriate confidential bins when no longer required. Electronic information should be stored on the FSH shared drive where access is restricted to appropriate persons.

ADOPTION AND AMENDMENT OF TERMS OF REFERENCE

These Terms of Reference were endorsed by the FSH HEC on the 1st December 2015. The Committee will evaluate its Terms of Reference, performance and need for ongoing continuation annually.