Hearing Loops at UHS FT

An audit of Hearing Loops at Southampton General Hospital

Introduction

The University Hospital Southampton Foundation Trust (UHS FT) established a group to advise on improving the patient experience of patients with sensory disability; i.e. Visual and Hearing disabilities.

This was part of a programme of work to ensure that UHS FT were compliant with the Accessible Information Standard introduced by NHS England which aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

Two members of the Healthwatch Southampton Strategy Group were invited to join the group to provide a patient perspective. The two members were Steve Beale and Harry Dymond both of whom have a hearing disability.

Healthwatch provided clear evidence that patients with sensory loss had great difficulty especially if attending outpatient clinics without support. In the case of hearing loss, we provided evidence of patients missing appointments having failed to hear their name called at clinics and of patients having difficulty in understanding instructions given at reception areas.

As a result, the group decided they should conduct an audit of hearing loops in UHS. The attached report was produced and approved by the sensory loss group. It was presented officially to the Patient engagement and experience group of UHS and subsequently escalated to the Quality Governance Steering Group. In view of the seriousness of the findings, Healthwatch Southampton decided to send a copy of the report directly to the CEO of UHS.

We are pleased to report that the trust has responded very positively to this report and the CEO has passed the issue to the Disability Steering Group chaired by the Director of Nursing for Prioritising and action and shared with the Director of Estates and Capital Development.

In the short term, Steve and Harry have offered to help with staff training and other advice and we have had a first contact with the estates Department.

The report submitted by the sensory loss group follows below:

Audit of Hearing Loops

Background Legislation

It is coincidental that on the day we conducted the audit, NHS England announced a survey which stated:

"Six months after it came into force, NHS England want to know if its Accessible Information Standard is working." It went on

"NHS England wants to understand the impact that the standard has had in three key areas:

- How the Standard has made a difference to people's experiences
- How organisations have implemented the Standard
- If there are any areas of the Standard that need updating or clarifying"

The Standard exists to make sure that people with a disability, impairment or sensory loss are given information they can access and understand, as well as any communication support that they need.

This includes making sure that information is available in different formats, such as large print, braille, easy read or via email. It also requires appropriate support to be available, such as a British Sign Language (BSL) interpreter, deafblind manual interpreter, or an advocate.

To ensure that the Standard is met, organisations may have had to change their policies and procedures, trained staff, and perhaps altered their systems to make sure people get what they need.

The Accessible Information Standard states that there are five ways NHS and social care organisations should be making information accessible:

1. You should be asked if you have any communication needs, and asked how these needs can be met
2. Your needs should be recorded in a clear and set way
3. Your file or notes should highlight these communication needs so people are aware and know how to meet them
4. Information about your communication needs should be shared with other providers of NHS and adult social care, when they have consent or permission to do so
5. Information should be delivered to you in a way you can access and understand, with the option for communication support if needed

The sensory group is making good progress to ensure that UHS FT is compliant. This report details work done and makes recommendations with respect to hearing loss.

Background to the Audit

As discussed at the last Sensory Group meeting, a memo to all matrons indicated that there were hearing loops in the following locations.

Cardiothoracic outpatients D level East wing

oncology outpatients D level East wing

C7 Haematology day unit

C6 TYA – Teenage and young adult unit On C level next to C6

Therapies outpatients – East wing physiotherapy outpatients

Wellcome Trust CRF Reception area

The Chapel

Note: The first two locations are in fact a shared location and there is just one loop

As far as we could ascertain there are no other hearing loops installed apart from the one in the main reception which was also audited, in the Heartbeat Centre which is the subject of a separate investigation, and in the academic block (Deans Committee Room) which was not audited at this time.

We were told in advance that the loop in Therapies Outpatients was not working and needs repair. This was therefore not audited. In Hindsight, we should have visited the area as it is entirely possible that it is not faulty but that the staff are unaware of how to use it.

Method

Harry Dymond and Steve Beale from Healthwatch and both deaf were accompanied by Sarah Halcrow and visited the locations on 31.01.17.

Sarah explained the purpose of the visit to staff at each location.

Harry using his T position on his hearing loop and Steve using earbuds linked to a loop receiver, tested the effectiveness of using the loops. The team then asked set questions and completed a questionnaire at each location.

Results

The individual completed questionnaires were submitted to the Head of Equality, Diversity and Inclusion

This was a very valuable exercise and regrettably showed that there is little understanding of hearing loops within the trust.

The hearing loop in the main reception is working and staff there are familiar with it.

The only loop that was working in a clinical area was the one in the reception area share by cardiothoracic and oncology.

It should be noted that this area had previously been visited by Harry and Steve who had found it not working and instructed the staff on its correct use. It should also be noted that the loop in the main reception had originally been incorrectly installed and had to be re-installed.

The Chapel is fitted with a room loop which was separately tested by Harry and was found to be working correctly. There are two microphones hanging from the roof and the music is separately controlled. The chaplains are all aware that for the loop to be effective they must use the lectern microphone and I was assured that the microphone is used at all times when there is a service.

We took the opportunity to visit two other locations where we considered hearing loops should be installed.

- ED reception

- X-Ray reception

Both confirmed that they did not have a hearing loop and, in particular, the ED reception staff said they had considerable difficulty when dealing with hard of hearing patients and would welcome a hearing loop.

We also considered other clinical areas where a hearing loop would be of benefit.

Recommendations:

Clearly there is a need to ensure that all existing loops are functioning correctly and that staff likely to have occasion to use them are properly trained in their use. Whilst Harry and Steve are willing to do this in the short term it would be sensible for this to be the responsibility of a named member of the Trust. Our recommendation is that this should be the member with responsibility for diversity supported by a named position/person in the estates department.

We note with pleasure that Occupational Health are to recruit a disability Access officer with experience, understanding and passion for disabled access issues. It would be helpful if these same aptitudes could be reflected in the position identified in the estates department who would then be able to advise on all new builds / re modelling etc. and would also be able to oversee the maintenance of equipment and facilities.

A full record should be kept of the location, staff familiar with it and regular testing to ensure that they remain fit for purpose. This person should also be the first point of contact for staff in the event of a loop failure.

Specifically, we recommend:

- Staff at locations of existing loops should be informed who is responsible for their correct function (i.e. if agreed, lead for diversity or named position in estates department)
- The volume of the loop in main reception is increased a little.
- The loop in the reception area of cardiothoracic/oncology needs no further action at present.
- Loop in C6 TYA to be investigated and staff trained. We do not know what type of loop is supposed to be installed but this is a small reception area and a portable loop would be adequate. A counter loop would be ideal. The sign should be replaced with something easier to see and not attached to a moveable piece of equipment.
- Loop in C7 Haematology day unit to be investigated and staff trained. The sign should be replaced with one more easily seen. There is no need to state ‘ask staff’ as there is no reason this cannot be left permanently on when reception is open. We do not know what type of loop is supposed to be installed but this is a small reception area and a portable loop would be adequate. A counter loop would be ideal.
- Wellcome Trust CRF Reception area needs further investigation. We cannot be sure that a loop exists for this location although there is an electrical point for one suggesting that this is a counter loop. We did not ascertain if the wire is installed under the counter but there was no unit present. Staff obviously thought there was a unit.
- The loop in the therapies outpatients’ department should be carefully examined and if not working it should be replaced/repaired. Staff should be questioned about its use and trained appropriately.

We also recommend that consideration is given to installing hearing loops at the General Hospital in the following locations:

- ED Reception – This would seem to be quite urgent and would make an immediate impact for both patients and staff. A counter loop would be ideal but as a temporary and quick measure, a portable loop could be provided that could then be moved onto another location once the counter loop is installed.

- X-Ray reception Perhaps not as urgent as ED. Installation as per ED.
- Paediatric out patients
- Surgical Day unit reception F level
- Eye Unit reception (confirmed that this is a problem for them)
- Non-invasive cardiology Reception E level
- Endoscopy F level
- Neurology
- In addition, as it is very likely that a high proportion of patients and visitors of patients in wards involving Medicines for Older People are likely to be wearing hearing aids, we recommend that these wards should have easy access to portable loops. (5 wards on G level and 1 ward on F level.) NB; initially this might be a shared resource.

Locations within Princess Anne Hospital as follows:

- Breast imaging and outpatients/pre-assessment

Locations in the Royal South Hants Hospital:

- X-ray reception
- ENT OPD.
- It is believed that Audiology at RSH have hearing loops and if so these need to be added to the list and tested.

Patient support services should also have a portable loop at their disposal for occasions when they are dealing with patients that are hard of hearing.

This is not an exhaustive list and no doubt there are other reception areas used by the public that should be included.

Nursing stations are usually very busy and it is quite normal for there to be multiple conversations in a small area. This is where a loop helps as the loop system reduces the background noise considerably. In an ideal world where money was plentiful, it would be ideal if all nursing stations were equipped but realistically we recommend that when an area is due for refurbishment, the provision of a counter loop should be included at the nurses station or reception area.

We recognise that there is a cost to these recommendations and that the Trust faces difficult budget constraints. Nevertheless, we would hope that consideration is given to the installation of the loops and basic training of staff in their use. If it is not possible to install loops in all locations at one time, we would hope that the diversity lead is encouraged to develop an agreed priority schedule based on patient usage of the area.

Generally, a portable hearing loop is adequate in environments where there is not too much external noise and the deaf person can be stood or sat in front of the aid. A portable unit is self-contained and transmits directly to the T position of the hearing aid. These retail for about £100. Counter loops need to be installed; and as the name suggests a wire is usually fitted beneath the counter and a microphone is fitted to an amplifier which transmits the magnetic signal to the hearing aid T position. These cost about £100 plus the cost of installation.

Room loops are useful where there is a gathering of people some of whom may be deaf. A microphone is essential as, in the T position, the hearing aid will only hear sound from the dedicated transmitter. Shouting is not a substitute! There are essentially two types of room system; one based on infra-red radiation (the type used in the Heartbeat lecture theatre which currently requires earphones that are compatible) and a system based on induction which simply requires the deaf person to use the T position on the aid. Price depends on the size of the room and other environmental factors.

Additional Finding

During our discussions, we were informed by one of the matrons of a member of staff involved in administration who is deaf and finds it impossible to use all types of normal phone as well as having difficulty with the use of a normal keyboard. We interviewed the matron and ward sister. Although she has tried to find assistance for the gentleman through the normal trust procurement procedures she has been unable to locate suitable advice. We informed her of a system using a simple neck loop costing about £30 and special portable phones costing about £50 – 100. We will put her in contact with a person who would be able to give further advice if something more is required.

We are concerned that there may be other members of staff who have hearing difficulty and who would benefit from simple inexpensive solutions.

H F Dymond

On behalf of the sensory loss Group and Healthwatch Southampton.