## *Be heard: Safe communication @ Redland Hospital,* Metro South Hospital and Health Service

NEW SPEAKER: This time we have be heard, safe communication at Redland Hospital and it's a metro South Hospital and health service and our speakers are Damien Dwyer and Shirley Edwards. So Damien currently works as a clinical nurse consultant quality for emergency services at Redland, Wynnum and various facilities in metro South. Shirley is a consumer representative at Redland Hospital on the Be Heard project. She has been involved for communication with persons and inquiring into Cochlear implants, CICADA and Secretary for over 15 years as well as other hearing loss organisations in various roles for many year, she is a bilateral Cochlear implant recipient and promotes and representing hearing awareness communication sessions to interested organisations and business personnel. The speakers and the panel have decided that they would like to sit down the front here and so they will present from the floor. Thank you.

DAMIEN DWYER: Did anyone want to move closer in? It's the microphone, it's OK. You're welcome to move closer if you'd like to, make it more personable. I also wanted to introduce, thank you for that introduction, I also wanted to introduce some very good friends that I've met in the course of this project. Jill and Peter Lindley who have also come up with us today to talk and you'll hear their stories and hear why this is such an important activity for us and why we're so excited to be here to present to you. We've also - they're also part of our steering committee and I'd be very grateful if you wanted to look into this further. Peter and Jill have always been huge advocates for hearing impaired consumers for many decades and if you Google Peter and look at the articles he's produced I think you'll agree they're quite spectacular. So I'll get along.

Just a quick - this is us. We're at Redland. It's a fantastic place, little place on the Bay. Very small community facility. There's 140 beds but that covers mental health, medical, surgical maternity services, so - it's very busy emergency department, almost 60,000 presentations, that's very significant because of the small bed stock, it's quite unusual like that, similar in size to Caboolture. So very busy, department, a lot of stress, a lot of anxiety and we know now what that does to communication. And why communication is so important. I just wanted to highlight to you what we're going to go through today. And try and talk you through the settings and the problem we're trying to solve. Why it's so important, and the different strategy we took to try and improve. Where we're at and what we're going to do next. The exciting thing for us is that it started from a complaint as we like to think of them, a gift, an opportunity. And when you take that approach, we know that we had a problem and we were uncomfortable that we had a problem, yes we tried to fix it but the fix wasn't sustained so we thought we had to do things a little differently and thus the project commenced. So to help me try and set the scene, I wanted to put it into context, above there are some of the strategies in place in metro South that are relevant to our cause, and there are many and I put a lot of them up there on purpose because there's actually quite a lot of focus in the area of person-centredness. You may or may not know that metro South has embarked upon Planetree credentials, I'd encourage you to look at their site for many opportunities that it brings from an executive level to become person-centred or to put the question, how person-centred is your facility? As you can see there, there are a number of other strategies and the links there should lend you to them if you have this presentation. For us, we actually know that hearing loss affects one in six patients, one in six people in our community and actually in health care settings that's higher. So we know that it happens a lot, and we also realise that we don't have all the answers and its impact is great. To help me sort of talk through through this, I wanted to first call on Shirley to tell us a little bit of her story and the significance for her.

SHIRLEY EDWARDS: Hello. And good afternoon. I'm happy to be with you today and add to what we are trying to do with communication and hearing loss issues in our local Redlands Hospital. First my name is Shirley Edwards, I have had a hearing loss for some

40 years which has never been diagnosed . During those years I have had a long and varied experience with Queensland health care system resulting in good and bad conclusions. I tell personnel in the health care role and explain that I have a hearing loss and if they slow down their speech, communication will be much easier and have better outcomes. This is not always understood, sometimes results in myself being shouted at by professional, personnel taking it upon themselves to go away and get a sign language interpreter. They simply don't understand that I don't understand sign language and this is not what I need. I just can't hear properly, that's all. These are the main negatives in my experiences. As well, one of the most responses I get "oh, she has a Cochlear implant she can hear OK, no need for any assistance." This could not be further from the truth. I also experienced sheer frustration particularly when the occasion rose that I was in hospital, of lying on a hospital bed and trying both to hear and lip read a medical professional when I was lying down and he was standing up at an angle like that, it's impossible to lip read. There are three categories of hearing loss, none of them you could put in the same basket. The first one is being born deaf, use sign language and they have no oral language. The second one is those who wear hearing aids, they have oral language, they hear, and they speak, and the third is termed as the new breed of hearing loss, people who have Cochlear implants who speak but hear new kind of sounds that is learned over time. All have different communication needs. They cannot be put in the same basket as I've said before. I have never been asked what type of communication that I need in all my years of dealing with Queensland health systems and other Government departments, in fact wherever I go. I need education, and training is the key and communication awareness with people who have a hearing loss be made compulsory as part of medical training. This would only result in positive outcomes for everybody concerned. For your information, I have more information here on Cochlear implants, some handouts if anyone would like them, a battery service that our organisation now has. It's a service to our members and we have a book, at a cost of $10 which we published last year made up of stories that people who have implants and how their lives have changed being able to hear again. I also

have a few of our latest magazine, free, if you want them. Published just last week. So thank you for listening. Are there any questions?

DAMIEN DWYER: Thank you Shirley. We might hold the questions to the end and make sure we have time. I'd like to introduce Peter.

PETER LINDLEY: Good afternoon. My name is Peter. A lot like you I lost my hearing when I was 7 years old and I'm 79 now. As a result, I have had a profound sensory neural loss for more than 72 years. During those years I have generally had negative experiences with Queensland's health care system as I discovered early in my life that health care workers do not seem to take hearing loss seriously. For example, I always tell health personnel that I have a hearing loss and explain that they need to face me and speak clearly and not too quickly. Because people with hearing loss cannot process spoken information at the same rate as the person who has good hearing. The first most common response I invariably receive is "no problem." However, yes it is a problem, a very big problem. The second response I receive is "that's fine." But the problem is it's not fine, again, it's a very big problem. Finally, I also get one of the most common responses I receive is a blank look, as much as to say "he has a Cochlear implant, what is this about?" The fourth response is obvious impatience and sometimes the comment "why don't you turn that up, the thing up?" What invariably follows is I make no attempt to speak clearly or more slowly. Nothing changes. Over the years I have experienced medication and treatment errors through poor communication. I could describe these errors, the put-downs and the embarrassment I've experienced, however time does not permit. Good communication is a prerequisite for good health and is also very important as a safety issue. We believe that education about the implications of hearing loss is a very important requirement. Hearing loss should be considered for what it is, a significantly disabling condition with the potential for treatment errors and a failure to adhere to each individual's right under the Disability Discrimination Act, thank you.

APPLAUSE

DAMIEN DWYER: Thank you Peter. For the project itself we knew we had a problem that we were uncomfortable with and we were very keen to fix it. Importantly the way it was set up was really significant because we had fantastic executive leadership and Gayle Gordon has been our executive sponsor. We also have consumers on our steering panel as you have heard, but we wanted to use a scientific approach that very simple looking diagram where we plan, do, study and act, was the approach that we used and our planning phase actually continues throughout the cycle. Our research question that we hope to publish work on to help us understand how change happens involves a couple of aspects, firstly we wanted to investigate the experience of hard of hearing and deaf patients, and how they act as our services and the question about improvement, how we do improvement methodology when we do it with consumers, with external partners, and executive-led, do the changes that the staff implement in the service remain? Are they sustained? To do this we had a couple of strategies. The first of which we started in the emergency department with a couple of aspects around discovering the information about our current state. So we went - launched with great fanfare, went to the emergency department and asked them how they felt about their confidence and their abilities and their ward's ability to service the needs of hearing impaired consumers? We also were interested to know the frequency that they thought interactions occurred, bearing in mind it's more than one in six. We actually had a wide variety of responses around the perception of the frequency in which they contacted patients. The graph there has a little example of the department's awareness in the blue and the individual awareness, just ranging from not aware to extremely aware. The picture on the right there is a very fantastic emergency clinical nurse, Michelle, Michelle is our local champion, that was one of the strategies that the project thought would help us with getting inside the culture of the department. She's the leader of the standard 2 committee engage consumers committee and she's got in her hand some of the equipment that we were reviewing with the survey. We also had an audit process, we used a special thanks to the Princess Alexandra Hospital audiology department for their departmental audit tool that we used and to Shirley and the

lovely Alicia who was the project officer for this project, when we did our audit with Shirley we walked through the department and trying to discover how the department was able to fulfil the needs of consumers with hearing impairment. The results there on the right were framed as things that were done well, and then the opportunities and I do know from that experience we wanted to change things right then and there, Shirley, didn't we? We were very keen to turn the chairs around in the emergency department so that they faced the right way, we wanted carpet, we wanted everything, so I think that's part of the learning of this, is that we're impatient for change but we have to do it in a way that staff agree, consumers agree and there's a line with executive. We used a couple of tools to help us with this process. You may have seen this very simple tool called a PICK chart, from all the information we've gathered from the survey and from the audits, we asked staff to rate them on how easy or hard they were to do and then what sort of gains we'd get from them, whether they were easy to do, but - and would pay off in a high, give us good return, we thought these were the ones that we would just do and there were quite a few of those. We ended up with a lot of actions from it. Just very quickly, this is one of the other tools, it's often called a story board report and it's communication tool where all of the staff can see how we're progressing. On the right hand column are a list of things that the staff, our steering committee and consumers agree with action. So we're using the same tool, we're just updating it for every occasion. It's good for telling the background to the story for people new to it. Outcomes so far - really great effect on our equipment stores, we had equipment but it was in the bottom drawer with rusty batteries and we didn't have people who knew how to use it well. It's now a part of standardised equipment, you need a new pocket talker for example you call up equipment stores and they bring one to you, and it's ready to go. The environment, that is a huge challenge, we don't design hospitals with noise reduction strategies in mind. But most importantly for us around the behaviours, we have to figure out ways to understand what barriers there are to implementing the best listening behaviours and what training strategies that we're currently in the process of developing we will be using with consumer, using simulation training and experience-based learning. This is one example of one of the signs that we

changed and because we were trying to do two things, we're trying to influence staff behaviour and by asking you know we'll try to face you, we'll speak clearly and not too quickly, and check that you understand. That's important for everyone regardless of their level of hearing. We also added a continuous improvement comment so that we could find opportunities to improve if they had an experience different to what we were trying to deliver. Time's up so I'll just show that lovely lady in the middle there is Gayle Gordon, and she's been fantastic for maintaining momentum and the community adding to executive when it goes across boundaries of departments. We're off to X-ray, pharmacy and pathology next and in the future we know we're in for the long haul. I'd recommend that paper from Planetree, Hearing Awareness Week is from August 21, that's not a picture of me. How much time do we have?

NEW SPEAKER: Questions. It's really interesting and really good to see that you've done it in a way that's proven it can work. Have you noted because one of your last slides said it's important for not just people with hearing problems, have you noticed any other benefits that those teams are getting maybe in helping other people with like any other disability needs or anything else?

DAMIEN DWYER: Yeah. Actually all of our... Actually most of my work is around clinical communication, safe clinical communication. So this affects everything in our facility now. Every opportunity we have, particularly when patients are stressed, how do we recognise this in people, how do we take time to quarantine time for our staff to make sure they look at the person in front of them and be there in the moment for them. We have a lot of stress on our staff and it's easy to do it well when you have time, how do we do it well when we don't have time? It affects everything we do.

NEW SPEAKER: Firstly apologies for coming late, I was held up by the other speaker who wanted some feedback and I really wanted to be here, my apologies. But what I did hear was very important and I just heard a little bit of you talking about changing some things in the environment and I have already said some things already today about the fact that I'm a care partner for someone living with dementia, younger onset dementia and what they're discovering more and more is that a lot of people with dementia have a lot of neurological sensory challenges whether it be visual, hearing,

every sense, smell, and we were just in a conference, John presented the Alzheimer's disease international conference at the end of April and there were people there walking around with their hands on their ears like this because they couldn't hear, those people don't have anything wrong with their ears, John has neurological visual issues and sometimes his brain doesn't tell him what he can see. If you're going to spend any money inspect hospital please encourage conversation and the narrative from everyone with a disability, be it mental health, vision impairment, everything because it would be terrible to think that you may be making it hard the reduce the noise and it would be an issue for the violence issue because a lot of people with dementia can interpret stripes on a carpet to be steps or dark spots to be holes so take that consultation process please.

DAMIEN DWYER: Absolutely will do and have done and the carpet isn't happening by the way. That was a conversation that we had around doing that. Is there time for another question?

NEW SPEAKER: Are there people waiting to come in for the next session?

KEVIN: Peter first told me a story about people who need the typing to the keyboard and I just came across a case a couple of weeks ago, a 48-year-old person when they went deaf, so they never learned Auslan and yet every time they asked for that particular type of equipment, at every hospital appointment they go to and every time there's an Auslan interpreter there which is absolutely useless for them because they don't speak that language. It's really something to watch out. The carpet idea though - I'm just - I don't have a loss of hearing as such but the top and the bottom of the range of my hearing are a bit out and I do find that I tend to visit about meal times which is strange! Trolley's going past, I have to ask for a special meal over and again and they're not happy little chappies or chappets should I say mostly! Thank you very much for that question.

NEW SPEAKER: Sorry we're just waiting to see the other group must be finishing as well.

DAMIEN DWYER: I do have one more thing to finish on if I could? Would you like to speak?

JILL LINDLEY: Wow. The ladies having a last word! It's a lost word on the importance of consumers. 40 years ago sociologist Peter Berger, this is 1977, wrote 25 theses pertaining to the consumer of services. These theses were widely circulated during 1981 the international year of the disabled. Two of these theses in particular have resonated for us over the years and have been a cornerstone of our advocacy work ever since. To quote thesis 13, "Each person knows their own world better than any outsider including the expert who makes policy." Thesis 14 ", "those who are the objects of policy should have the opportunity to participate not only in specific decisions but in the definitions of the situations on which those decisions are based." He goes on to add "what people have to say about their own reality should always be taken with great seriousness. Not only because this is morally right but because failure to do so can lead to great and sometimes catastrophic consequences." These remain just as relevant today. I'm going to make a consumer statement now that Damien didn't know anything about, I'm going to state that I had such lot of difficulty hearing and understanding what when on this morning, I've just tuned out this this afternoon. The rabbit speech is something that my brain cannot follow when the sound is distorted. Thank you.

APPLAUSE

NEW SPEAKER: Thank you Shirley, thank you Jill and Peter who are linked with members of our consumer database and thank you Damien for a great presentation and congratulations to Redland Hospital for having such a project and considering the needs of your consumers but it also shows the power of those consumer voices doesn't it in creating change. So thank you.