Charter for disabled people using hospitals: a completed access audit cycle

L Turner-Stokes, T Turner-Stokes, K Schon, H Turner-Stokes, S Dayal and S Brier

ABSTRACT — This completed audit cycle assessed access for disabled people to a district general hospital, in relation to standards laid down in the Royal College of Physicians Charter for Disabled People using Hospitals. The project was effective in demonstrating problems and implementing change to overcome them. It was also useful in raising disability awareness in the young investigators, who easily recognised the shortcomings in facilities for disabled people, and is proposed as a possible model for inclusion in medical undergraduate training programmes to raise disability awareness amongst a new generation of doctors.

In 1992, the Royal College of Physicians (RCP) published a Charter for Disabled People using Hospitals. This laid down standards for ensuring that hospital facilities were accessible for use by people with disabilities. Standards not only concerned physical access to parking, lifts, toilet facilities etc., but also touched on management and training to improve staff attitudes and awareness.

In 1995, a second working party set up a project coordinated by the Research Unit at the RCP to explore routes to implement the Charter. The project involved teams from seven different hospitals, as well as groups representing disabled people. It eventually led to the publication of a revised Charter and Guidelines in 1998. This builds on the initial Charter, probing more deeply into issues of equality for disabled people and spreading awareness among professionals in hospitals. It also explores in more detail the problems of access for patients with hidden disabilities, such as partial loss of vision or hearing, and difficulties with cognition or communication.

At Northwick Park Hospital, one of the seven hospital teams in the implementation project, an audit of access for disabled people was first carried out in 1994, following the publication of the first Charter. The items selected for audit were based on comments on access made by people attending the rehabilitation unit. The audit was undertaken by two local schoolchildren, as part of a school endeavour to make its own premises accessible as well as to raise awareness among its pupils of the problems faced by disabled people. The two young students meticulously planned and executed their project, making recommendations in two categories: (a) changes that could be made at minimal extra expense and (b) changes requiring financial investment, to be borne in mind when planning and building new facilities.

The audit was repeated in 1997 by two more pupils from another local school to assess changes made in response to the first audit, particularly in newly built areas of the hospital, and to make further recommendations for change.

This paper describes briefly the methodology and findings of the completed audit cycle, which represents a model not only for audit of access, but also for the education of a new generation with regard to disability awareness.

The purpose of the study

The purpose of the study was therefore four-fold:

1. To assess the extent to which our district general hospital complied with the RCP standards for access by disabled people, and to make recommendations for change.
2. To re-audit after three years, and assess the implementation of those recommendations and their incorporation by management in areas of new building.
3. To use the audit process to educate members of a younger generation in disability awareness, as well as in audit methodology.
4. To involve disabled people themselves in corroborating the findings of the young investigators and in continued reporting of problems with physical access for disabled users of the hospital.

Audit phase 1

Method

The initial audit study was carried out in 1994 by two 12-year-old pupils from North London Collegiate School, Stanmore (authors T T-S and K S), to assess the extent to which Northwick Park Hospital met standards for physical
access, as laid down in the RCP Charter for Disabled People using Hospitals 1992'.

The students, who were not themselves disabled, used a standard 8l self-propelling wheelchair to access key areas in the hospital, which included (1) parking provision, (2) main entrance, corridor and key outpatient areas, (3) lifts, (4) toilets and (5) telephones. Observations were made by two methods: (a) direct measurement, eg width of door or cubicle, height of buttons; and (b) subjective assessment: can I reach this from a wheelchair?

For the purpose of subjective assessment, the students were told 'You can move your arms but not your legs' and were instructed in how to self-propel in a wheelchair and perform a side-to-side transfer. Their findings were confirmed by two disabled patients from the Regional Rehabilitation Unit, Northwick Park Hospital who were wheelchair users, but were able to transfer independently.

Results

1. Parking provision for disabled drivers. Parking in reserved spaces was monitored during four peak times in one day (9.00 am, 11.30 am, 2.30 pm and 4.00 pm). All 16 spaces were full at 9.00 and 2.30 pm. Fourteen out of 16 spaces were full at 11.30 and 4.00 pm. On two of the four occasions, one to two spaces were occupied by cars of non-disabled people. There was no evidence of policing on any of the occasions.

A further 11 spaces are reserved for disabled motorists in a second car park on the lower ground floor. However, there were no clear signs in the main entrance area giving directions to it, and it was in any case inaccessible by lift (see below).

2. Access to main hospital and services. The main hospital entrance was accessible to wheelchair users, with flat access and automatic doors and, in general, departments particularly used by disabled people (eg rehabilitation departments, orthotics, audiology, outpatients, pharmacy) were also accessible. However, sign-posting was poorly legible and the main corridor, which is over 100 m long, had no seats or resting points.

The eye clinic, adjacent to the hospital main entrance, had an access ramp for wheelchair users; the entrance door was on a heavy spring and could not be negotiated in a self-propelled wheelchair. Nor was there a bell to call for assistance, and our investigators were unable to attract the attention of reception staff inside to let them in.

3. Lifts. Seven lifts in four key areas were examined. Although the Charter standards stated that lifts should be 'large enough' and control buttons 'within reach', the Charter did not suggest acceptable measurements. The investigators found that lift-car widths of less than 1.5 metres provided insufficient space to turn a chair, requiring wheelchair users to reverse in or out. Automatic door-opening times were not mentioned in the Charter, but are important: if doors are open for less than 12 seconds there is insufficient time for the wheelchair user to get in and out.

Buttons more than 1.4 m off the floor could not be reached from a wheelchair. In the main ward block, which has 10 floors, the wheelchair users were unable to reach buttons above level 4 (ground-floor level) in any of the three lifts.

The lift in the main entrance block – the only lift to the car park that provided further parking provision for disabled drivers – had an additional chair-height control panel. However, the lift car was so shallow that by the time the user had manoeuvred the wheelchair to allow the doors to close, the adapted panel was out of reach behind them.

4. Toilets. There were 'adapted' toilets in or near all the departments where disabled people may have to wait for some time, including the main entrance lobby, outpatients, pharmacy, X-ray, A&E, orthotics, rehabilitation and the ward block.

Again, the Charter standards were found to be rather too general and gave a false sense of adequacy. For example, although nearly all toilet cubicles were more than 1.5 m wide, other obstacles impeded access in 11/15 toilets examined. Common problems were:

1. Heavily sprung inwardly opening doors (9/15 toilets). Sliding doors were much easier to use.

2. Towel bins were often unnecessarily large and carelessly placed, impeding entrance or preventing positioning of the chair to allow side-to-side transfer onto the toilet (8/15 toilets).

3. Although basin, taps and soap-dispenser were usually reachable, the dryer or towel dispenser was mounted out of reach in 4/15 toilets.

5. Telephones. Fourteen pay-phones were identified in the main lobby areas and in the ward block. Two of these were mounted at a lower level to be accessible to wheelchair users, and both were sited in the main entrance hall. No low-level phones were found in any other lobby area of the hospital. Even where the phone could be reached, the instructions were still in small print and mounted on the wall above the phone, where they could not be read from a wheelchair. No other modifications (such as larger buttons or volume control) were provided.

Recommendations

Recommendations from the first round audit were made in two categories:

Category A: changes that could be made at minimal expense
- Parking provision for disabled people should be actively managed to avoid abuse by other drivers
- Lift control panels should be lowered, and lift doors set to open for at least 12-15 seconds in designated lifts marked as for use by disabled people
- Heavy springs on toilet doors should be removed
- The placement and size of towel bins in adapted toilets should not impede access for wheelchair users
- Towel dispensers/dryers should be mounted lower down the wall, within reach by wheelchair users
• ‘Wheelchair’ signs should be removed from toilets which do not meet the standards, in order to direct disabled people appropriately and save embarrassment.

Category B: changes to be borne in mind when planning new facilities

• There should be adequate parking provision for disabled motorists within 50 m of the entrance
• All lifts should be at least 1.5 m wide, with all control and call buttons accessible to wheelchair users
• Adapted toilets should be at least 1.5 m wide, with lightweight sliding doors, and basins, dispensers and bins placed so as to ensure that they do not impede wheelchair access to the toilet seat for a side-to-side transfer
• Low-level phones should be provided in all lobby areas, and seats for resting in long corridors.

Implementation

The results of the audit and its recommendations were circulated widely within the trust to raise awareness among service managers. They were discussed with the chief executive, the director of the estates department, and the trust architects who head project design teams for any new constructions. Follow-up reminders were sent at repeated intervals when disabled users reported that changes, particularly in category A, had not yet been made.

Audit phase 2

Methods

In 1997 a re-audit of physical access was planned as part of the project co-ordinated by the RCP Research Unit to implement the Charter. The re-audit used the same methodology to assess areas examined in the first audit and document changes that had been made. In addition, new buildings and refurbishments were also assessed for their accessibility to wheelchair users.

The original investigators, who had been 12 years old and approximately 5 feet 3 inches tall during the first round audit, were now 14 and some 5–6 inches taller. For the subjective assessments (can I reach this from a wheelchair?) this gain in height and reach could have introduced observer error giving a false impression of improvement where no structural changes had actually been made. To overcome this, a second pair of 12-year-olds was recruited (authors H T-S and S D), this time from Haberdashers Aske’s School for Girls, Elstree. Once again, their findings were checked and corroborated by a disabled wheelchair user.

Results

Changes in response to the recommendations made in the previous audit are listed in Table 1. In general the response was encouraging, and in particular, newly built areas met the standards set by the Charter, in nearly every respect. There were also significant improvements in existing areas, notably better sign-posting, the provision of seats and trained staff available to help in reception areas.

Paradoxically, some of the recommendations that seemed the simplest to apply – for example, removal of springs from toilet doors and ‘wheelchair’ signs from unsuitable toilets – had not been accomplished. Bulky towel bins continued to obstruct wheelchair manoeuvres in nine toilets, despite the fact that towel dispensers had now been replaced with air dryers. And although a splendid new adapted lift car had been provided in the main ward block, there was no mark or sign to indicate its presence to disabled visitors. This has since been rectified.

The revised Charter emphasises staff training to improve disability awareness and communication with people with hidden disabilities. Although not included in the recommendations from the first audit, the second audit also found that disability awareness training is provided for all front-line staff as a routine part of their induction, and a video on communicating with patients with hidden disabilities (visual or hearing loss and aphasia) is included in the induction programme for junior medical and other clinical staff. This video3 was produced at Northwick Park as part of the RCP implementation programme, and was filmed by the makers of The Link Programme, a TV programme made by disabled people for disabled people.

Discussion

This audit project has been useful in identifying problems experienced by disabled people using our hospital, and in implementing change in some areas. It is necessary to strike a balance between changes that are desirable and those that are feasible within the available resources and without undue delay. It is not surprising, therefore, that we have been more successful in meeting the standards in new constructions than in existing areas, but some simple omissions in the latter suggest that there is still some way to go in raising disability awareness among general managerial staff.

Education in disability awareness and equality is emphasised in the revised Charter, together with the strong recommendation that such training, along with access audits, should be undertaken by disabled people themselves. A valid criticism of this study would therefore be the use of able-bodied schoolchildren as investigators.

On the other hand, the children themselves gained enormous educational value from the exercise in understanding the problems faced by disabled people in getting around in the community. Their initial report and recommendations also had a certain added power, first, because they had not been produced by any particular lobby, and second, because problems that were obvious even to a 12-year-old were difficult to ignore. However, the authors would also like to stress that reported findings for each audit were
Table 1. Improvements made in response to first round audit.

| Area                        | Improvements in existing provision                                                                 | Provision in new constructions                                                                 |
|-----------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Parking for disabled motorists | No increase in main entrance parking provision  
                              | Persisting unmanaged inappropriate use                                                             | New constructions have increased proportion of designated spaces meeting standards  
                              |                                                                                                     | Spaces available at each time point examined                                                   |
| Main entrance and corridors | Improved sign-posts with larger lettering  
                              | Manned enquiries desk in main lobby to direct visitors  
                              | Resting seats now placed on long corridors                                                          | All entrances meet the standards  
                              |                                                                                                     | Better contrasted colour schemes  
                              |                                                                                                     | Manned enquiries desk and staff in reception areas being willing and able to help disabled visitors |
| Lifts                       | New lift in main ward block with audible and visual announcement of floor levels and tactile controls  
                              | Lifts in other areas unchanged but due for refurbishment shortly                                   | All new lifts meet the standards  
                              |                                                                                                     | Doors open for only 5 seconds but reopen quickly with obstruction                             |
| Toilets                     | Dryers/towel dispensers have been lowered  
                              | – now all within reach                                                                               | Most new toilet facilities excellent  
                              | Obstructing bins and heavily sprung doors remain a problem                                          | Only one with obstructing bin and inward-opening door                                          |
| Telephones                  | All public phones now marked as having ‘loop-system’ for people with hearing impairment  
                              | Two new low-level phones, but instructions still too high to read                                   | Low level phones fitted with loop system with volume control, easy buttons and instructions at readable height |
| Staff training in disability awareness | New programme in disability awareness training  
                              | introduced as part of induction for all front-line staff  
                              | Video on communicating with patients with hidden disabilities shown to all professional staff    |

corroborated by disabled people, and the audit department continues to receive and collate reports from disabled users, and to respond to these by pressing for change where standards have not yet been met. Reports are now routinely passed through to the trust’s quality committee for monitoring and intervention.

Although doctors are trained to think in terms of impairment, the social model of disability stresses that the individual’s impairment is irrelevant. Instead, society is held responsible for inequality, by being too inflexible to allow for an individual’s needs. The investigation reported here focused primarily on physical access from the viewpoint of a wheelchair user with functional level and impairment mimicking that of paraplegia. The subjective findings may have been very different for other impairments, such as upper limb involvement, and therefore standards cannot be too prescriptive about exact measurements and solutions. When planning structural adaptation, it is necessary to consider the common impairments in order to make provision for them, but what suits one person may not suit another. For example, an ambulant patient with arthritis in the knees and hips may find a high toilet seat easier, while someone in a wheelchair may prefer a lower seat on a level with their chair seat. Training in disability awareness, therefore, is aimed at particular solutions, but at understanding what the problems may be and how to establish quickly and sensitively the best way to help, without giving offence.

The seven hospital teams involved in the project to implement the Charter explored various different models of disability awareness training – wherever possible provided by disabled people themselves. Those that were most successful were sensitive to the time constraints and professional background of the recipients, adapting their message accordingly. Understandably, many disabled groups frown on the use of role play by able-bodied people who may find it ‘fun’ to spend an afternoon in a wheelchair. Nevertheless, direct experience remains a powerful educational tool. Given the limited time that the average medical student’s curriculum allows for training in chronic disability, time spent negotiating different quarters of the hospital in a wheelchair, on crutches, with glasses that simulate different types of visual impairment, or with ear plugs, may provide more direct insight into the problems encountered by disabled people than an afternoon in the lecture theatre.

Conclusions

This completed audit cycle on access for disabled people in our hospital has been effective in identifying problems and implementing change. It was particularly gratifying to note the extent to which the trust’s management and architects had taken heed of the RCP standards when planning new constructions.

Individuals from a new generation have gained education in the application of audit methodologies as well as enhanced awareness of the problems faced by disabled people. Extended to the medical undergraduate curriculum, this model has potential to form the basis for disability awareness training in a new generation of doctors.
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Address for correspondence: Dr Lynne Turner-Stokes, Audit Department, Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ.

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Disabled people using hospitals

A CHARTER AND GUIDELINES

Of all public buildings, hospitals should be the most accessible and accommodating for disabled people — whether patients, visitors or hospital employees. Too often this is far from the case. In fact hospitals frequently present barriers to disabled people through badly planned buildings and facilities and lack of awareness and understanding of their needs.

The charter and guidelines presented in this document were prepared by a working group of doctors, multidisciplinary hospital teams and representatives of disabled people’s organisations, with the aim of radically improving the hospital environment for disabled people. They are directed to all those involved in planning and managing hospital services and to those who work in them whatever their role.

The premise on which the charter and guidelines are based is that everyone should be treated equally — as required by the Disability Discrimination Act 1995. In the case of hospitals this means that buildings and facilities should always be planned or provided with disabled people in mind — including those who use wheelchairs, walk only with difficulty, have impaired vision, hearing or communication, or are disabled in any other way. It also means that arrangements for disabled patients — both inpatients and outpatients — should always be made with their involvement and tailored to their specific needs.

The Charter sets out what disabled people have a right to expect when using hospitals. The Guidelines set out what managers and planners should consider in terms of the physical environment and good communication, and how disability awareness can be fostered throughout the hospital by training. The need for involvement of disabled people is stressed, and the issues are discussed in terms of priorities and costs.

The guidance and recommendations contained in this document should be read and adopted by all those concerned with designing and managing hospitals and with patient care.

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Executive Summary  What is disability?  Whose responsibility?  Recognising the needs of disabled people  Improving communication  The physical environment  Spreading and improving disability awareness  Costs and priorities  Appendices: Sources of evidence  Resource material and references  An audit agenda

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