AlfredHealth

PILOT PROJECT: Disability Liaison Officer – Rapid Response Secondary Consultation Service in the Emergency and Trauma Centre

Final Service Report (October 2022 – June 2024)

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Contents

1 EXECUTIVE SUMMARY

This report outlines the planning, implementation and outcomes of the Disability Liaison Officer – Rapid Response (DLO-RR) service at The Alfred Hospital, Melbourne between October 2022 and June 2024. The DLO-RR service was implemented by Alfred Health as part of the SPEAK Project. The project received funding from the Australian Government's Department of Social Services under the Information, Linkages and Capacity (ILC) – Mainstream Capacity Building grant program. The project's focus was on building capability in the health workforce and improving processes to meet the healthcare needs of people with lived experience of disability, in particular autism, intellectual disability and communication disability.

The DLO-RR service commenced in the Alfred Emergency and Trauma Centre (E&TC) in October 2022, following a thorough co-design phase. This pilot service was developed to address the needs of patients with hidden disabilities through dedicated support within the department. Operating 7 days a week from between 8:30am and 4:30pm, the aim was to improve patient care and streamline interactions for patients with disabilities.

The service was staffed by a team of 2.4 – 2.8 FTE Disability Liaison Officers (DLOs), all of whom were recruited with qualifications in relevant disability fields. The DLOs were strategically located within the E&TC Allied Health team to facilitate immediate and effective support. Their role included identifying patients needing assistance, secondary consultation, developing disability care plans, liaising with treating teams to ensure appropriate care and communication, and staff capability building.

Over the nearly 21 months that the DLO-RR service operated, it supported a total of 1426 patient encounters involving 729 patients. Referrals primarily came from nursing staff and through DLOs' proactive identification of patients with an electronic medical record (EMR) disability alert. Key interventions provided included advocacy and communication, sensory and emotional support, which were instrumental in managing patient care and improving the overall emergency department experience.

An evaluation of the DLO-RR service demonstrated a statistically significant impact on patient care, with a 1.8-hour reduction in length of stay in the E&TC and 1.44 times increased likelihood of earlier discharge for patients with disabilities. Feedback from staff highlighted the service's positive contributions to patient management, staff education, and care coordination, with suggestions for expanding service hours and further education being common themes in staff surveys.

The DLO-RR service was recognised for its excellence and contribution to equity and inclusion, receiving accolades such as Alfred Health's Recognising Excellence Award for Equity and Inclusion and a nomination for the Australian Network on Disability's Inclusive Impact Award. The pilot's success underscores the critical need for such services and provides a foundation for future enhancements and potential service expansions.

The pilot service was funded by the SPEAK Project to continue until June 2024, with efforts to advocate for sustainability of the service continuing.

2 BACKGROUND

2.1 SPEAK PROJECT

In April 2020, Alfred Health received an Information, Linkages and Capacity (ILC) – Mainstream Capacity Building program grant from the Department of Social Services to undertake the SPEAK (**SP**ecialist **E**ducation **A**nd **K**nowledge) Project. The aim of this grant opportunity was to fund projects to produce improved practice approaches in health service systems that enable:

- People with disability to use and benefit from the same mainstream health services as everyone else.
- Improved access and use of mainstream health services by people with disability.

Alfred Health partnered with South West Healthcare (SWH), a regional health service based in Warrnambool, Victoria, to deliver this project. Alfred Health was granted $2.3 million to undertake the project and the project commenced in September 2020.

2.1.1 Project aim

To build capability in the health workforce and improve processes to meet the healthcare needs of people with disabilities, particularly autistic people, and people with intellectual disability or communication disability.

2.1.2 Project objectives

1. Test a rapid-response secondary consultation model (key areas – emergency, acute wards and acute mental health services).
2. Provide evidence-based staff training to build the capacity of the workforce (improve communication processes between staff and people with disabilities and resource use).
3. Develop improved consumer feedback processes to amplify the voice of people with disabilities.
4. Improve the range of resources to facilitate improved communication between staff and people with disabilities.
5. Develop/enhance data systems to identify, plan and support people with disabilities to maximise outcomes and improve safety.

This report is focussed on the delivery of Objective 1.

2.1.3 Disability Liaison Officers at Alfred Health

During 2020, in response to the COVID-19 pandemic and the resultant negative impact on service access by people with disability, the Victorian Department of Health provided funding to health services to employ Disability Liaison Officers (DLOs).

Various ways of working were trialled and the work priorities of the DLOs regularly pivoted to address changing government priorities (e.g. risk assessments for supported disability accommodation, supporting people with disability to receive vaccinations), and this impacted their ability to provide inpatient support.

The funding was initially granted for 6 months (September 2020 to March 2021) and was used to set up a secondary consultation service to support patients with any disability across Alfred Health. Following this initial grant, Alfred Health received multiple funded extensions of 6 to 12-month periods.

In 2023, Alfred Health boosted this workforce by funding hospital wide DLOs on a permanent basis.

2.2 WHERE WE STARTED

2.2.1 Rapid response secondary consultation service iterations

2.2.2 Initial plan

Following commencement of the SPEAK Project, the plan was to design and implement a SPEAK Project funded Rapid Response Secondary Consultation (RRSC) Service that would work in conjunction with the existing DLO service.

In order to develop a model of care for how the service would operate, a Rapid Response Secondary Consultation Working Group (RRSCWG) was implemented and met between May and September 2021. The plan was to implement the RRSC service as follows:

Prototype: Implement a service prototype focusing solely on General Medicine specialty wards at The Alfred Hospital.

Following a thorough co-design and evaluation process, the protype would be refined and expanded as follows:

Phase 1: Expand to support the E&TC and all acute wards (including Psychiatry) at The Alfred Hospital as an onsite service.

Phase 2: Expand to provide a telehealth service to support the other Alfred Health campuses and services, and SWH.

Alfred Health's response to the surge of COVID-19 cases from September 2021 meant that the RRSCWG meetings were put on hold, the General Medicine wards become dedicated COVID-19 wards, and the usual General Medicine caseload was cared for across different campuses / locations. It was therefore no longer possible to commence the prototype in the initial wards planned.

2.2.3 Final plan

In February 2022, two workshops were held with Allied Health staff to progress planning for the RRSC. Activities included patient persona development, patient journey mapping, identification of key clinical roles, and brainstorming of ideas for service development. The consensus in the group was that the E&TC at The Alfred would be the ideal location to commence the RRSC Service as this would provide the opportunity to set up a successful patient journey from E&TC presentation to discharge.

Phase 1: In March 2022, discussions commenced with E&TC medical, nursing and allied health leadership to plan and implement a pilot service in conjunction with the existing Disability Liaison Officers. Co-design workshops with consumers with lived experience of disability commenced in 2022, and the outputs from the co-design work would be used to refine the pilot RRSC planning and implementation.

Phase 2: Provision of telehealth support to SWH.

2.2.4 Ethics approval

The Alfred Health Ethics Committee granted ethical approval for the SPEAK Project, including the DLO RRSC service in 2022 – Project Number: 81347 7 Local Reference: Project 697/21

2.2.5 Service implementation

The remainder of this report outlines the design and implementation of Phase 1 of the RRSC service in the E&TC at Alfred Health.

Implementation of Phase 2 at SWH was unable to be completed. Various models of care were explored as possibilities including a telehealth model where SWH staff could access a specialist DLO at Alfred Health for secondary consultation. At the time of implementation, SWH did not employ a designated DLO role and it was not feasible to coach and train ED staff at the time about a new referral pathway due to some senior management changes. The decision was to pause testing at the regional site due to limited resources.

SWH has, however, been privy to the learnings of the design and implementation testing of the pilot service.

3 DLO Rapid Response Service in the Emergency and Trauma Centre

3.1 What We Discovered

3.1.1 Service development from a clinical perspective

3.1.2 Why is a RRSC service needed?

Consultations with nursing, medical, allied health and disability liaison staff working either in General Medicine wards or the E&TC, identified some of the challenges experienced in healthcare by people with disability (PWD) and the staff who support them. This information was obtained from staff focus groups and 1:1 meetings during 2021 and 2022 and is summarised below:

Disability awareness

- There are inconsistent approaches used across teams to support PWD.
- Staff aren't aware of the abilities and support needs of many PWD.
- Staff need greater understanding of autism, including challenges with change and meltdowns.
- Lack of understanding of a patient's sensory preferences and how that may explain 'behaviour'.
- Staff need to understand the importance of supported decision making and consent.

Communication breakdown

- Patients may be unable to share feelings, pain, needs and wants and this may impact their behaviour, wellbeing and experience.
- Staff cannot always communicate effectively with patients (verbally or non-verbally) to determine their care needs, thus impacting clinical care.
- Staff may be unaware of how to modify their communication.
- Staff find that they are repeating information to some people with disability because they can't get their message across.
- Difficulty obtaining informed consent for procedures and sensitive examinations.
- Staff not introducing themselves or gaining informed consent for procedures – this often results in behaviours of concern.
- Communication resources are available on the wards, but staff are unsure of their location and how to use them.
- Surgical/N95 masks exacerbate communication breakdown.
- Patient needs may not be 'heard' because we are not listening to the patient and their support people e.g. carer, family member, disability support worker.
- Interpreters are in high demand and not always available when needed.

Environmental triggers

- Hospitals are noisy, brightly lit, busy and overstimulating environments that for some patients can trigger meltdowns and patients leaving the hospital against medical advice.

Resourcing / systems

- Staff are busy and may not be able to allocate the time needed to support patients who need communication support.

- Insufficient support staff or nurses on the ward supporting patients.
- Challenges in obtaining and effectively sharing a patient's disability support needs prior to or during an admission.
- Information about disability support needs not being effectively communicated between home and hospital.
- Care is routinely focussed on responding to acute medical needs and may not holistically consider the impact of the person's disability support needs.

Support network

- Patients may not have access to their usual support network due to COVID-19 visitation restrictions.
- Minimal social interactions and/or meaningful activities occurring, often resulting in cognitive decline or behaviours of concern.

3.1.3 Services to be provided

Staff consultations and a review of literature relating to Learning Disability Liaison Nurses in the United Kingdom helped shape ideas for a model of care in the E&TC. Desired features of a RRSC service included:

Rapid response:
Aim for a prompt response (within 2 hours of referral) during staffed hours and service to be of short duration, ending once patient leaves the E&TC and handover completed.

Secondary consultation:
RRSC staff to enhance existing services, deliver services where there is a gap currently, and work with other existing supports such as Allied Health, Hospital DLOs and Allied Health Assistants.

Pilot the delivery of access and inclusion supports:
Trial provision of the following supports by DLOs to determine what is feasible within a RRSC model:

- **Collaborative development of care plans with the patient / support people, detailing patient disability support needs and facilitating communication of the care plan to staff**
    - Obtain existing support plans e.g. behaviour support plans, communication / hospital passport / about me documents.
    - Conduct and/or support screening assessments to determine disability related needs.
    - Establish systems to facilitate timely communication of care plan to staff.
    - Ensure communication of care plan when patient is transferred to other wards/services.
    - Ensure care plans are recorded in the electronic medical record (EMR) and disability alert activated on the EMR banner bar.

- **Communication supports**
    - Provision of visual aids to support verbal communication e.g. communication boards, visual schedules, Yes/No cards, large print, social stories.
    - If required, connect patient with usual support people via phone/video link when there are visitation restrictions.
    - Support communication of information between clinical staff, non-clinical staff, patient and patient's support people, for example:
        - When support people have missed important information e.g. document in writing
        - Regular check-ins with staff, patient and support people to ensure patient needs and staff needs are being met
        - Support/facilitate communication at the bedside.

- **Sensory modulation supports**
    - Provision of sensory tools/resources.
    - Review and set up of **environment**, as able, to support successful delivery of care and meet patient's sensory preferences e.g. lighting, sound, space to move etc.

- **Positive behaviour supports**
    - Support the patient to understand what is happening in the clinical environment by providing accessible communication and emotional support.
    - Share information obtained from the patient/support people about known triggers and strategies with staff in the department.

- **Staff training**
    - Educate staff around individual patient abilities and support needs, including communication and sensory resources.
    - Provide education to E&TC staff on relevant disability related topics e.g. communication, autism spectrum disorders, executive functioning.
    - Advocate for and initiate **referrals to other hospital support services** (e.g. Neuropsychologist, Music Therapist, Allied Health Assistant) to support daily activities and/or social connectedness of patients on the wards.

- **Discharge**
    - Support complex discharge planning – identify unmet needs and work with members of the team (e.g. Social Work, NDIS Support Coordinators).
    - Develop accessible discharge documentation as indicated e.g. Easy Read / plain language.
    - Follow up with post discharge supports (e.g. staff at supported disability housing/clinical staff within disability organisation) to reduce unnecessary readmission.
    - Refer patients to Hospital DLO team if required to support future service access.

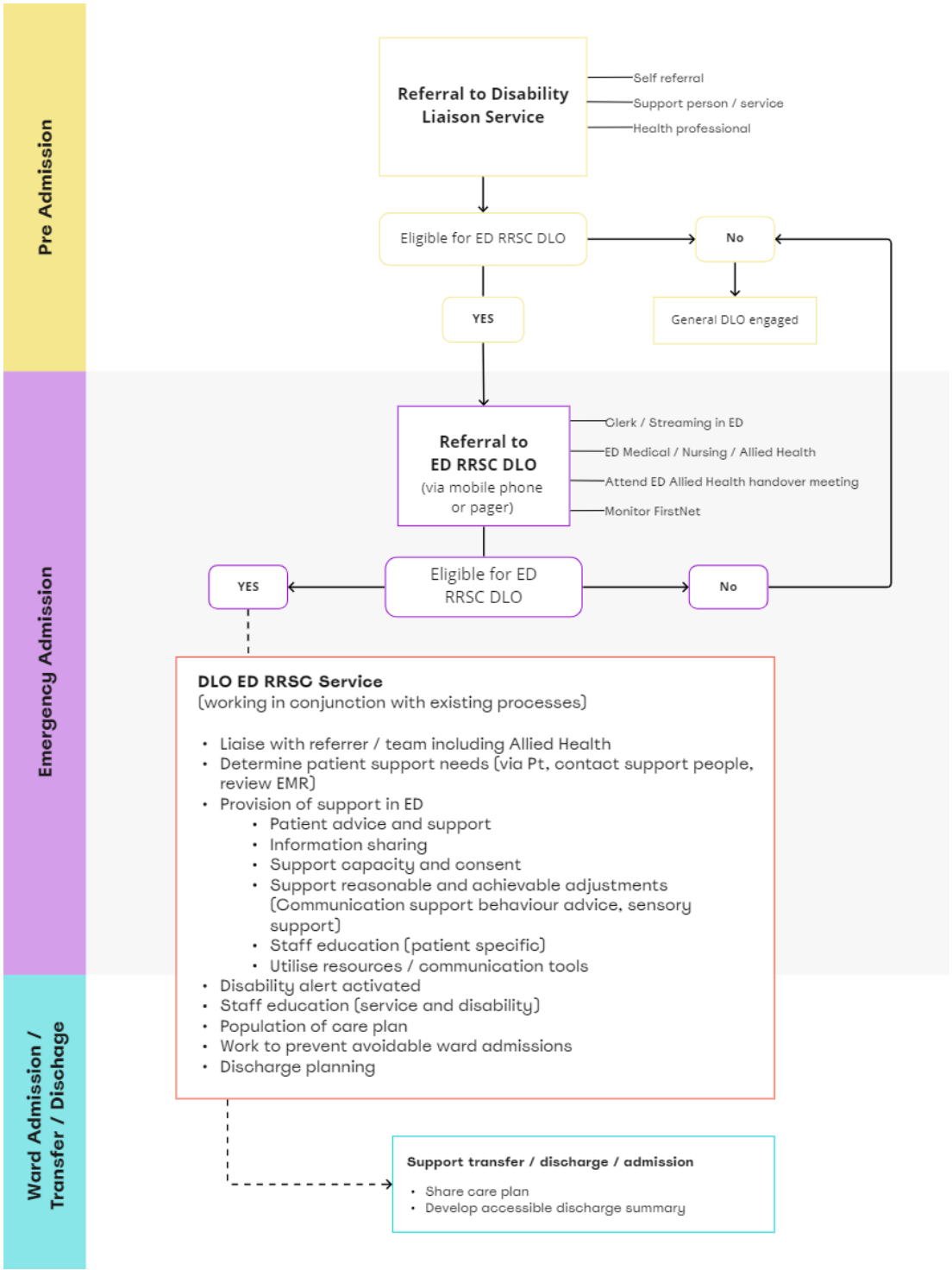
In addition, codesign workshops with consumers with lived experience of disability and SPEAK Project evaluation data, supported the need for a RRSC service. Details of these findings can be found in Appendix 1 SPEAK Project consumer co-design findings, and Appendix 2 SPEAK Project evaluation findings.

3.2 SERVICE DESIGN

3.2.1 Model of Care

A Model of Care was developed to document the design and implementation plan for the pilot service. Figure 1 provides an overview of the service plan.

Figure 1 RRSC E&TC Model of Care



A summary of key service details included in the model of care for the DLO RRSC service pilot with details of how they operated throughout the pilot is provided below in Table 1:

Table 1: Model of Care Description

Feature	**Detail**
Service Name	Disability Liaison Officer – Rapid Response (DLO-RR)
Commencement	Staff commenced in September 2022, 1.5-2 weeks prior to Go-Live on 10 October 2022
Operating hours	7 days a week 8:30am to 4:30pm
After hours on call	Commenced 7 November 2022 Budgeted as 2 occasions of recall per week Mobile phone allocated to each staff member Service ended 1 October 2023 due to a combination of challenges staffing the service, and many of the referrals could have been made prior to the end of the day shift or waited until the service commenced at 8:30am

Staffing	**Position descriptions** included key qualifications and skills as follows:
	• Qualifications – Allied Health, Nursing or other relevant Disability qualification / experience.
	• Knowledge and experience in:
	  ○ Supporting people with disability e.g. communication disabilities, including autism spectrum disorder and intellectual disability
	  ○ Behaviour and restrictive practices
	  ○ Multi-model / augmentative and alternative communication
	  ○ Sensory processing and supports.
	• Experience in delivery of staff training in communication, behaviour, and sensory supports.
	• The ability to access, obtain and develop resources and implement them in the hospital environment.
	• Knowledge of the health and disability service sector to support referral and service access.
	
	Positions funded:
	Initially the following positions were funded.
	• DLO Rapid Response Stream Leader (Grade 3 Allied Health Professional (AHP) equivalent) – 1.0FTE
	• DLO Rapid Response (Grade 2 AHP equivalent) – 1.4 FTE
	
	Variations to the staffing makeup were made based on service need, the applicant pool, sustainability planning and broader project need following staff attrition during the pilot. Staffing ranged from 2.4 – 2.8FTE.
	
	Employment Enterprise Agreement:
	• All staff recruited came with other relevant disability qualifications / experience rather than an allied health or nursing background and were employed as Community Development Workers under the Allied Health Professionals Agreement (2021-2026).
	
	Matrix supervisory structure

	• Operational reporting to the DLO Team Leader (Hospital Team) with dotted line reporting to Emergency Department Allied Health Team Leader. • Reporting to SPEAK Project Lead for project accountabilities. • DLO Team Leader supervised the DLO Rapid Response Stream Leader who provided supervision to the DLOs.
Staff location	1 x Desk located with E&TC Allied Health team office to assist with a rapid response and promoting the service within the department. Addition desk space was provided with the broader Disability Team (SPEAK Project, Hospital DLO and Access and Inclusion Leads) in a separate Alfred Health office building adjacent to the hospital.
Service Contacts	For Alfred Health staff: • DLO RR Mobile phone • DLO RR Pager number – sends message to mobile phone • DLO RR Email address • EMR referral via existing Allied Health order (no specific DLO RR referral during the pilot) Consumers and external clinicians were directed to contact the main hospital DLO service, with follow up by RRSC DLOs as required.
Identification of patients needing DLO support	• Referrals accepted - In person, by mobile phone, or electronically from all staff working in E&TC • DLOs attended E&TC Allied Health Team daily morning huddle to identify patients. • DLOs monitor E&TC patient list in EMR to look for patients with a disability alert or information indicating the patient has a disability • Referrals from patient, support people, care facility or hospital staff accepted prior to planned E&TC presentation, on arrival or during stay.

Referral eligibility criteria	Referral criteria based on SPEAK Project target group as follows. Diagnosed or suspected:
	• Autism spectrum disorder
	• Intellectual / Cognitive disability
	• Communication disability (suggested definition)
	  ○ Deaf / hard or hearing
	  ○ Blind / low vision
	  ○ Speech impairment
	  ○ Language impairment
	  ○ Cognitive – communication impairment
	  (Including life long and acquired communication impairment that may or may not be progressive, but excluding dementia, delirium, and temporary communication impairments)
	• Any combination of the above needed to be present. Could be in combination with other disabilities e.g. physical, mental illness.
	• Permanent disability / not temporary
	• Disability does impact on healthcare.

Triage and Prioritisation	• DLO-RR reviewed all patients with disability referred to the service.

	• Patients with disability identified who did not meet the SPEAK Project DLO-RR criteria, or who were transferring to an inpatient ward, were referred to the Hospital DLO team where indicated.
	• If prioritisation of referrals by DLO-RR was required, high priority patients with disability were identified when there was evidence of:
	  ○ Communication breakdown with the patient
	  ○ Patient distress / in pain with unknown origin
	  ○ Concerns re patient and/or staff safety (code greys)
	  ○ Risk of patient exceeding hospital Key Performance Indicators e.g. 24hrs in E&TC.

Service delivery	• Following identification of patients with disability, DLOs liaised with clinicians, patient and patient's support people for background information. • DLO providing first response obtained consent from patient where possible before getting involved. • DLO developed and or reviewed a 'disability care plan' to capture patient's support requirements and documents in the EMR. • DLO liaised with relevant members of the patient's treating team to ensure information was shared and implemented. • DLO assisted staff with patient management and advocated for the patient's needs e.g. to support successful communication, advocate for sensory supports. • DLO worked with treating clinicians to develop accessible information for patients to support understanding of any discharge plan (e.g. provide a discharge plan in plain language and/or Easy Read). • Service ceased once necessary supports were put in place or patient transferred or discharged from E&TC.
Resources	• Sensory - The DLOs maintained a stock of single use and reusable sensory tools such as fidget toys, scented stickers and coloured markers, ear plugs, to provide distraction and/or sensory support. • Communication – visual communication tools such as communication boards, pain scales and white boards were obtained and developed by DLOs for use with patients. A hearing amplifier was also frequently used with patients who were hard of hearing.
Documentation	• Documentation of information captured regarding the patient recorded by DLOs in the Oracle/Cerner EMR using pathway of Clinical Notes, Emergency, Allied Health, and then under specific note type. • Notes were also referenced in the Inpatient notes section of EMR if patient was transferring to an inpatient ward from the E&TC. • For patients requiring specific Emergency Department Management Plans, DLO worked with Quality and Risk Team/delegate to contribute to the plan.
Service delivery data	As the DLO RR service was implemented as a pilot, approval to set up a specific EMR referral to the DLO RR service could not be obtained. This meant that collection of service delivery data was a manual process. An Excel spreadsheet was developed to track service delivery data and was entered by the DLOs. Data captured included:

	• Patient information – Medical record number (MRN), surname, first name, DOB, Sex, Aboriginal and/or Torres Strait Islander status, interpreter requirements, communication support required, existing funding supports, Disability type, residential setting. • Referral – Date/time of referral to DLO, Date/time DLO service commenced, whether a disability alert existed, referral mode, referral source. • Services provided – consent provided by, DLO staff member name(s) providing service, why the DLO support was required, accessible discharge summary completed, date of discharge, comments. • Statistics – MRN, surname, first name, date of service, service provided to, service activity/intervention, time spent, DLO staff member, mode of service, comments • Ineligible patients – date, surname, first name, DOB, Disability type, referral mode, referral source, actions taken.
Service Promotion	A range of methods were utilised to promote the DLO RR service to staff working in the E&TC which included: • Alfred Health Emergency newsletter, and SharePoint posts • Attendance at daily nursing musters at shift changeover during DLO service operating hours where possible • Attendance at Allied Health daily morning handover meetings • Presentations at E&TC new nurse orientation sessions • Regular DLO department walkthroughs to touch base with the Resource Nurses and Team Leaders. Key messaging included: • Services offered and benefits of referral • How, when and who to refer • Introductions to the DLO staff • Service operating hours
Service Monitoring	Monthly 30-minute meetings were held with DLO Team Leader (Hospital Team), Emergency Department Allied Health Team Leader, SPEAK Project Lead, Emergency Department Nursing Quality and Risk Nurse Manager and DLO RR Stream Leader to continually review progress, determine communications and make changes as required.
Service cessation	The service was funded by the SPEAK Project until the 30 June 2024. The service was subsequently funded by the Allied Health department at Alfred Health until the 25 August 2024 as an interim measure while awaiting the outcome of an organisation business case for ongoing funding. While there was strong commitment to continue the service by both Allied Health and E&TC leadership, funding pressures meant that the service couldn't be continued.

3.3 SERVICE OUTCOMES

3.3.1 Service delivery data

The following information covers the period of 12 October 2022 to 30 June 2024 and was obtained by analysing spreadsheet data entered by the DLOs. It is therefore indicative data as there may be some data entry errors or inconsistencies.

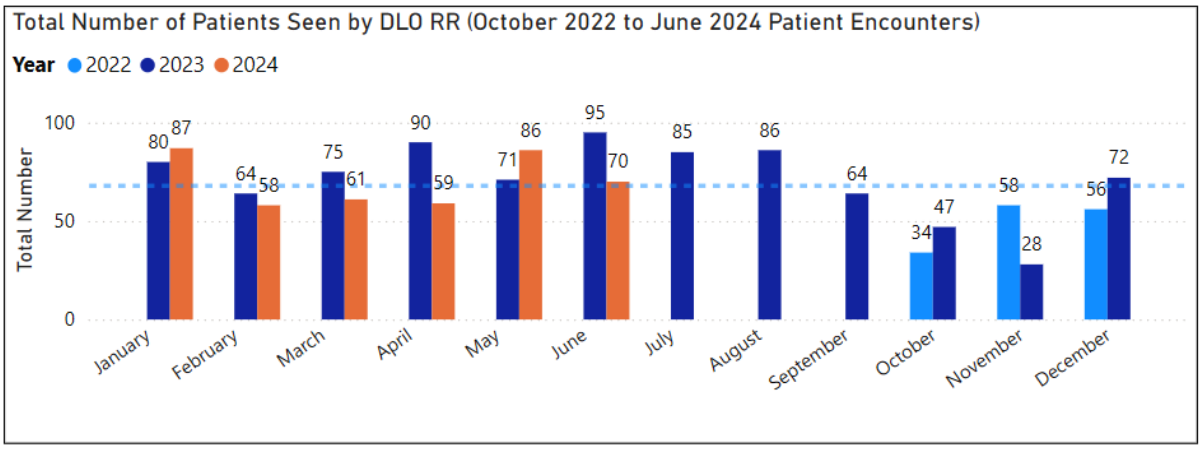
3.3.2 Patient numbers

The DLOs supported a total of 1426 patient encounters (individual visits by patients) made up of 729 different patients. Most of the patients seen were supported once, however many of the patients attended the E&TC multiple times and were supported by the DLOs two or more times (range 1 – 44).

3.3.3 Referrals

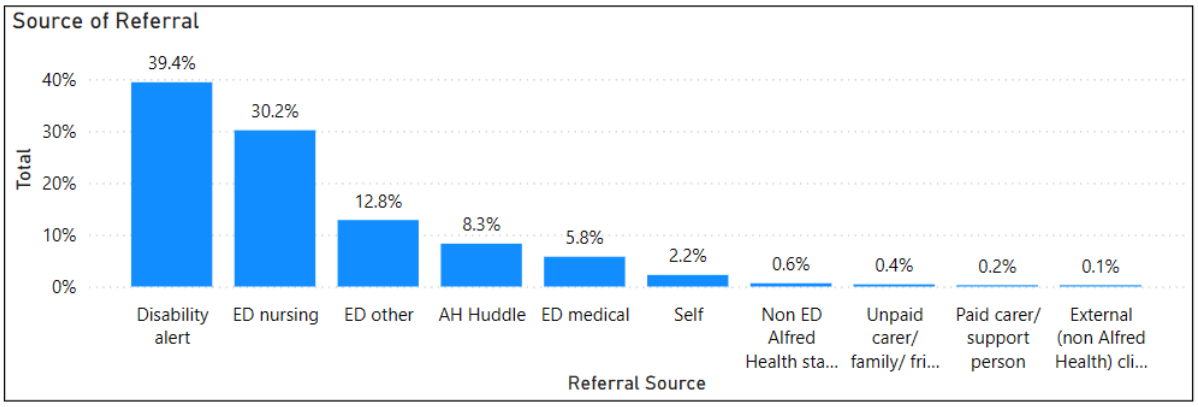
Figure 2 below shows the breakdown of when patients were seen by month. The average number of patients seen was 68 per month. From October to December 2023, there were staff vacancies, resulting in a drop in the number of patients seen.

Figure 2: Total patient encounters (October 2022 to June 2024)



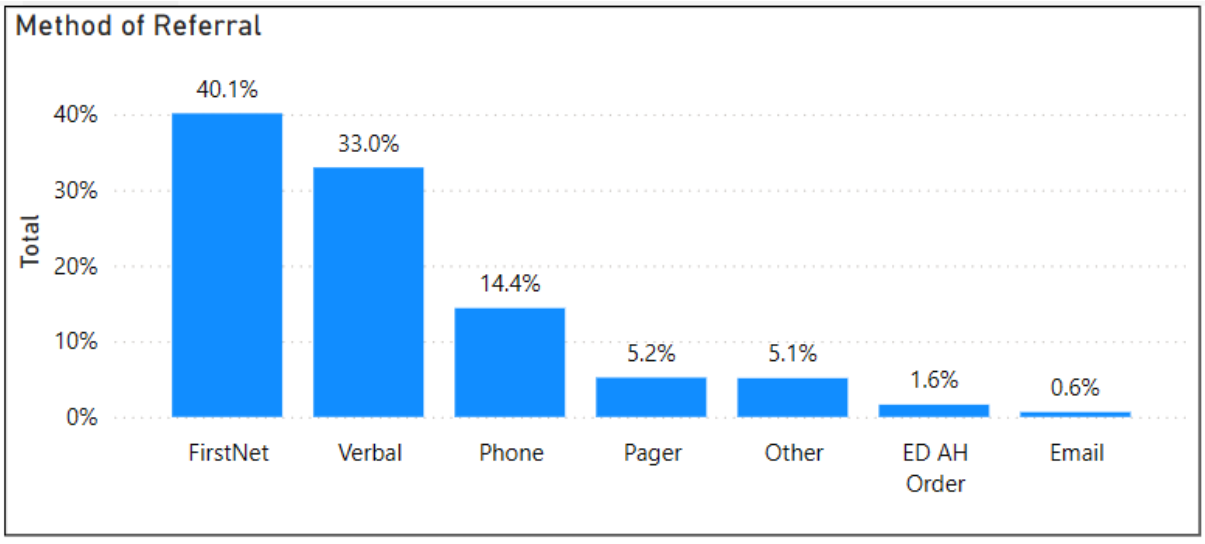
Of the 730 referrals received by the DLOs, the majority were self-sourced by the DLOs monitoring the current electronic patient list for disability alerts and disability indicators (39.4%), followed by referrals from nursing staff (30.2%). Other staff in the department also made referrals such as individual allied health clinicians, phlebotomists, ward clerks (12.8%), and doctors (5.8%). The Allied Health team morning huddle was where 8.3% of referrals were made. A small number of patients (2.2%) requested support of the DLOs on arrival. See Figure 3 for further details.

Figure 3: Source of referrals to DLOS (who referred)



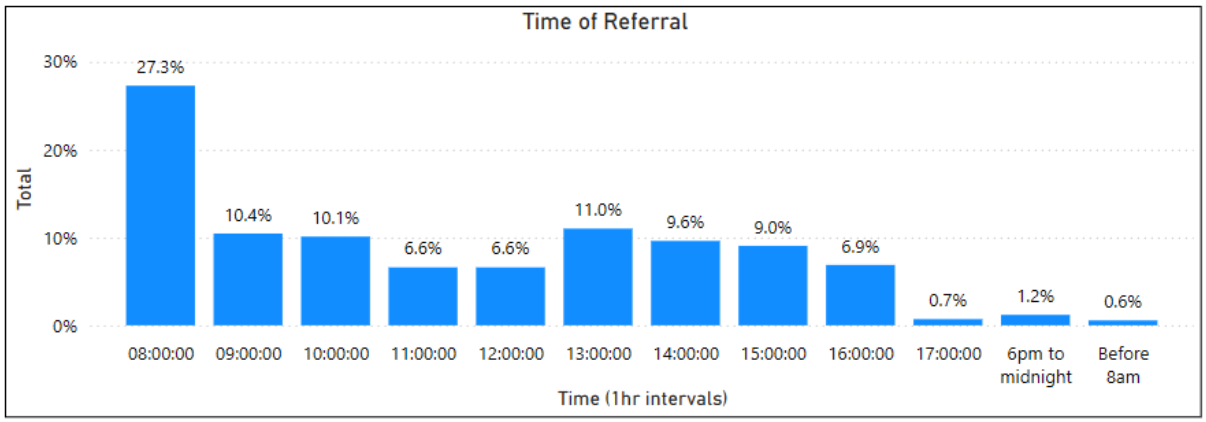
The DLOs record the method of referral and 40.1% of referrals were obtained by DLOs viewing patient details on FirstNet. They received 33% of referrals verbally during attendance at the Allied Health morning huddle meetings or via informal communication with clinical staff on the floor. The high numbers of verbal / in person referrals highlight the benefit of the DLOs being located within the department (see Figure 4).

Figure 4: Method of referral (how the referral was made)



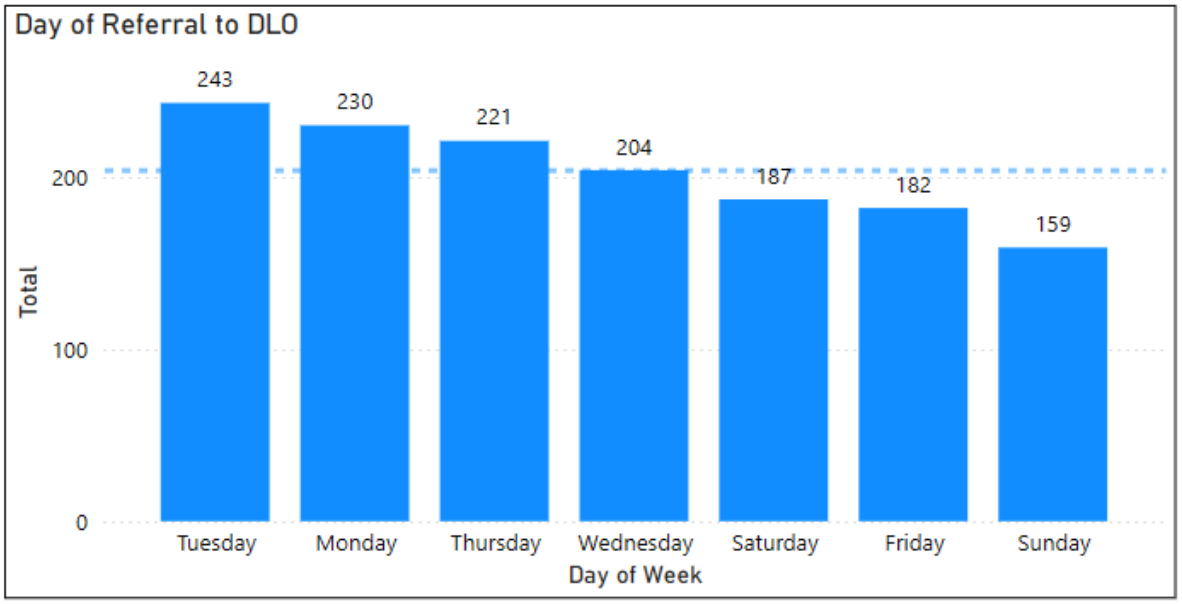
The majority of referrals were received by DLOs between 8am and 9am, coinciding with service commencement each day (27.3%). Between 9am and 5pm, there were on average 6.6 – 10.4% of referrals received per hour and 2.5% of referrals were received after hours (see Figure 5)

Figure 5: Time of referral (by hour)



Tuesdays were the busiest day of the week for the DLOs with 243 (17%) of all encounters, followed closely by Mondays and Thursdays. Sunday was the quietest day (see Figure 6).

Figure 6: Day of referral (by encounters)



3.3.4 Services provided

Figure 7 highlights the type of supports that the DLOs provided to patients in the E&TC. Communication support was most frequently provided (38%). Other frequently provided supports included emotional, behavioural and sensory supports.

Figure 7: Types of support provided to patients by the DLOs

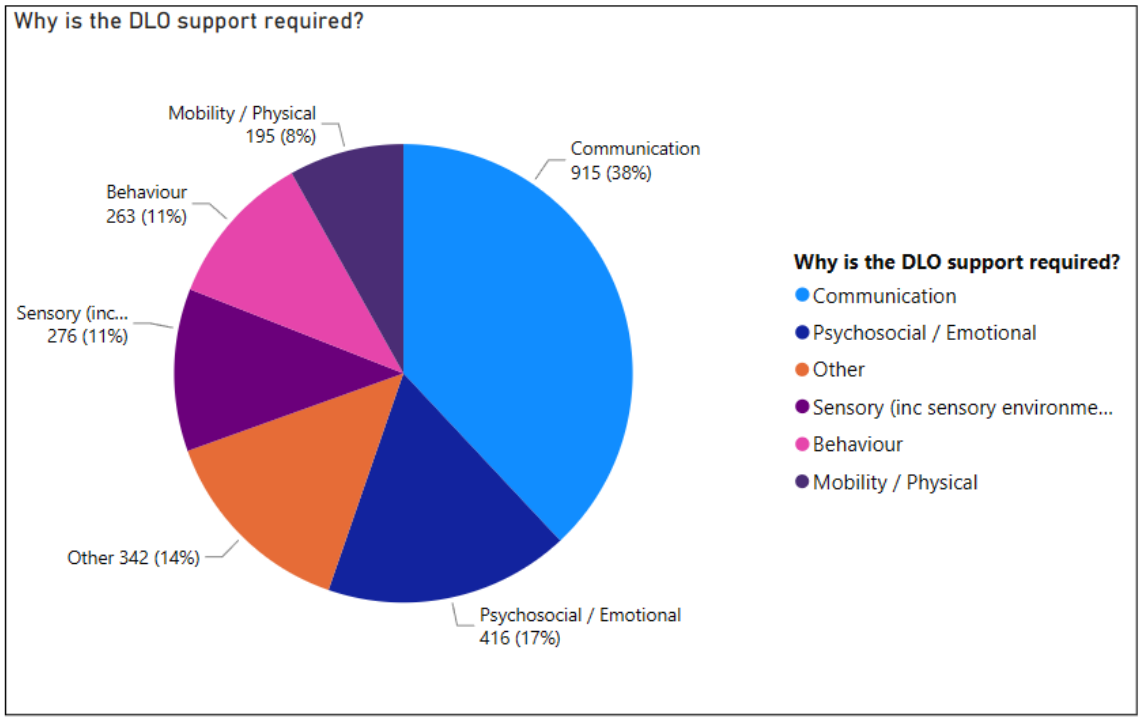


Table 2 outlines how much time the DLOs spent with patients during the 1426 encounters. Most patients received support for under 2 hours. Support of less than 30 minutes was most frequently provided.

Table 2: Time spent with patient (by encounters)

Time interval	Percentage of time spent
0 – 30 minutes	47.34%
30 – 60 minutes	28.26%
1 – 2 hours	17.38%
2 – 3 hours	4.14%
Over 3 hours	2.88%

3.3.5 Patient demographics (by encounter)

Patients supported by the DLOs were primarily aged between 18 and 64 years of age (68.4%), with 31.3% over age 65 and less than 1% under 18 (see Figure 8).

Figure 8: Age breakdown of patients

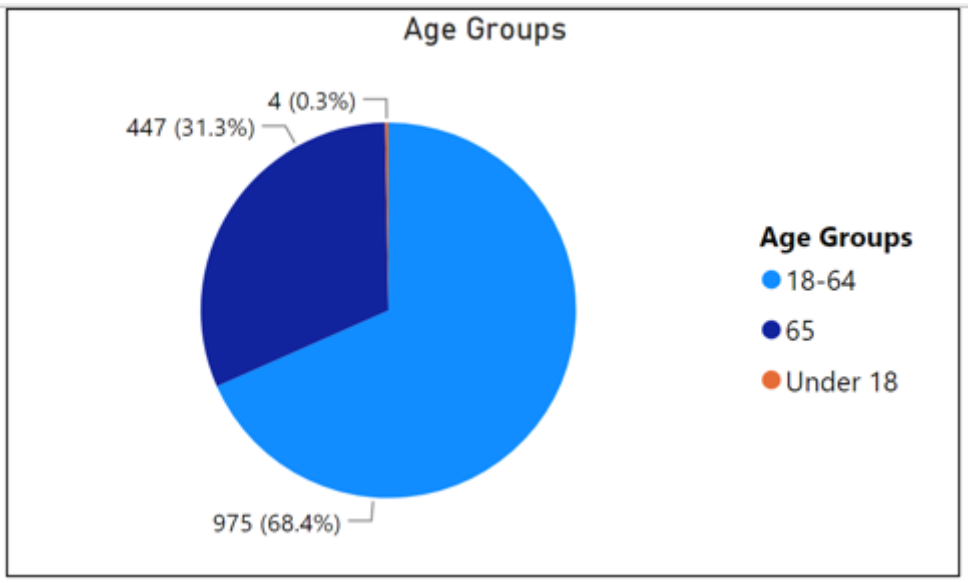
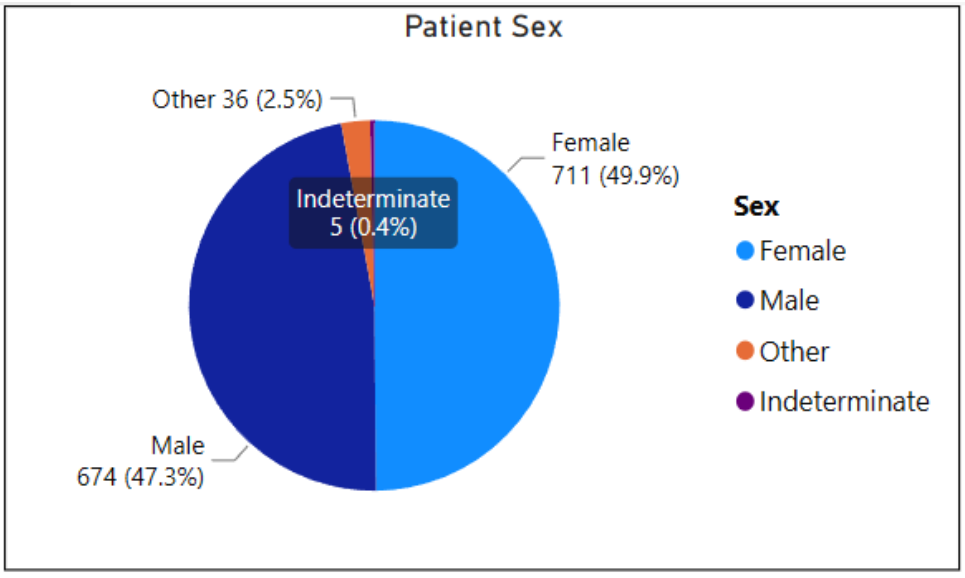


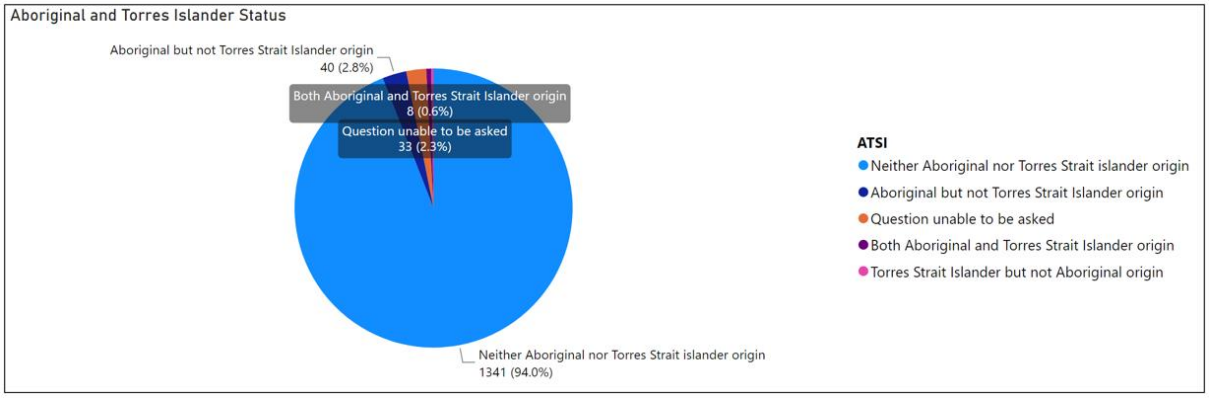
Figure 9 provides a breakdown of the sex at birth of patients. Females were seen in 49.9% of encounters and males in 47.3%.

Figure 9: Patient sex at birth



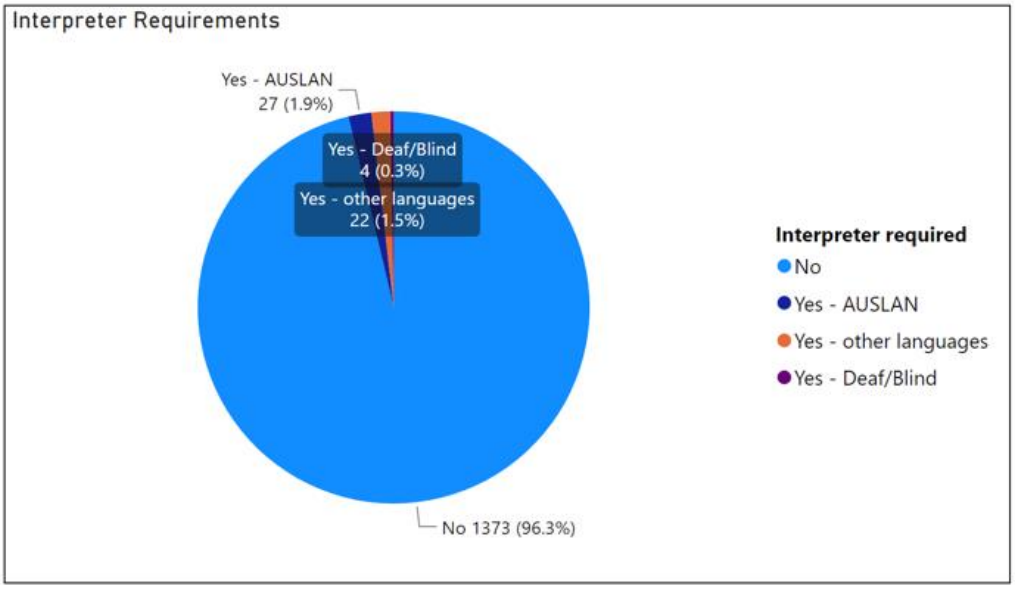
Patients who identified as Aboriginal and/or Torres Strait Islander accounted for 3.7% of all patient encounters supported by the DLOs as demonstrated in Figure 10.

Figure 10: Aboriginal and Torres Strait Islander Status



There were 2.2% of patients who were Deaf or Deafblind and required an Auslan interpreter. Another 1.5% of patient encounters required an interpreter for other languages (see Figure 11).

Figure 11: Patient interpreter requirements



DLOs recorded the known disability diagnoses of the patients they supported according to the National Disability Minimum Dataset categories (see Disability Services National Minimum Data Set (DS NMDS): data guide July 2016 (AIHW)). Where a patient had more than one disability, these were recorded.

Figure 12, highlights that the most frequent presenting disability was an intellectual disability (23.1%), followed by mental illness (13%) and autism (12.8%). Patients with a diagnosis of mental illness or physical disability, were supported by the DLOs if they had another diagnosis which met the eligibility criteria for the DLO RR service.

Figure 12: Presenting disabilities of patients

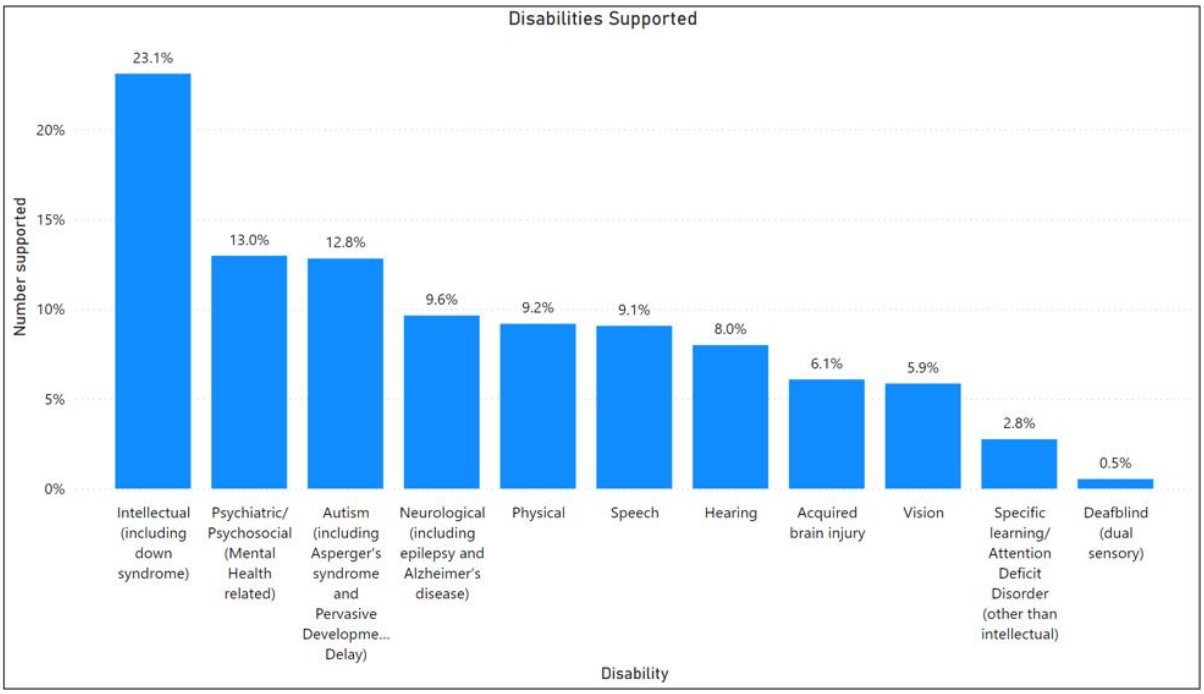
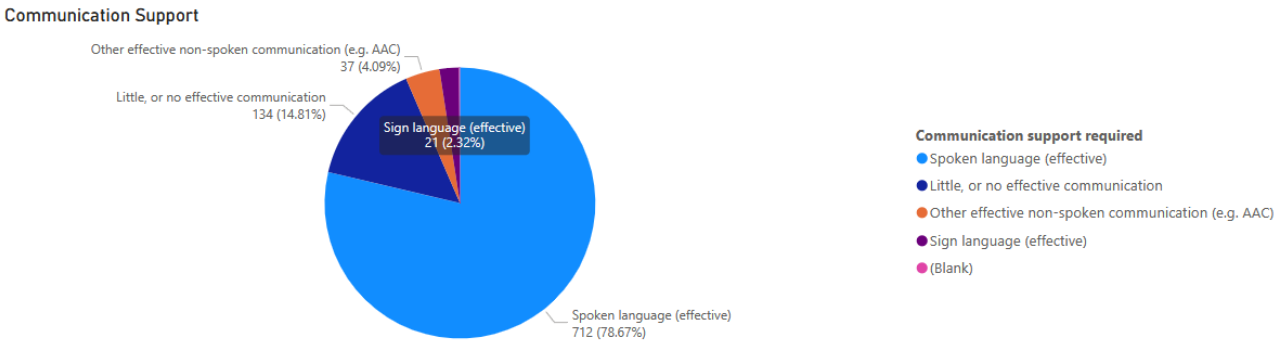


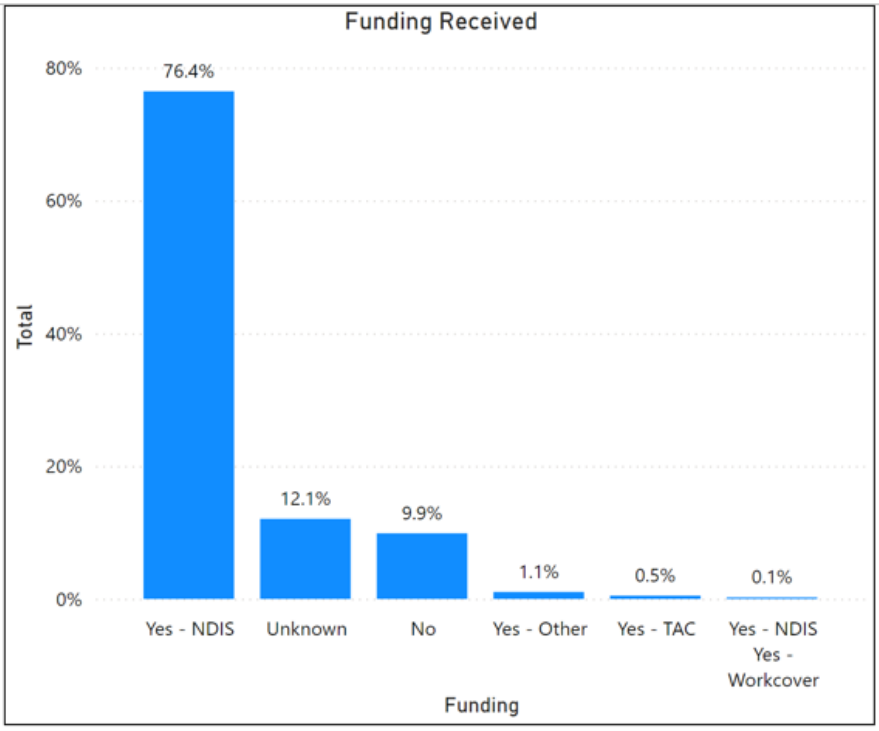
Figure 13 provides a breakdown of patient's communication methods. For 80.2% of patient encounters, English was spoken by the patient. While spoken language was their primary form of communication, there was still a role for DLOs in supporting patients in this group, especially for understanding information. Nearly 14% of patients had little or no effective communication. Smaller numbers of patients had other effective communication through sign language (2.2%) or augmentative and alternative communication (3.8%).

Figure 13: Patient communication methods



Most of the patients received funding government funding, with the National Disability Insurance Scheme (NDIS) the main funding source at 76.4%. Around 10% of patients with disability reported not receiving any funding to support them with their disability (see Figure 14).

Figure 14: Funding types received by patients



3.3.6 Disability alert

At Alfred Health, a 'Disability impacting care alert' existed within the EMR. The alert was primarily triggered through a mandatory disability identification question set within the electronic nursing admission history form completed by nurses in inpatient settings.

While this question set was not part of nursing workflows in the E&TC, the alert would show in the EMR when a patient with a pre-existing alert was admitted to the department. This alert was a key tool for the DLOs to identify patients who may need their support. Figure 15 shows that for 67% of patient encounters, the disability alert existed prior to the encounter. If it didn't exist, the DLOs had the ability to turn on the alert manually which they did with patient consent where it could be obtained. 63% of patient encounters had a DLO turn on the alert manually during the current or past encounter (see Figure 16).

Figure 15: Disability alert status prior to encounter

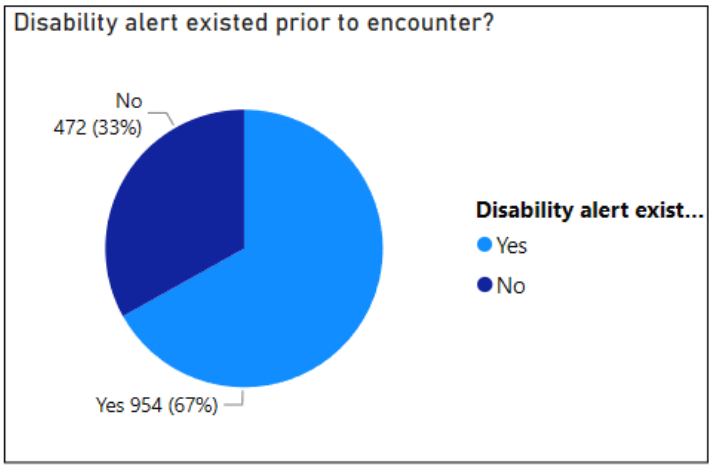
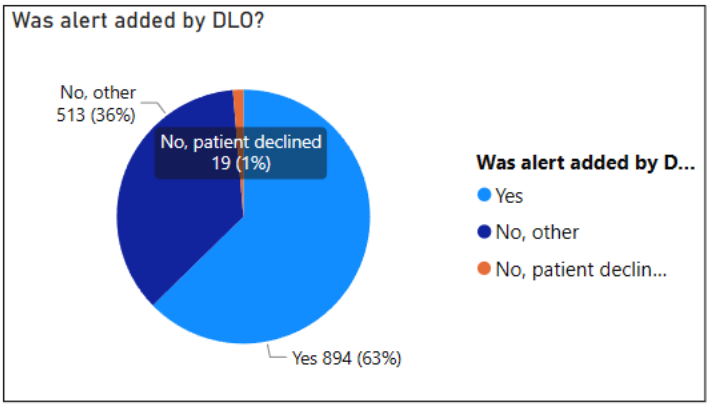


Figure 16: Disability alerts activated by DLOs



In May 2024 as part of the SPEAK Project, the disability identification questions used by nurses in the inpatient setting, were updated and implemented to the primary nursing survey used in the E&TC as 'Disability and Support Needs Questions'.

3.4 EVALUATION OF EFFECTIVENESS

The following retrospective cohort study was published related to the DLO service:

> *O'Shannessy E, Talarico C, McCaskie D, Lakhani A, Koolstra C, Standen J, Roberts K, Smit DV, Mitra B. Effectiveness of a Disability Liaison Officer service in a metropolitan emergency department. Emergency Medicine Australasia. 2025 Feb;37(1):e14513.*

This study compared the length of stay (LOS) of patients with disability in the E&TC 6 months prior to the commencement of the DLOs and a 6-month period after the commencement of the DLOs (01 November 2022 to 30 April 2023).

Results indicated that the DLO RR service in the E&TC was associated with 1.8-hour reduction in length of stay in the ED. Patients were 1.44 times more likely to be discharged sooner, and for the patient group discharged directly from ED, they were 2.47 times more likely to be discharged sooner.

3.5 FEEDBACK FROM PATIENTS AND CARERS

While feedback from patients and their support people during the pilot of the DLO RR service was not specifically sought, the service received compliments via Alfred Health's Patient Experience and Consumer Engagement Team as follows:

"I was experiencing heart palpitations. I am deaf. Upon telling the staff I couldn't hear I was thrilled to be warmly greeted by the DLO your disability liaison person. I want to let you know what a wonderful kind and understanding girl she was. She went out of her way to inform all the people I came in contact with that I was hearing impaired. Everyday is obviously difficult with my disability, and I expected the worst when I decided to go to hospital. How wrong was I. She is an Angel"

Patient with lived experience of being Deaf

"Our daughter XXXX was brought into the ED with Gallbladder reoccurrence problems last week. She has a mild intellectual disability and hospital can be her worst nightmare. The doctors and nurses were amazing despite her being extremely hysterical at times. Their respectful caring of her was so much appreciated. I have to say that all the gold stars have to go to the Disability Liaison Officer. Her support to XXXX and ourselves was wonderful and the experience would have been far more difficult without her. She devoted all her expertise to XXXX and comforted us especially by calling and letting us know what was going on. XXXX is returning to the Alfred on Friday to have the gallbladder removed and the DLO already has a program in hand for that. The DLO program is fabulous and a brilliant initiative. Despite the improvements in treating the disabled, there are still so many staff who have no clue how to do this. So huge thanks to the DLO and the Docs and Nurses on that and following days."

Parents with lived experience of a daughter with intellectual disability

3.6 FEEDBACK FROM STAFF

3.6.1 E&TC Staff Survey

Staff who had used the DLO RR service in the E&TC were invited to complete a short four question survey. A total of 17 responses were received to the online survey. Responses were collected over one month (17/08/2023 – 13/09/2023). Findings are outlined below:

- 100% of respondents reported *it was easy to access the DLO RRSC service*.
- 100% of respondents reported that *working with the DLO RRSC Team helped them*.

Responses to the question "*How did they help you?"* are outlined below:

- **Behaviour and Emotional Support**
  - Managed distressed patients and implemented distraction therapy.
  - De-escalated violent and distressed patients.
  - Reduced code greys and code blacks.

"DLOs spoke with the patient, put them at ease, then explained to the author what specific services/equipment the patient will need. When the patient received the right support, they felt cared for and comfortable. This is a necessary role and it is surprising these services weren't implemented earlier. Great initiative."

- **Communication**
  - Explained processes to patients who lack understanding of medical jargon.
  - Helped staff understand best ways to communicate with patients.
  - Assisted with communication aids and hearing devices.

- **Education and Resources**
  - Assisted staff with education on the floor offering expertise and knowledge for a smoother patient experience.
  - Provided staff with additional knowledge in looking after patients with certain disabilities.
  - Explained to staff what specific services and equipment a patient will need.

"Many patients with disability come through the door that I don't have much experience with dealing with".

- **Better Patient Care**
  - Enabled a much higher standard of care for patients with disabilities.
  - Helped our most vulnerable patients have a better and safer journey.
  - Formed strong therapeutic relationships with patients.
  - Knew what the patients and families need resulting in a smoother experience for all.

"I recently was caring for a patient with an intellectual disability. The patient was required to go to theatre and was extremely anxious. The DLO was a wonderful resource to provide additional tailored care to the patient and his partner (who also had a disability)"

- **Care Coordination and Discharge Planning**
  - Collaboratively formed care plans for patients with disabilities.
  - Quickly and effectively ensured plans and support were in place.
  - Assisted with discharge planning.

"The DLO service is a service that we want, need and appreciate for every point of care involving patients not only with disabilities impacting their care but challenging cohorts as well."

- **Team Collaboration and Support**
  - They make nursing staff's job easier and are valuable members of the team.
  - An asset to the Emergency team.

"Our department and patients are so much better off having them in our team. I can't believe we haven't always had them."

These themes reflect the diverse ways in which the DLO team contributes to patient care, staff support, and overall department effectiveness.

We asked staff **how we can improve** the DLO service in the E&TC and they told us:

- **Maintain and expand the service**
  - Permanent role – continue to have ongoing disability support within ED.
  - Operate 24/7 – increase operation hours to increase availability to patients.
  - Have them on all shifts at both The Alfred (E&TC) and Sandringham Emergency Departments.
  - Expand the team to include 'nursing champions' who can assist after-hours to potentially reduce the on-call usage and champion disability care.

"The more access the better! We have vulnerable patients that they can help with present 24/7".

- **Education to nursing staff**
  - Run sessions on different disabilities and how to best manage/assist with care requirements and communication strategies.
  - Contribute to in-service calendar.
  - Clarify role of DLO in providing secondary consults.
  - Spotlight on common things we see in ED.

- **Education to DLOs**
  - Some DLOs suggest differing plans for the same patients – all being on the same page with care of patients.
  - How to advocate for patients while recognising that nursing staff are busy and under time constraints – DLO requests can feel like an additional burden.
  - Verbally share key information with nursing staff – don't just rely on notes.
  - Recognise that nursing staff often have limited experience of disability and may still make errors despite receiving DLO instruction.

- **Words of Encouragement**
  - Keep up the amazing work

- Phenomenal!

"Nil need for improvement from my personal experience! All the DLOs are amazing :)"

- I think the DLO service is great and needs to stay as is.

3.6.2 Other Staff Feedback, Requests and Outcomes

Hi all,

I just wanted to say how FANTASTIC the DLO service was this morning!

X was working as the DLO this morning and went above and beyond to support the patient. EPS were pretty busy this morning, and without X I anticipate there would have been multiple code greys called for the patient. X quickly put together some strategies that we could use with the patient and ensured everyone who was involved in his care (Nurses/EPS/NDIS) were aware of the plan. The patient's behaviour settled significantly due to this service/intervention and he went happily off to SKRC for his apt!

Feedback from an Allied Health clinician working in the Emergency Psychiatry Service in the E&TC

- Request from nursing staff to support development of a Care Plan for a patient with disability who had sent some complex complaints to the Emergency Department:
  - Outcome: DLO was able to work with the patient to understand how the E&TC team could best provide support in the event of future encounters. A plan was developed which detailed steps from the point of arrival to care provision for ward clerks, streaming nurses, and onto medical and nursing care. This was documented into a Complex Care Plan and referenced via an Emergency Department Management Plan.

- Feedback from the Alfred Health A.W.A.R.E. Team (team responsible for delivering training to to help staff recognise and manage the growing issue of aggression and violence in healthcare)
  - The A.W.A.R.E. Team have played a role in promoting the DLO Team to Emergency Department staff during training sessions and have included a slide about DLOs in their training session presentation.
  - They have shared that Sandringham Hospital Emergency Department staff would like the service expanded to their site and see the DLO work as very beneficial
  - E&TC staff have shared how the DLO work has been beneficial during training sessions.

4 NOTABLE MENTIONS

- A presentation on the DLO RR service titled 'Disability Liaison Services in the Emergency Department – Supporting Patients with Hidden Disability' was delivered at the Health Round Table Innovation Showcase, May 2023.
- The DLO RR team was the winner of Alfred Health's Recognising Excellence Awards 2023 for Equity and Inclusion (Supporting diversity and fostering inclusion at Alfred Health), Team Category.
- Mention of the DLO RR service in the Chair and Chief Executives year in review in the Alfred Health Annual Report 2022-23 https://www.alfredhealth.org.au/images/resources/corporate-publications/Annual-Report/Alfred_Health_Annual_Report_2022-2023.pdf
- The DLO RR service was a nominee in the 2023 Australian Network on Disability Inclusive Impact Award of the Year.

5 RECOMMENDATIONS

1. Alfred Health and/or Victorian Department of Health to support an ongoing dedicated DLO service to the E&TC. It is recommended that this service is fully integrated into the existing hospital wide DLO team.

2. All clinical and non-clinical Emergency Department staff to complete the Online Disability Awareness Training developed by the SPEAK Project at a minimum. In addition, completion of follow on face-to-face training by clinicians to support practical skill development is also recommended.

3. Consider implementing a disability champion model in the E&TC where staff with a special interest in supporting patients with disability receive training and are promoted as a resource to clinicians on duty. This would be particularly beneficial for after-hours care when DLOs are not on duty.

4. Develop a DLO specific order / referral to standardise the capture DLO service delivery information.

6 FURTHER INFORMATION

For further information, please:

- Contact the Disability Team, Alfred Health, by emailing inclusion@alfred.org.au
- Visit the SPEAK Project website https://www.alfredhealth.org.au/about/patients-come-first/speak

7 APPENDICES

7.1 APPENDIX 1 – SPEAK PROJECT CONSUMER CO-DESIGN FINDINGS

The SPEAK Project conducted co-design workshops with people with lived experience of hidden disability during 2022. Participants were asked about the types of disability support they need in hospital and the role of Disability Liaison Officers (DLOs).

There was overwhelming support among co-design participants for a service in hospitals that helps staff and PWD. The main recommendation for Alfred Health was to continue trialling the DLO service in the E&TC. They also stated the importance of ensuring that participants' recommendations are part of improving and evaluating the service before rolling it out across other areas in Alfred Health and South West Healthcare.

Participants in the co-design workshops recommended that DLOs are:

- Translators, changing medical jargon into plain language
- Good communicators
- Calm and empathetic
- Kind and patient
- Advocates for both patients and support people
- Supporters of the social and human rights models of disability
- A mix of professionals and people with lived experience of disability or supporting people with disability
- Good at connecting with healthcare staff, including doctors.

DLOs can create sustainable change across the hospital by:

- Role modelling how to support people respectfully and effectively
- Advocating for people with disability and their support people
- Collaborating with healthcare staff, disability support services, and the disability community
- Providing education to healthcare staff
- Collecting and sharing patient feedback.

For further SPEAK Project co-design findings and recommendations, refer to the full report – Improving Hospitals for People with Hidden Disability, SPEAK Project Co-design Report, November 2022 available from https://www.alfredhealth.org.au/about/patients-come-first/speak/what-is-co-design

7.2 APPENDIX 2: SPEAK PROJECT EVALUATION FINDINGS

The SPEAK Project surveyed and interviewed healthcare workers (HCW) across both Alfred Health and South West Healthcare (SWH) between May and September 2022, prior to implementation of project objectives. The surveys and interviews formed part of the Stage 1 SPEAK Project evaluation activities, designed to understand the impact of the project. Findings relevant to a disability liaison service are outlined as follows.

Disability data must be captured "early", "easy to find" and regularly referred to by hospital staff.

Insights from the staff and support people interviews demonstrated that disability data must be captured early in a patient's admission, clearly marked on the patient's file, collated in a specific location, updated as new information is received, and referred to by staff throughout the patient's admission in the hospital.

Need for the Disability Liaison Officer role to be promoted and strengthened in hospitals: *"It's a good service…but not well integrated into the system"*

DLOs employed at Alfred Health assist PWD and their support people to access services across The Alfred and in the community (Note: at the time of interview, SWH did not have a specific DLO service).

Not all patients and support people interviewed had used or were aware of the DLO service. Two support people provided positive feedback about the service, while another expressed the need for improvement in terms of DLO availability, noting that, at the time of the interview, the DLO service only operated on weekdays during business hours.

Of the five Alfred Health staff members interviewed, only one had utilised and was aware of how to contact the DLOs. All other staff members either had not heard of the DLO service or were aware of the service but did not know how to utilise/access it. All hospital staff interviewed emphasised the need for promoting the DLO service more widely to ensure integration into the broader hospital system.

Key learnings were that the role of disability support staff needs to be clearly articulated so that it is understood by staff and patients, and the DLO service needs to be promoted to all stakeholders (staff as well as PWD and support people). This should include information on how to contact a DLO.

Need for more disability resources in the hospital: *"We need more resources"*

For the purpose of the SPEAK project, a disability resource has been defined as:

A communication or sensory support that facilitates the participation of a person with a sensory or communication disability or support need. The resource may be a physical object, such as a room, communication aid or sensory item or a person, such as a paid or unpaid support person or staff member.

When asked about disability resources participants primarily discussed communication resources. The importance of good patient-staff communication was viewed as a key factor in optimising hospital experiences for PWD. However, staff reported limited access to resources to support patient-staff communication, or not being aware of resources that could help support PWD in the hospital setting.

PWD and their support people stressed the importance of patients being asked about their communication preferences and having their communication needs accommodated in the hospital. Failure to ask about use of communication aids, equipment, or devices was viewed negatively by PWD. Suggestions made by PWD and their support people regarding ways in which staff can improve communication with patients with a disability included being more prepared with resources and increasing the use of visuals and other communication resources such as social stories.

Overall, there was a clear reiteration of the need to; (1) increase the number of disability resources available in hospitals, (2) improve access to a range of practical disability resources for hospital staff, and (3) ensure that staff confirm communication preferences with PWD and accommodate this whenever possible.

Time as a barrier to the provision of reasonable adjustments for PWD: *"It's always busy"*
Note: This theme was identified by healthcare workers only.

All hospital staff interviewed spoke about how having more time with a patient (including time taken to provide reasonable adjustments) is correlated to more positive patient outcomes and experiences in hospital. However, HCWs consistently mentioned being time-poor and that making these adjustments requires additional time. This is challenging for staff to prioritise amidst demanding schedules and staff shortages.

In busy settings like Emergency Departments (ED), staff reported that it can be particularly difficult to provide adequate reasonable adjustments to
PWD. Expanding the DLO service and having additional staff in areas such as ED was suggested by staff as strategies to alleviate time pressures. Cultivating a ward culture where staff are encouraged to identify and act upon reasonable adjustments for PWD was also raised as important by HCWs. Overall, the ability of staff to accommodate reasonable adjustments for PWD was consistently raised across interviews as being essential for patient safety and key to delivering truly patient-centred care

A DLO service can support healthcare delivery by supporting the collection and sharing of patient support needs, advocating for and providing resources, having the time to focus PWD.

For further SPEAK Project evaluation findings and recommendations, refer to the full report – Stage 1 Evaluation Summary Report (Interviews + Surveys) available from
https://www.alfredhealth.org.au/about/patients-come-first/speak