Factsheet 7: Issues Relating to Specific Impairments

This document provides background information on a range of impairments as well as a set of associated fact sheets. These contain suggested strategies that can be used when supporting disabled students. This information deals with impairments that are most commonly experienced by students. You may come across students who have other impairments that are not covered here. It is possible to apply many of the strategies suggested here to a variety of situations. Following this guidance will contribute to the development of inclusive approaches to teaching and learning.

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Background

Disabled students span the same spectrum as do their non disabled peers with differing levels of ability and aptitude. Some enter HE equipped with a variety of effective personal strategies; others may not have given much thought to the importance of developing these. These students should be encouraged and guided to acquire and develop a range of effective strategies.

More advice and assistance might be needed by students whose impairments have been recently diagnosed. If you don't feel equipped to provide this level of support, you could contact the university Disability Services, the Allied Health Professions Support Service and/or disability-specific organisations.

Ideally, all relevant staff and the university Disability Service should work with disabled students to identify appropriate personal strategies in the academic setting. Students should be encouraged to think about how these strategies could be applied in practice placement situations. You can also help disabled students by encouraging them to reflect on previous experiences and to apply effective strategies to the new environment.

Staff anxiety

You may feel quite anxious when you find out that you will be supervising disabled students, especially if you have little or no prior experience. You might find the following ideas useful:

- Discussion of disability issues and possible support strategies in advance
- Specific staff development sessions to raise awareness of disability issues
- Contact with colleagues who have experience of supporting disabled students/colleagues
- Supportive management – providing time and resources for staff development in this area
- Targeted training
- Good communication with the universities that send students to you
- Access to resources, information, advice and guidance

These strategies will help to develop a culture of awareness and support that will improve the working environment for everyone.
Supportive atmosphere

All students find practice placements stressful. For disabled students, lack of confidence due to fear of discrimination or previous negative experiences could add to this stress. You can help to combat this in a number of ways:

- By having an open and non-judgmental approach
- By encouraging and supporting the student to establish an atmosphere of trust and safety
- Trying to be as patient as possible
- Not placing undue emphasis on time pressures

An inclusive approach improves the learning experience for all students. Some disabled students may also require more specific adjustments in practice placements. Ideally you should discuss and agree these with the student in advance (input from all relevant staff as necessary: academic, practice based, Disability service). Agreed support should be recorded and signed by all parties.

If you follow these steps, students should arrive at the placement with some idea of personal strategies that might be useful. They will have developed some strategies in the academic setting but many students find that new environments require them to adopt additional techniques.

A SWOT analysis at the beginning of the placement can identify helpful strategies that have been developed during previous practice based placements. You might be able to help the student to modify these to apply more closely to the current situation.
Specific impairments: some background information

1. Dyslexia

Identified as a specific learning difficulty, dyslexia is included under the broad category of neurodiversity. This term recognises that:

“…developmental diversity is an aspect of human development…and emphasises the social model of disability” (Pavey et al 2010)

The British Dyslexia Association defines dyslexia (using a psychological, individual deficit view) as:

“…a specific learning difficulty that mainly affects the development of literacy and language related skills. It is likely to be present at birth and life long in its effects. It is characterised by difficulties with phonological processing, rapid naming, working memory processing speed and the automatic development of skills that may not match up to an individual’s other cognitive abilities. It tends to be resistant to conventional teaching methods, but its effects can be mitigated by appropriately specific intervention including the application of information technology and supportive counselling” (Singleton 2008)

It is more appropriate, however, to view dyslexia from the perspective of the social model of disability:

“…dyslexia is an experience that arises out of natural human diversity on one the hand and a world on the other where the early learning of literacy, and good personal organisation and working memory is mistakenly used as a marker of ‘intelligence’. The problem here is seeing difference incorrectly as deficit” (Cooper 2006)

Many successful people from a wide range of occupations have dyslexia. It is estimated that approximately 4% of the population has a significant disability and that an additional 6% have a milder or more moderate form of dyslexia. Students who have dyslexia, therefore, comprise the largest category of disabled students who will need support on practice based placements in particular.

People who have dyslexia are often very talented. Traditional study methods can, however, erect barriers which prevent some students from attaining their full potential (Hardie 2001). Dyslexia-friendly initiatives work on the principle that by improving the learning environment, the likelihood of achievement of successful learning outcomes is increased (Pavey et al 2010).
People who are already aware of having dyslexia may not declare this before starting their course; this is often due to the fear of being labelled.

Some students develop study strategies before they arrive at university. Whilst these may have been adequate previously, they are often insufficient for studying at a higher level. Others may have received considerable informal support (e.g. proof reading of texts by family/friends) which has enabled them to achieve acceptable standards. This level of support may not be available to them in HE.

Many mature students may not have been previously diagnosed as having dyslexia. They may have left school early with no diagnosis of their specific learning difficulties.

**Individual differences**

Students who have dyslexia are, like all learners, individuals. They share some characteristics with others who have dyslexia, but there are just as many differences. They may show some of the following characteristics:

- Signs of tiredness
- Fragile self esteem
- Signs of stress e.g. frustration, anger, distress
- May find reading and writing tasks tiring
- Difficulty remembering what is read and needing to re-read for full understanding
- Misinterpreting questions
- Left/right confusion
- Issues with organisation and processing instructions
- Difficulties transferring information from short term to long term memory
- Time management issues
- Short concentration span/easily distracted
- Difficulties expressing information, ideas and concepts – both written and spoken
- Issues with jumbling or reversing letters when writing and transposition of numbers e.g. door codes, telephone numbers
- Issues in carrying out tasks simultaneously such as listening and taking notes
- Ability to think creatively
- Preference for visual and kinaesthetic learning strategies
- Good practical skills
- Resourceful and ingenious personal strategies
- Good analytical and problem solving skills
- Good speaking skills
- Proficiency in synthesis and in making intuitive links
Principles to facilitate learning

The Association of Dyslexia Specialists in Higher Education (ADSHE) has produced some overarching principles which should be useful to Practice Educators. To be most effective it is helpful if the students also understand these principles:

- **Metacognition** – knowledge of how individuals prefer to process information. If students can understand their learning preferences, strengths and areas for development, they can consciously develop particular approaches/strategies to study which can enhance their learning.
- **Multisensory** – multisensory teaching and learning (i.e. visual, auditory, tactile or kinaesthetic) using multiple perceptual pathways is thought to enhance memory.
- **Relevance** – better learning occurs when the relevance of the material is obvious. This principle applies to all students. It is, helpful for dyslexia tutors to teach strategies that relate to the context of the work that the student is expected to undertake.
- **Motivation** – many students who have dyslexia have had negative experiences in their past education and can be easily discouraged. “Motivation can sustain their expectations, aspirations, self esteem and confidence” (ADSHE 2009 pp9).
- **Overlearning** – many people who have dyslexia may learn things quickly. In comparison with other learners, however, they have a greater tendency to forget this material more quickly following a teaching session. Overlearning and reinforcement with repetition, refocusing and reapplication of the material is necessary to enable the student to feel in control of her/his learning.
- **‘Little and often’** – most students who have dyslexia (or other elements of neurodiversity) often find it helpful to divide their learning into more manageable amounts and to take frequent short breaks. Dyslexia tutors should help students to plan this together with drawing up personal goals which can be used to draw up a personal learning programme. As students start to achieve these goals, their motivation and self esteem may increase and anxiety levels may also fall.
- **Modelling** – dyslexia tutors - and others such as academic staff and Practice Educators - should model learning strategies and approaches that students, with guidance, can put into practice. This may need repetition initially but can help the students to move towards more independent and autonomous learning.
2. Visual impairment

Causes of visual impairment

The main causes of visual impairment include:

- Ageing
- Damage to the optic nerve
- Diabetes
- Disease of one or more components of the eye
- Genetic factors
- Infections
- Lengthy exposure to toxic substance substances (e.g. smoke)
- Trauma

Visual impairment has been the subject of many myths which have led to misconceptions relating to definitions of 'blindness' and 'partial sight' and the practical significance of these impairments.

According to RNIB's Booklet: The Benefits of Registering as Blind or Partially Sighted (2006):

"For a person to be registered as severely sight impaired/blind, vision has to fall into one of the following categories:

Visual acuity of less than 3/60 with a full visual field
Or
Visual acuity between 3/60 and 6/60 or above but with a very reduced visual field (e.g. tunnel vision)
Or
Visual acuity of 6/60 or above but with a very reduced visual field, especially if considerable sight is absent from the lower part of the visual field.

For a person to be registered as sight impaired/partially sighted, vision has to fall into one of the following categories:

Visual acuity of 3/60 to 6/60 with a full visual field
Or
Visual acuity of up to 6/24 with a moderate reduction in the visual field or with a central part of vision that is cloudy or blurred"
Visual acuity

Visual acuity is defined as clarity of distance vision. The figures given above refer to the results of an assessment using the Snellen chart. Interpretation of these results reveals that a severely sight impaired/blind person can see at a distance of 6 metres or less what a sighted person can see at 60 metres; a sight impaired/partially sighted person can see at a distance of between 6 to 24 metres what a sighted person can see at 60 metres.

Reductions in visual acuity do not necessarily result in a blurring or fragmentation of images. Images may, however, be indistinct or unrecognizable, as they might appear to a sighted person who stands too far away.

Severe sight impairment/Blindness

It is estimated that only about 8% of registered people in the UK see nothing at all; a further 60% can read large, clear print. Many people can write legibly although some may be unable to read their own or other people’s handwriting. Only a small percentage of blind people read and write Braille.

Sight impairment/Partial sight

Partial sight is often difficult to understand. The reasons include:

- the individuality of each person's (often fluctuating) visual experience
- differences in depth and distance perception
- differences in colour perception
- a person's behaviour may vary depending on fluctuations in vision and/or changing environmental conditions (e.g. lighting levels)
- development of personal strategies in response to visual impairment

Partially sighted people are often asked the following questions:

- 'What can you actually see?'
- 'Can you see the building over there?'
- 'How much can you see?'

These questions are asked with a genuine intention to obtain useful information; people who have a visual impairment cannot provide a satisfactory answer because they don’t have full vision. Even if a person has had full vision in the past, memories of that experience may be unreliable.

Partial sight may be characterised by one or more of the following:
Peripheral field loss

The degree of field loss will vary from minimal to considerable. It may take the form of 'tunnel vision' which has been described by one person as 'standing at the exit of a tunnel whose walls are black, merging into a kind of grey' and by another as 'seeing through a pin hole'. The person may be unable to see a complete image and may, for example, require text in a small font size. Colour perception may not be affected and many visually impaired people use colour as a means of identifying objects and people and when memorising information.

A person who has had peripheral field loss since birth may be unaware of it because the images that fall within it are not seen at all. For example, a partially sighted person may appear to ignore someone who is standing outside of the visual field. In fact, that person just hasn’t been seen. For safety reasons, partially sighted students may need to be advised to check for obstacles (e.g. furniture, equipment) positioned in corridors or wards.

Central field loss

Central field loss may be experienced as 'floaters' that periodically occlude central vision or as more stable large 'clouds'. This can result in an inability to see fine detail and colours. Additionally, low light levels may cause 'night blindness' i.e. residual vision is reduced or non-existent. This issue might mean that a partially sighted person prefers (and can work more effectively) in specific environments. It may also affect travel arrangements i.e. travel in the dark or dull/wintery conditions may be difficult or impossible to some locations. These issues must be considered when organising student placements.

Some people who have a combination of patchy peripheral and central visual field loss still perceive a coherent picture. They know that there are missing areas but the brain's perceptual mechanisms compensate for these.

People who have central field loss utilise their peripheral vision to view objects; this means that they rarely make direct eye contact. This needs to be taken into account when feeding back to them on their communication skills.
Depth and distance perception

People who have this difficulty are unlikely to be able to perceive in 3D and objects may appear to be small and flat. Steps and stairs will be difficult to negotiate unless they are clearly marked in a contrasting colour. Similarly, the interpretation of graphical information that employs 3D can be difficult and therefore the use of models is helpful. As a strategy, the person may use touch to check the nature, position and distance of objects.

Perceptual processes

Perceptual processes are as active in people who have a visual impairment as in those who have full vision. In all forms of visual impairment considerable energy is required to perform everyday tasks: little can be taken for granted. Incoming sense data is tested against past experience and hypotheses; cognitive skills being used to interpret sensory input. This can be exhausting and stressful particularly if this level of concentration has to be maintained for a long period of time.

A range of personal strategies can be developed to manage the environment. For example, it might be impossible to read the destination of a bus, but recognition of the shape of the word can help to identify the place name; planning journeys carefully in advance can reduce stress levels.

Individual differences

Visually impaired students will share some characteristics with others, but there are also significant differences. They may show some of the following characteristics:

- Signs of tiredness
- Signs of stress
- Reading and writing tasks may be tiring because visual processing is serial (i.e. they cannot take in the ‘whole picture’ at a glance and have to look at separate elements in turn)
- Initial disorientation in unfamiliar environments
- May take longer to become familiar with new environments
- Difficulties recognising people and objects out of context
- Difficulties distinguishing between particular colours and judging depth and distance
- Variable ability to access materials and environments which have reflective surfaces and changes in lighting levels
- Time management issues
- Issues with presenting visual information to an audience
- Preference for auditory and/or tactile learning methods/strategies
- Preference for text and description rather than diagrams
- Resourceful and ingenious personal strategies
- A well developed visual memory
- Good verbal communication skills
- Good insight into disability-related issues
- Ability to empathise with patients
- Good analytical and problem solving skills
- Good planning/organisational skills
3. Mental health difficulties

Background

The term ‘mental health difficulties’ encompasses a range of experiences and situations. Mental health is often viewed as a continuum of experience, from mental well-being through to severe and enduring mental illness. Everyone will experience changes in their mental health state and this can be influenced by a range of factors, for example:

- social, personal and financial circumstances
- bereavement
- leaving home

These factors can have a significant impact on how people feel about themselves and can lead to mental health issues such as anxiety or even depression.

A Government Priority

A great deal of policy has been produced over the last 3 years relating to mental health issues indicating that this is a priority area for the Government. Mental health issues are a key factor in denying many people the opportunity to work and there is a large cost implication. “People with mental health conditions remain among the most excluded within our society. And nowhere is this exclusion more evident than in the workplace” (Perkins et al 2009 p10).

In 2011, the Department of Health said: “In terms of the wider society, helping more people to return to work will help reduce the costs of managing mental health conditions to the economy. Cost benefit analysis which informed the Perkins Review suggested a redesign of employment services is likely to be cost effective” (DH 2011).

At any one time, just over 20% of working-age women and 17% of working-age men are affected by depression or anxiety. Half of those with common mental health problems are limited by their condition and around a fifth are disabled by it (DH 2009). It is estimated that over 1 million people are on benefits and another million are out of work (Perkins et al 2009).

“The Government commits to working with government departments, the NHS, local authorities and other public sector organisations to examine ways of ensuring that more people in contact with secondary mental health services are employed by these organisations” (DH 2011)
Mental health and the workplace

It is recognised that people with mental health problems represent an undervalued and untapped pool of talent. Most want to work and if appropriate support is in place, can make valuable contributions to the workplace. There is evidence that being employed is generally good for mental health and wellbeing, with the workplace providing opportunities to build and develop resilience and mental capital and to develop social networks. Employers play a key role in supporting the mental health and wellbeing of staff by providing healthy workplaces. The public sector in general and the NHS in particular, are expected to play lead roles in this process (NMHDU 2009). Boorman (2009) made a large number of recommendations for improving staff health and wellbeing in the NHS. These include:

- All NHS trusts should implement guidance …..on promoting mental health and wellbeing at work
- All NHS trusts must put staff health and wellbeing at the heart of their work, with clearly identified champions and support at senior management levels
- Training in health and wellbeing must be undertaken by managers and leaders – built into annual performance review and personal development planning
- Priority should be given to ensuring that managers have the skills and tools to support staff with mental health issues
- All NHS organisations should put staff health and wellbeing strategies in place that are routinely monitored, reported and discussed with staff and their representatives.

It is well recognised that many people with mental health issues are reliable and conscientious workers. They can perform well in pressurised and responsible positions. In most cases mental health issues have no effect on job performance; some people’s mental health may temporarily affect their work.

A minority of people experience mental health difficulties to such a degree that they are diagnosed as having a mental illness. This often requires the involvement of specialist services and support. Most people do not experience mental illness, but may experience mental health difficulties and variations in mood at different times in their lives.

With appropriate support and information, people who are experiencing mental health difficulties can make positive changes and improvements. This support ranges from non-specialist help to professional assistance.
Mental health issues and the NHS approach

NHS Employers is also providing guidance to highlight the gain to the NHS in ensuring it supports people with mental health conditions into employment. In January 2010 they launched a campaign called ‘Mental Health - Open Your Mind’. They are developing online resources to support organisations to increase the employment rates of people in contact with secondary mental health services. This includes examples of good policy, good practice, individual and organisational case studies and information on training. They are also developing and sharing models of good practice for delivering anti-stigma materials to NHS organisations (www.nhsemployers.org).

There are many reasons why it is useful to include people who have mental health difficulties in the workforce. They have personal experience of living with, and managing, mental health difficulties. This can prove useful to clinical colleagues who have not experienced such difficulties. It is also possible that they may be well placed to understand the needs of patients due to their own personal experience. The skill mix of staff is increased and the presence of these people in the workforce provides an important role model. If appropriate support is in place it is much less resource intensive to retaining staff than to replace them. This approach will develop an open, supportive and inclusive culture which, in itself, can reduce stress and consequently reduce or prevent further instances of mental distress.

Some facts about people who have mental health difficulties

- They can successfully gain and retain employment if the appropriate help and support are available
- With appropriate support, they take less time off sick than other staff
- It does not mean that their skills/qualifications are inferior to those of others
- It is not necessary to reduce expectations relating to their performance
- In the majority of cases they are not, and never have been, violent and present no risk to anyone else
- The discrimination they typically experience leads to a secretive climate in which many people prefer to deny that they have mental health difficulties

The Royal College of Psychiatrists states that students are more likely to experience mental distress than other young people (Royal College of Psychiatrists 2003). The National Union of Students notes that one in four students will experience mental health difficulties during their studies. Some students, some of the time, will experience barriers that impede effective learning as a direct result of their mental state (Birnie and Grant 2001).
Most of these students are will respond to some form of intervention which could range from counselling to medication or more rarely to a period of hospitalisation.

**Possible indications of mental health difficulties**

Students may be undergoing counselling or other intervention and/or may be on medication. They may show no signs of mental distress when interacting with staff or their peers.

There are, however, some students in rather different situations who could exhibit behaviour that indicates a level of mental distress. Examples include students who:

- have difficulty in managing that distress
- are subjected to additional levels of stress
- have chosen not to access available support mechanisms
- have not appreciated that they have difficulties
- have mental health difficulties that are triggered by such milestones as moving from home to university or going from the university environment to the more demanding practice based setting

These students may show some of the following characteristics:

- Signs of tiredness (due to disturbed sleep and/or drained energy levels)
- Tiredness at certain times of the day or fluctuating concentration levels due to the effects of medication
- Fragile self esteem
- Loss of confidence
- Signs of stress e.g. frustration, anger, distress
- Lability of mood
- Pessimism
- Signs of vulnerability and helplessness
- Erratic behaviour
- Agitation
- Paranoia
- Difficulty in articulating thoughts and ideas
- Unusual or inappropriate behaviour
- Inattention, loss of concentration
- Loss of interest in the course
- Repetitive actions
- Holding fixed, irrational beliefs
- Evidence of self harm
• Evidence of body image issues
• Indications of addiction to alcohol or drugs

These characteristics may be evidence of a recognised mental health difficulty or they may be unrelated. For example, they could be temporary reactions to bereavement or stress. Staff dealing with students in these circumstances must be patient, open and non-judgmental. Equally staff should be aware of the range of services to which they can refer these students.
4. Deafness and hearing loss

Background

Causes of deafness

The main causes of sensorineural deafness (the most common type of deafness – see below) are:

- Ageing
- Lengthy exposure to loud noise (or brief exposure to extremely loud noise such as explosions)
- Drugs that can cause damage to sensory hair cells inside the ear (ototoxic drugs include some antibiotics and anti cancer drugs used in life saving situations)
- Infections
- Genetic factors

Types of hearing loss

- Conductive – sound is unable to pass through the outer or middle ear.
- Sensorineural – caused by problems with the cochlea or auditory nerve which reduces both loudness and the quality of sound heard.
- Neural – absence of, or damage to the auditory nerve. This leads to profound and permanent hearing loss (Action on Hearing Loss 2007)

Statistics

According to Action on Hearing Loss (2010), the latest estimated figures for the number of deaf and hard of hearing adults in the UK are as follows:

- 8,945,000 deaf and hard of hearing people
- 2,474,000 deaf and hard of hearing people aged 16 to 60
- 6,471,000 deaf and hard of hearing people aged over 60
- 8,257,000 people with mild to moderate deafness
- 2,366,000 people with mild to moderate deafness aged 16 to 60
- 5,891,000 people with mild to moderate deafness aged over 60
- 688,000 people with severe to profound deafness
- 108,000 people with severe to profound deafness aged 16 to 60
- 580,000 people with severe to profound deafness aged over 60.

There are an estimated 50,000 people who use British Sign Language as their first or preferred language.
The ratio of interpreters (including trainees) to sign language users is 1 to 156.
The ratio of fully-qualified interpreters to sign language users is 1 to 275.

Definitions of deafness

Mild deafness
People who have mild deafness have some difficulty following speech which is most marked in noisy situations. ( Quietest sounds heard in the better ear average between 25 and 39 decibels).

Moderate deafness
People who have moderate deafness usually need to make use of hearing enhancement equipment in order to follow speech. ( Quietest sounds heard in the better ear average between 40 and 69 decibels).

Severe deafness
People who have severe deafness often use hearing enhancement equipment but also rely heavily on lipreading. BSL may be their first or preferred language. ( Quietest sounds heard in the better ear average between 70 and 94 decibels).

Profound Deafness
People who are profoundly Deaf often communicate by lipreading. BSL may be their first or preferred language. ( Quietest sounds heard in the better ear average 95 decibels or more).

‘Deafened’ people
The term ‘deafened’ describes people who were not prelingually deaf, but have become profoundly deaf in adult life. This often happens suddenly as a result of trauma, infection or ototoxic drugs: drugs that can cause hearing loss.
Communication

Deaf and hard of hearing people choose to communicate in different ways. Some may use lip reading and/or auditory enhancement equipment whilst others may use a Lip Speaker or British Sign Language (BSL) as their preferred mode of communication.

The legislation states that an “inability to hold a conversation with someone talking in a normal voice” or an “inability to hear and understand another person speaking clearly over the voice telephone” counts as a ‘substantial adverse’ effect under the Act.

When the consequences of someone’s deafness or hearing loss are being considered, the effect of background noise should be taken into account. Under the legislation, any attempts to treat or correct a person’s deafness or hearing loss are ignored. This means that even if a person uses hearing enhancement equipment, what counts is the level of hearing loss without correction.

BSL/English interpreters

BSL/English interpreters are used by people who are Deaf and whose first or preferred language is BSL. This is a face-to-face method used to facilitate communication between Deaf sign language users and hearing persons.

Video interpreting

The issue of obtaining an interpreter at short notice or for brief appointments can be addressed, in some cases, by arranging video interpreting. This is not, however, a replacement for face-to-face interpreting.

If a webcam or videophone is available, video interpreting is possible. Some councils, hospitals and police stations use this method.

Lipspeakers

Lipspeakers are used by people who prefer to communicate through lipreading and speech. Good English skills and confidence in lipreading are necessary to use this method. This technique can be used to facilitate communication between people who are Deaf and people who are hearing.

Lipspeakers repeat what is said without using their voice, so that their lip movements can be read easily. The shape of words is produced clearly, with the flow, rhythm and
phrasing of speech. Natural gestures and facial expressions are also employed to enable the user to follow what is being said. Lipspeakers may also use fingerspelling.

**Speech-to-text reporters**

This type of communication method can be used by people who are Deaf as long as they are proficient in reading English. This is a high speed method which can be used for up to two hours at a time. Speech-to-text reporters use systems called Palantype® or Stenograph®.

Each word spoken is typed by the reporter using a special keyboard. Words are typed phonetically and the software converts this back into English on the screen. This enables the reporter to keep up with the speed of spoken English. This method is often used at large events such as conferences with the text being projected onto a large screen or a range of smaller screens positioned around the room to facilitate viewing.

**Electronic notetakers**

People who are employed as Electronic Note takers type a summary of what is being said on a laptop computer. This information appears on the Deaf person's screen. This method does not provide a full word-for-word report.

Electronic notetakers use particular software such as Action on Hearing Loss SpeedText®, Stereotype or Microsoft Word. The user can also type replies, which can be read to hearing people in the room.

(Action on Hearing Loss, 2007)
Factsheet 1: Dyslexia

Suggestions for support

Adjustments may need to be implemented in a number of areas; it may also be necessary for you to modify your approach to help students participate fully in placements and to gain maximum benefit. The students should discuss and negotiate their adjustments with you (practice based and/or academic staff). A record should be kept of any agreed adjustments and signed by all parties. These arrangements will be different for each individual.

If a student is offered a range of possible modifications, but refuses to implement them, this should also be recorded and signed.

Disclosure

As with other disabilities, a student’s decision to disclose information about his or her dyslexia is purely personal.

You should ask all students whether they have any support needs – this provides them with opportunities to discuss any issues and indicates an open and non-judgmental approach within the department.

Some NHS settings provide training to enable you to support individuals who might disclose disabilities. All staff should attend these sessions. These issues may also be covered in training days provided by universities sending students on placement.

If students have disclosed, you should ask what kind of support would be most helpful. Different students and situations will require different strategies to increase access to information. At the end of the first week of placement, you should timetable a review to assess how effective and appropriate the strategies have been. Further changes may need to be negotiated as the placement progresses. A flexible approach is essential.

Preparation for placement

Checklist

Not all students who have dyslexia show the same pattern of strengths and difficulties. Ideally the student’s specific requirements and preferred support strategies should be discussed prior to placement and a checklist drawn up. This can be used to help the student to negotiate reasonable adjustments for the placement.
Disability Officer Role

University Disability Services normally provide students with access to a Disability Officer. The main role of these Officers is to discuss and recommend reasonable adjustments for the academic setting. It is also possible for the students to ask for help in deciding on appropriate modifications/strategies that could be used in the practice based setting. They may be able to suggest ways in which the student can be most effectively supported.

Orientation process

It is important to arrange a physical orientation session: the use of a map may be helpful to some students. A member of staff on site should walk the student through the environment identifying significant places and people and their roles/functions. If the student needs to access number coded doors, an opportunity should be provided to practice entering the code. Some people find it easier to remember the tactile pattern rather than a number.

Specified times

Set aside some time, if necessary, for students to discuss issues related specifically to dyslexia. Many students report that they feel they need to repeatedly flag up issues with practice educators. This is frustrating and they believe that you might perceive this as being ‘a nuisance’.

Suggested support strategies

The following are helpful for many students but crucial for those who find reading and writing tasks difficult and/or tiring:

- Provide a glossary of new terminology (or encourage the student to formulate a glossary of relevant terms prior to the placement)
- Ensure that written information is clearly laid out and unambiguous
- Use a clear font such as Arial, size 12 point or above on cream or pastel coloured, matt paper (this reduces the effects of glare)
- Provide written materials in advance – preferably in an electronic format
- If students are expected to undertake a large amount of reading prior to and during placement, identify key/essential material
- Be aware that extra time may be needed to complete reading and writing tasks
- Provide verbal explanation as an adjunct to written information if necessary
- Be aware of variations in standards of written communication
• Encourage the student to use an electronic dictionary/thesaurus and to add to the lists of terminology as necessary
• Give the student clear guidelines for specific record keeping formats and if necessary provide help with planning and structure
• If errors occur give feedback on the sequence of steps required to complete the writing task effectively
• Provide some proof reading for patient records
• Offer good examples of previously written patient notes

Planning teaching sessions
The following points are helpful when planning teaching sessions. These are inclusive principles that improve the learning experience for everyone:

• Provide a glossary of key terms
• Provide a lecture/session summary in advance or at the start of the session so that students can concentrate on listening and understanding rather than having to take notes
• Provide a general overview of the topic before going into detail
• Allow the use of digital recorders
• Whenever possible, use multi-sensory methods (i.e. visual, auditory, tactile as appropriate)
• Allow time for students to absorb information
• Break up the learning session to allow for information processing
• Use as many concrete examples as possible when explaining ideas
• Try to avoid external distractions as this can cause loss of concentration or information can be missed

Student presentations
These are useful guidelines when you ask students to prepare presentations:

• Provide encouragement and support
• Establish an atmosphere of trust and safety to reduce stress
• Be open to discussing an overview of the presentation to ensure the student is not trying to include too much material
• Be aware of possible issues with organisation, time management and pronunciation of some terms
• Assist students to articulate points if there seems to be a particular difficulty
Practical demonstrations

You can use the following strategies to support students in practical demonstration settings:

- Be accepting and non-judgmental
- Give clear, logical instructions, repeated in different words, broken down into steps, reinforced by written instructions if necessary (brief demonstration summaries)
- Use a range of methods i.e. visual, aural and hands-on.

Instant recall can be difficult/stressful. Students may perform well practically but find it difficult to give immediate verbal feedback. Provision of a prompt sheet including questions such as ‘What did you do first – why?’ and ‘How did you decide on your next question/technique?’ will help the student to reflect prior to giving feedback.

Placement management/organisation

- Ask all students on first contact whether they have any particular educational requirements, so indicating an open and non-judgmental approach within the department
- Construct timetables to assist organisation – encourage students to be actively involved in this process
- Encourage the use of a diary for forward planning and reflection (this could be recorded)
- Allow additional time for students to write up patient notes
- Encourage flexible working patterns - these enable students to work at their most efficient level e.g. allowing notes to be written at intervals during the day rather than expecting them all to be written up at the end of the day
- Encourage the use of digital recorders to note key points during patient assessment
- Use proforma sheets or brief crib notes during patient assessments (if you use proformas, it is helpful for the student to see these prior to the placement)
- Where possible enable students to use computers to write up notes. This will improve spelling and grammar due to the inbuilt software features
- If appropriate allow the student to use a portable computer for note keeping
- Avoid overloading students’ study time and provide guided reading
- Encourage peer support and group working if there is more than one student working in the practice based area.
Contact Us

**We welcome enquiries by phone or email.**

Jane Owen Hutchinson  
Manager, AHPSS  
**Mobile:** 07748 657457  
**Email:** jane.owenhutchinson@rnib.org.uk

Karen Atkinson  
Manager, AHPSS Resource Centre  
University of East London  
Stratford Campus  
Water Lane  
Stratford  
London, E15 4LZ  
**Tel:** 0208 223 4950  
**Mobile:** 07918197995  
**Email:** k.a.atkinson@uel.ac.uk
Factsheet 2: Visual impairment

Suggestions for support

Adjustments may need to be implemented in a number of areas; it may also be necessary for you to modify your approach to help students participate fully in placements and to gain maximum benefit. The students should discuss and negotiate their adjustments with you (practice based and/or academic staff). A record should be kept of any agreed adjustments and signed by all parties. These arrangements will be different for each individual.

If a student is offered a range of possible modifications, but refuses to implement them, this should also be recorded and signed.

Disclosure

As with other disabilities, a student’s decision to disclose information about his or her visual impairment is purely personal.

You should ask all students whether they have any support needs – this provides them with opportunities to discuss any issues and indicates an open and non-judgmental approach within the department.

Some NHS settings provide training to enable you to support individuals who might disclose disabilities. All staff should attend these sessions. These issues may also be covered in training days provided by universities sending students on placement.

If students have disclosed, you should ask what kind of support would be most helpful. Different students and situations will require different strategies to increase access to information. At the end of the first week of placement, you should timetable a review to assess how effective and appropriate the strategies have been. Further changes may need to be negotiated as the placement progresses. A flexible approach is essential.

Transport/travel

Placements should be organised that are within walking distance of the university or a student's accommodation or that are easily accessible by public transport. If necessary, the student could travel the route prior to the start of the placement to become familiar with key landmarks etc. You could suggest this strategy, but it is the student’s responsibility to do it. If the route is complex, some support might be required.
Guide Dogs for the Blind Association (GDBA) can provide mobility training in advance for guide dog users. You would need to give the student information about the placement well in advance to allow time for training to be arranged and undertaken.

Provide an accessible description of the route from local bus/rail connections.

It might be possible to access funding from the DSA to pay for taxis if transport is inconvenient or non-existent, or if the student is undertaking a community-based placement. We have been informed by DSA assessors that this is likely to be taken from the General Allowance and not the Travel Allowance (work placements are not necessarily recognised by the funding body as part of the programme of study and so they will not allow the Travel Allowance to be used for this purpose).

Living away from home/college

If the student is expected to move into accommodation during a placement, liaison between relevant staff (university and placement) is essential to ensure accessibility. The student should also speak to the Accommodation officer and ideally visit the accommodation in advance to facilitate orientation and mobility.

Room size and facilities may be important. A student may need space for access equipment/assistive technology e.g. a desktop CCTV/video magnifier. If the student is a guide dog user, facilities for a basket, water bowl and relief area must be provided. GDBA may be able to offer some mobility training locally and should be contacted for advice.

Timing of placements

Some partially sighted people experience ‘night blindness’ in low levels of light or at night making it difficult to negotiate environments during winter months when it gets dark early. This should be considered when allocating placements. Students experiencing night blindness should not be placed in settings that involve difficult journeys. If this situation is unavoidable, the student must be consulted and support organised in advance.

Specialist equipment

Students may need to use specialist equipment to participate fully in the placement. Many have their own portable equipment e.g. lap top computers, braille note takers, portable video magnifiers/close circuit televisions (CCTVs) which can be taken into the placement setting. If not, some items may need to be provided. Some universities
have funding to purchase equipment for these purposes. The Allied Health Professions Support Service can loan equipment on a short term basis if necessary.

Extra space may be needed in the department for larger pieces of equipment. Access technology is expensive and must be stored securely for insurance purposes.

Students can use a digital recorder during assessments to make verbal notes. These are used as a reminder when producing patient records. Students should be responsible for explaining to their patients the reasons for using what may be unfamiliar equipment and techniques.

**Access to information**

You should make sure that all information that is issued to students prior to, or during, the placement is available in their preferred format i.e. text, enlarged text, digital recording, in braille or an electronic copy. Detailed information on accessibility can be found in the Key Concepts document.

Most students who have a visual impairment will require reasonable adjustments to access and produce written information. This may involve a support worker, low vision equipment (e.g. a magnifier), video magnifier/CCTV, a computer with access technology, braille note taker or a combination of these. You must consider accessibility issues if you use electronic patient records or patient appointment systems.

Students should have developed, or be developing, personal strategies to deal with these issues. At the very least, they should have some ideas/suggestions as to which reasonable adjustments might be helpful.

**Guide Dog users**

Guide dogs are working dogs; do not treat them as pets. Do not distract or pet them whilst working (when wearing a harness) and you must ask for permission from the student before engaging with the dog. Additional facilities for Guide Dog users will be required. These might include:

- Allocated space for the dog in the staff room or ward office
- Water bowl
- Designated relief area
- Allocated time for exercising the dog

Contact Guide Dogs for the Blind for additional information.
Mobility
For the settings listed below, levels of mobility will depend on the complexity of the setting and the abilities of the student.

In the workplace:
Encourage students to visit the practice based setting before the placement begins. They can meet you and begin to learn the environment.

Induction:
Provide a slightly longer induction process to enable the student to negotiate the surroundings

Outpatients:
You could allocate one cubicle for the student's own use although this is not essential. Lighting levels may be an issue and some students may need more or less light whilst treating patients. If window blinds or curtains are fitted, this can provide flexibility; a task light should also be available if required.

The area should be kept tidy and all staff should be asked to return equipment to its designated place. This creates a predictable and safe working environment in which the student feels more secure. This will improve self-confidence and performance during the placement.

Inpatients:
If patients are spread over a number of wards, the student can be asked to concentrate on one or two of those wards to reduce mobility issues as long as this does not have an impact on the quality of the clinical experience.

Mobility and light levels:
Variation in light levels can cause mobility issues for some students when negotiating any environment. Slow visual accommodation can cause difficulties when going from a brightly lit to a dimly lit area and vice versa. Photophobia makes brightly lit areas difficult to navigate; dimly lit areas may also reduce available residual vision.

It is common practice in some areas for lights to be dimmed after lunch to enable patients to rest. For some partially sighted students, this makes the environment difficult to navigate and they are unable to read patient notes. In this situation, providing them with duties in alternative settings during this period can avoid this becoming an issue.
Alternative/modified techniques
Some students use alternative or modified techniques in their patient interventions. This is very variable and you need to discuss it with each student. Some examples include:

- the use of touch to explore the environment or to ascertain information about a patient’s condition/problems
- use of tactile markers on equipment such as therapeutic machinery and equipment
- working with a sighted colleague or Support Worker to check for patients’ particular signs/responses

Completing Patient Records and other documentation
There is a legal requirement, in both the public and private healthcare sectors, for clinicians to sign and date all entries in patients’ notes. Each entry should be followed by the recognised signature of the clinician who has treated the patient on that occasion. AHP students are not exempt from these regulations.

It is often assumed that visually impaired people cannot sign patient records and so are unable to fulfil their legal obligations. This is not the case. Many partially sighted people write legibly and can read their own and others’ handwriting; some can write legibly although they cannot read what they have written or any other handwritten script. Blind people, whose sight is affected by an accident or degenerative condition, retain the ability to write; those whose blindness is congenital are able to produce a ‘mark’ which, for legal purposes, is recognised as their signature.

Some visually impaired people require assistance to complete patient records (in print and electronically) and other relevant documentation such as Learning Contracts. Electronic versions of forms might improve access to all clinicians, including access technology users. Many electronic patient record/patient administration systems remain inaccessible to blind and partially sighted users because they are incompatible with available access technology.
Contact Us
We welcome enquiries by phone or email
Jane Owen Hutchinson
Manager, AHPSS

Mobile: 07748 657457
Email: jane.owenhutchinson@rnib.org.uk

Karen Atkinson
Manager, AHPSS Resource Centre
University of East London
Water Lane
Stratford
London, E15 4LZ

Tel: 0208 223 4950
Mobile: 07918197995
Email: k.a.atkinson@uel.ac.uk
Factsheet 3 - Mental health issues/difficulties

Suggestions for support

Adjustments may need to be implemented in a number of areas; it may also be necessary for you to modify your approach to help students participate fully in placements and to gain maximum benefit. The students should discuss and negotiate their adjustments with you (practice based and/or academic staff). A record should be kept of any agreed adjustments and signed by all parties. These arrangements will be different for each individual.

If a student is offered a range of possible modifications, but refuses to implement them, this should also be recorded and signed.

Disclosure

As with other disabilities, a student’s decision to disclose information about his or her mental health difficulties is purely personal.

You should ask all students whether they have any support needs – this provides them with opportunities to discuss any issues and indicates an open and non-judgmental approach within the department.

Some NHS settings provide training to enable you to support individuals who might disclose disabilities. All staff should attend these sessions. These issues may also be covered in training days provided by universities sending students on placement.

If students have disclosed, you should ask what kind of support would be most helpful. Different students and situations will require different strategies to increase access to information. At the end of the first week of placement, you should timetable a review to assess how effective and appropriate the strategies have been. Further changes may need to be negotiated as the placement progresses. A flexible approach is essential.

Anxiety – points to consider

All students will experience some degree of anxiety in relation to practice based placements.

Raised levels of anxiety are common in many mental health difficulties. The level of anxiety can vary. Some students experience ‘panic attacks’ when the level of fear rises suddenly and sharply (for example, when speaking in a group or being trapped in conversation with another person without having any natural exit).
Students who have high levels of anxiety can experience physical sensations: palpitations, sweating, stomach pains and headaches. They may find it very difficult to receive (even constructive) criticism. Due to low self-esteem they may sometimes abandon tasks and withdraw from participation in social situations.

Some students display an exaggerated concern for detail, for example, when receiving instructions or collecting information. They may strive for perfection in the preparation and presentation of information or the performance of practical skills. Very anxious students sometimes make what are considered to be excessive demands on practice educators for advice and support about matters that, to others, might appear trivial. Anxious students might encounter more difficulties on placement because it differs from other, more familiar, forms of study.

Planning and preparation can reduce levels of anxiety and enhance the experience for everyone. If the student feels confident enough to provide information in advance of the placement, this enables you to devise strategies that might reduce stress.

Offer students opportunities to talk about their concerns before the placement begins. This could be done by telephone or face to face if there is a pre-placement visit. A joint plan of action can be drawn up noting strategies that you and the student can use during the placement. If the issues do not become apparent until part way through the placement, arrange a discrete meeting with the student to establish the causes of anxiety. If a student has experienced panic attacks in the past, the fear of one occurring is often the main sensation or concern.

This process should result in a plan of support to be implemented during the placement including agreed ‘rules’ to create a more supportive structure for the student. For example:

- Agree places and times that the student can access you to discuss clinical issues
- Agree places and times that the student can access you to discuss issues around mental distress/anxiety
- Specific times for accessing academic staff who can also provide a degree of support
- Allocate formal times for teaching
- Provide alternatives to certain clinical activities as appropriate

This provides a helpful framework for you and other staff as well as students on the same placement. Adopt a positive attitude and provide as much encouragement as possible. All relevant staff (academic, clinical and/or Disability service) should be included in this process to provide a seamless approach to support for the student.
General points

By adopting the following general strategies you can provide a supportive environment:

- Be sensitive and responsive to the student’s potential needs
- Listen to the student’s concerns
- Offer practical advice
- Provide reassurance
- Show concern by following up conversations at a later time
- Ensure the student does not work alone OR
- Ensure the student does have time when s/he can work alone
- Enable the student to leave a particular situation or to go early on a particular day if s/he is unable to manage the experience
- Enable the student to access other staff for support as required
- Provide alternative locations for certain activities as requested if possible (e.g. a quiet area for writing up patient notes)
- Allow extra time for tasks if necessary
- Be aware that temporarily reducing workload may enable the student to continue on the placement
- Organise flexible work patterns to enable optimum performance
- Be aware that the student may need to take time out for appointments e.g. regular counselling sessions
- Be aware of ‘bad days’ and let the student work through them as s/he needs to (within the framework of the placement)
- Be aware of, and sensitive to, fluctuations in mood states and how this may affect the student’s interpretation of colleagues’ language and/or actions

If it is obvious that the student is experiencing an acute increase in mental distress, you should refer him/her as appropriate. The process for this will vary locally and you need to be aware of available resources. The student may already have a support network in place which could consist of the GP and/or a Crisis Resolution Home Treatment Team (CHRT). Sometimes a Psychiatric Liaison Team may need to be involved depending on circumstances. Information on these procedures should be identified and discussed during staff development sessions: this benefits both students and staff who may be experiencing mental distress. They should also be included in Practice Educator training days provided in HEIs. Some universities have excellent in house support systems for students with mental health difficulties. It is useful for you to be aware of these.

You should liaise with appropriate university staff if a distressed student is identified. This will ensure that you are supported throughout the episode. It will also ensure
that the student has appropriate levels of support whether or not s/he is able to continue on that particular placement.

Web links

Useful information can be found on the following websites:

www.mind.org.uk

www.mentalhealth.org.uk

www.rethink.org

www.sane.org.uk

Royal College of Psychiatrists (2011) CR166. The Mental Health of Students in Higher Education. Royal College of Psychiatrists, London (available http://www.rcpsych.ac.uk/publications/collegereports/cr/cr166.aspx)

Contact Us

We welcome enquiries by phone or email
Jane Owen Hutchinson
Manager, AHPSS
Mobile: 07748 657457  Email: jane.owenhutchinson@rnib.org.uk

Karen Atkinson
Manager, AHPSS Resource Centre
University of East London
Stratford Campus
Water Lane
Stratford
London, E15 4LZ  Tel: 0208 223 4950  Mobile: 07918197995
Email: k.a.atkinson@uel.ac.uk
Factsheet 4 - Students who are Deaf or hard of hearing

Suggestions for support

Adjustments may need to be implemented in a number of areas; it may also be necessary for you to modify your approach to help students participate fully in placements and to gain maximum benefit. The students should discuss and negotiate their adjustments with you (practice based and/or academic staff). A record should be kept of any agreed adjustments and signed by all parties. These arrangements will be different for each individual.

If a student is offered a range of possible modifications, but refuses to implement them, this should also be recorded and signed.

Disclosure

As with other disabilities, a student’s decision to disclose information about his or her impairment is purely personal.

You should ask all students whether they have any support needs – this provides them with opportunities to discuss any issues and indicates an open and non-judgmental approach within the department.

Some NHS settings provide training to enable you to support individuals who might disclose disabilities. All staff should attend these sessions. These issues may also be covered in training days provided by universities sending students on placement.

People who are Deaf or hard of hearing use preferred communication methods. When students have disclosed, you should ask what kind of support would be most helpful. Different students and situations will require different strategies to increase access to information. At the end of the first week of placement, you should timetable a review to assess how effective and appropriate the strategies have been. Further changes may need to be negotiated as the placement progresses. A flexible approach is essential.

Communicating with students who lip read

There are many ways that you can facilitate a lip reader to enable him/her to follow what is being said:

- Stand or sit facing the student, three to six feet away, and at the same level as him/her
Check that the student is looking before starting to speak. A strategy for attracting attention could be negotiated e.g. touching the student’s arm or shoulder. It may startle the student if someone suddenly approaches him/her from behind.

Face the light: do not stand in front of a bright light source.

Ideally, there should be no distractions behind the speaker e.g. people moving around or brightly patterned wallpaper.

Do not obscure the mouth with objects, such as pens or cups and do not eat whilst speaking.

Keep background noise to a minimum.

Do not shout - this distorts the voice and lip patterns. Speech should be clear with a normal rhythm.

Sentences and phrases are easier to lipread than single words.

Rephrasing is necessary if the student does not understand what is being said.

Provide the student with time in which to absorb what has been said.

Keep your head still and stop talking if you turn away.

Mouth movements and facial expressions should be clear and not exaggerated or misleading.

Gestures should be used where relevant.

Remember the access needs of Deaf and hard of hearing people when speaking to a group comprising students who are Deaf/hard of hearing and those who can hear.

Ensure that the student knows when the subject changes.

Check that the student is following what is being said.

When a student cannot hear what is being said, attention may appear to drift and the assumption made that the student is not concentrating. This rarely the case; rather, it is more likely to be due to lip reading being tiring. Keep periods of talking short or break sessions up into sections to allow time for resting.

Write down any points that need to be clarified.

Teaching sessions

Keep the following points in mind when planning teaching sessions:

- If the session introduces a large amount of new terminology, provide a glossary of key terms.
- Lip reading is easier when the subject area is known: provide a lecture/session summary in advance or at the start of the session so that students can concentrate on the speaker. The student cannot take notes and follow what is being said simultaneously.
- Projection of PowerPoint slides onto a screen allow you to face students throughout the session.
Avoid showing slides in a darkened room as the speaker’s lip movements or the interpreter’s hand movements cannot be seen. If unavoidable, shine a light source onto the speaker or the interpreter to facilitate information transfer.

- Provide copies of the slides in advance of the session.
- Use captioned DVDs/videos or provide the student with a transcript/brief synopsis (if the commentary is particularly important).
- Make it clear whether handouts provided during the session are to be read immediately (in which case time needs to be allowed for this) or whether they should be taken away and read in the student’s own time. If the information is needed in the teaching session, provide the information in advance.
- Provide important information on paper or in electronic format as a back up to a verbal presentation.
- Stop speaking when turning to write on a board or flipchart.
- Allow time for students to absorb information.
- Break up the learning session to allow for information processing.

### Group work

Participation in group work raises communication issues for students who are Deaf/hard of hearing. Following discussions in a large group can be difficult, particularly if students cannot see each speaker. If you are using a radio microphone or loop system, this eliminates background sounds and can cut out other students’ contributions, especially if they are sitting behind the Deaf/hard of hearing student. This means that parts of the discussion might be missed.

Consider the following points if students who are Deaf/hard of hearing are in your group:

- Where possible, keep numbers low: if there are more than 6 – 10 participants, it will be difficult for the student to lipread everyone and to follow the flow of contributions.
- Arrange the group in a circle or horseshoe formation, ensuring that nobody is silhouetted against the light.
- The student may prefer to sit next to you as comments will often be directed that way.
- Participants should take turns in speaking and allow the student time to look in their direction before starting to speak.
- Provide some repetition or summaries of contributions from other participants to allow the student to follow the discussion.
- Ensure that all contributors to the discussion speak into the microphone if you are using a radio microphone or loop system. Ensure that group members are aware of the potential distraction caused by background noises, e.g. clicking pens or rustling paper, especially for people using a hearing aid.
Practical situations

You might find the following strategies helpful:

- Don’t stand behind the student when s/he is working practically. The student will be unaware when you are speaking and will have to turn away from the activity to find out
- Don’t expect the student to lipread and continue with the practical/clinical work or observations at the same time
- Attract the student’s attention prior to beginning an explanation/discussion if a practical technique is being demonstrated
- Ensure that the student can see both what is being said and what is being done during practical demonstrations

Physical environment

- Fundamental alterations to the environment in the practice based setting are generally not possible. When you are arranging teaching sessions or one-to-one tutorials, the choice of room can make a considerable difference to the level of student participation.

The following strategies can be helpful:

- The speaker’s face should be well lit
- If possible the environment should be quiet - certain levels and types of background noise can make communication difficult
- Rooms that are carpeted, that have soft furnishings and ceiling tiles are better for people who are hard of hearing. These items reduce echo and absorb incidental sound
- Where available use teaching rooms that are fitted with induction loop systems
- Try to avoid using rooms with bright or distracting décor as this can affect concentration when lip reading

It is helpful if there is a quiet area where the student can work e.g. for writing up patient notes; this reduces the distractions of background noise.

Contact Us

We welcome enquiries by phone or email
Jane Owen Hutchinson
Manager, AHPSS
Mobile: 07748 657457  Email: jane.owenhutchinson@rnib.org.uk
Factsheet 5 – Long term health conditions and physical disabilities

Suggestions for support

Adjustments may need to be implemented in a number of areas; it may also be necessary for you to modify your approach to help students participate fully in placements and to gain maximum benefit. The students should discuss and negotiate their adjustments with you (practice based and/or academic staff). A record should be kept of any agreed adjustments and signed by all parties. These arrangements will be different for each individual.

If a student is offered a range of possible modifications, but refuses to implement them, this should also be recorded and signed.

Disclosure

As with other disabilities, a student’s decision to disclose information about his or her impairment or health condition is purely personal.

You should ask all students whether they have any support needs – this provides them with opportunities to discuss any issues and indicates an open and non-judgmental approach within the department.

Some NHS settings provide training to enable you to support individuals who might disclose disabilities. All staff should attend these sessions. These issues may also be covered in training days provided by universities sending students on placement.

When students have disclosed, you should ask what kind of support would be most helpful. Different students and situations will require different strategies to increase access to information. At the end of the first week of placement, you should timetable a review to assess how effective and appropriate the strategies have been. Further changes may need to be negotiated as the placement progresses. A flexible approach is essential.

Background

Although there are many similarities between long term health conditions and physical disabilities, there are significant differences that make it relevant to consider them separately.
Long Term Health Conditions

You are likely to have experience of supervising AHP students who have a range of health conditions. These may or may not have been declared by the student whilst on placement as they may have no impact in that situation. The range and variety of support for students who have health conditions is considerable. Many of them could be included in this category if they are considered to have substantial, adverse and long term effects on the student’s ability to carry out normal day-to-day activities.

Long term health conditions include:

- Diabetes
- Epilepsy
- Chronic fatigue syndrome
- Symptoms resulting from AIDS
- Multiple sclerosis
- Glandular fever
- Various forms of arthritis

You need to deal with each student on an individual basis as the requirements of each will be different. You can apply many of the fundamental guidelines detailed in the other fact sheets to provide a framework for formulating a plan of support.

In general terms

An open and non-judgmental approach is the key for students who:

- Require time out for medical appointments
- Request flexible work patterns
- Need regular work patterns with set breaks to allow for regular food intake
- Use appropriately modified techniques

Any reasonable adjustments should be negotiated and agreed with the student prior to the placement. All relevant staff (academic, practice based and/or Disability Service) should be involved in this process. If you adopt an open attitude to these issues this will encourage the student to approach you early enough to avoid the development of difficulties.
Epilepsy

Due to specific requests and as a result of general uncertainty about epilepsy, some specific facts and suggestions for support are provided here.

Background

Epilepsy is a neurological condition that can affect anyone, at any age. One in every 131 people in the UK has epilepsy and the impact of this varies from person to person. While some people have regular seizures, up to 70% of people who have epilepsy stop having seizures as soon as the appropriate medication is being taken. In this case, their epilepsy may have little or no effect on their performance in the placement setting. Many students may hold a driving licence. The current driving regulations state that a person can apply for a driving licence when s/he has been completely free of seizures for one year or has had a pattern of sleep seizures only for three years.

NB: Regarding employment legislation: advertisements which state that the post involves travel, it is illegal, under the legislation, for the employer to stipulate here or in the person specification that a ‘driving licence is essential’ unless there is no other way in which the requirements of the post could be fulfilled. For example, if an employee who has epilepsy is asked to travel to various locations and is unable to drive, the employer must make a ‘reasonable adjustment’ and permit the use of public transport and/or taxis.

Consider each student’s situation individually and realistically. Base all of your decisions on fact. If a student decides to disclose, you should talk to that student about the condition and find out in which ways it may affect work-related duties. Avoid making assumptions about how the condition affects an individual.

People who have epilepsy work successfully in most practice settings. Within the allied health setting, a risk assessment may need to be carried out. This is important if the person does have seizures and if the placement involves working alone, particularly with vulnerable groups such as elderly patients or children. This situation is unlikely to arise on practice placements as students are usually under supervision or working with other staff.

Independent research suggests that people who have epilepsy have excellent attendance records at work and that absence through sickness is no better or worse than that of the working population as a whole (Epilepsy Action 2001). If a student does need to take time off - for example, to attend a medical appointment or to recover from a seizure - this is considered to be a reasonable adjustment. Such
absence is usually recorded separately to time off for other reasons, for example, sick leave for a cold (National Society for Epilepsy 2008).

**Student responsibility**

Under the Health and Safety Act, students have a duty to ensure that they and others are as safe as possible in the practice setting. They should inform you if:

- They believe that there is any possibility that they may be a danger to themselves or others if they had a seizure whilst on placement
- They believe that their duties need to be changed to accommodate a potential risk

This enables you to allocate appropriate work in discussion with the student and other relevant staff (academic, clinical and/or Disability service).

Students may also decide to disclose for the following reasons:

- so that colleagues are aware of how to offer appropriate help if they have a seizure
- to challenge inaccurate ideas and general misconceptions about epilepsy (adopting such a positive and pragmatic approach takes a considerable amount of courage on the part of a student who is entering what is an already stressful environment.)

If the epilepsy is well controlled and the person is seizure free, there is no need to disclose.

**Some useful questions**

If a student does disclose, you can use the following questions to explore appropriate reasonable adjustments:

- What type of epilepsy do you have?
- Do you have any seizures?
- What are the seizures like, how often do they occur and how do they affect you?
- Do you have any warning before a seizure (sometimes called an aura)?
- Do you lose consciousness and what effect does this have?
- Do we need to call an ambulance and who would be responsible for this?
- How long does it take you to recover from a seizure? Some people can return to work quickly and others may need more time.
- Are the seizures triggered by particular factors, such as tiredness or stress?
Do you take medication to control the seizures and what effect does this have? Do you feel tired or find it hard to concentrate?

**Effects on memory and possible strategies**

People who have epilepsy may notice that their memory is affected; this can be as a result of seizures and/or anti-epileptic medication that they are taking.

**Some useful strategies:**

- Following a set routine - this helps to improve memory. Students can get used to what to expect at certain times of the day, which helps to reduce the demands placed on their memory. Many people find it useful to make a note of regular activities in a diary or calendar.
- Adapting surroundings – this means there is less need to use memory which, in turn, reduces stress. Strategies could include keeping a note pad by the phone for messages; using a notice board to record important information; allocating a particular place to keep things and always putting them in the same place; labelling shelves/cupboards as a reminder of what items are stored there. Adopting this strategy benefits everyone.
- There is a wide range of external memory aids. These include: diaries; notebooks; making lists; alarm clocks or timers; mobile phones with alarms; calendars; wall charts or wipe clean memo boards; digital recorders; electronic organisers; pill reminder boxes for medication; Post-It notes.
- Mnemonics - a mnemonic is a verbal or visual aid which facilitates memorisation of information, e.g. sayings, rhymes or pictures. Some people find pairing items visually can be useful; other people try to remember information in the form of a story they have made up. These are suggestions only. Students should be encouraged to be imaginative and use techniques that are personally relevant and work for them.
- Improving well-being: living with memory problems can cause feelings of vulnerability which in turn can result in reduced self-confidence leading to anxiety. Anxiety management and the use of relaxation techniques can therefore be beneficial.

(Epilepsy Society 2012)
Web links

http://www.epilepsy.org.uk/employment

http://www.epilepsysociety.org.uk

Physical disabilities

Issues relating to physical disabilities are wide ranging and appropriate support will depend on individual requirements. Again, the general guidelines detailed in other fact sheets provide a framework that you can use.

Some issues that you should consider:

- Physical access to the workplace itself and navigation around the premises
- Availability and type of public transport especially if the placement is in the Community
- Availability of parking spaces for disabled users
- Location and security of specialist equipment
- Modification of treatment techniques possibly including the help of a support worker
- Flexible working practices
Contact Us

We welcome enquiries by phone or email

Jane Owen Hutchinson
Manager, AHPSS

Mobile: 07748 657457
Email: jane.owenhutchinson@rnib.org.uk

Karen Atkinson
Manager, AHPSS Resource Centre
University of East London
Stratford Campus
Water Lane
Stratford
London, E15 4LZ

Tel: 0208 223 4950
Mobile: 07918197995
Email: k.a.atkinson@uel.ac.uk
References


Birnie J. Grant A. (2001) Providing Learning Support for students with Mental Health Difficulties Undertaking Fieldwork and Related Activities


Royal National Institute of Blind People (2006), The Benefits of Registering as Blind or Partially Sighted. RNIB, London


Contact Us
We welcome enquiries by phone or email
Jane Owen Hutchinson
Email: jane.owenhutchinson@rnib.org.uk

Karen Atkinson
University of East London
Stratford Campus
Water Lane
Stratford
London, E15 4LZ
Tel: 0208 223 4950
Email: k.a.atkinson@uel.ac.uk
Acknowledgment

The Allied Health Professions Support Service (AHPSS) was launched in 1991 in response to the closure of the Royal National Institute for Blind People's (RNIB) School of Physiotherapy which catered exclusively for visually impaired students. AHPSS's remit was to provide support to disabled allied health profession students in mainstream higher education in the UK. It also offered information, advice and specialised disability awareness training to academic and practice-based staff.

In 2002, AHPSS staff were invited by the Chartered Society of Physiotherapy (CSP) to join a team of specialists to produce a training manual specifically designed to provide guidance for practice based staff in supporting disabled students on practice based placements. The document: "Supporting Physiotherapy Students on Clinical Placement", was published in 2004 and received very positive feedback from all stakeholders.

By 2007, it was evident that the document needed updating in response to UK legislative and technological changes and the increasing use of online information. Following discussions with CSP staff, it was agreed that the AHPSS team (Jane Owen Hutchinson, AHPSS Manager and Karen Atkinson, Senior Lecturer and Manager of the RNIB Resource Centre at the University of East London), would take on this project.

Between 2007 and 2010, considerable time was spent in obtaining feedback from a wide range of stakeholders regarding the content and format of the future document. Whist it was unanimously agreed that it should be available in both hard copy and electronically, all staff identified the importance of being able to access some of the specific guidance on disability management from the AHPSS website.

"Into Physiotherapy" was published by the CSP and RNIB in 2010. Thirteen related information sheets were subsequently uploaded onto the AHPSS website (between 2010 and 2013), at which point the AHPSS was decommissioned by NHS London. As a result of the positive feedback these fact sheets received and requests from a number of organisations, Jane Owen Hutchinson and Karen Atkinson have given permission for these materials to continue to be available online.