CHANGING PRACTICES

Arveen Bajaj takes a look at the Disability Discrimination Act and what it means for dental surgeries.

From the 1st of October this year, providers of dentistry all over the UK will be expected to take reasonable steps to make their practices accessible to people who are disabled. They will be expected to remove, alter or provide means of avoiding physical features that make it impossible or unreasonably difficult for disabled people to use their services.

This will include possible alterations to the design or construction of the building, the approach and access to and exit from the building - for example disabled parking bays and ramp access for wheelchairs and fixtures and fittings, furniture and furnishings and equipment and materials.

The changes stem from the Disability Discrimination Act 1995 (DDA). Under the act, it is unlawful to treat a disabled person less favourably for a reason related to that person's disability (unless it can be justified). The Act defines a disabled person as 'A person who has or has had a physical or mental impairment which has a substantial and long-term adverse effect upon his or her ability to carry out normal day-to-day activities.'

The first set of rights under the goods, facilities and services part of the DDA came into force in 1996, and part II came into force in October 1999. This stipulated that service providers should amend their policies, procedures and practices, provide auxiliary aids or services and provide methods round physical barriers to a person with a disability.

For example, a 'no dogs' policy or rule would have to be amended to allow entry to service animals such as guide dogs or hearing dogs.

The requirements mean that dentists will have to take reasonable steps to provide auxiliary aids or services, which will enable disabled people to make use of their service. So, for example, when carrying out any treatment, the dentist should make a point of looking straight at a deaf or partially deaf patient, speaking clearly, removing any mask to allow the patient to see the mouth.

Where physical barriers make it impossible or unreasonably difficult for disabled people to use a service, the dentist will be expected to take reasonable steps to provide the service by a reasonable alternative method. So, for example, where the treatment rooms of the practice are upstairs and are inaccessible for those in wheelchairs and there is no possibility of using a ground floor surgery, a reasonable alternative may be to carry out a domiciliary visit if possible/appropriate or to refer a patient to an alternative practice with adequate facilities.

On 1st October 2004 Part III of the Act comes into place. Providers will be expected to take reasonable steps to remove, alter or provide means of avoiding physical features that make it impossible or unreasonably difficult for disabled people to use their services.

This will include possible alterations to the design or construction of the building, the approach and access to and exit from the building, eg disabled parking bays and ramp access for wheelchairs and the fixtures and fittings, furniture and furnishings and equipment and materials.

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While newer practices may have had the opportunity to incorporate the guidelines on disability into their new practices, older practices may be looking at physically restructuring their practices to make them more accessible to those with disabilities.

One such practice is Oasis Dental Care in Sutton-in-Ashfield. Associate dentist at the practice Dr Ralph Davies says: 'Changing the practice in order to comply to the DDA guidelines was a frightening prospect and a considerable worry. I was concerned as to what would be challenged, what was reasonable to change and what would happen if my practice could not be adapted to comply.'

He explained that the practice had steep entrance stairs, different levels, narrow doors, and that spending £100k would not get it compliant.

Instead he decided to move premises to a property for sale by tender in the town centre. 'This new property had huge potential, and nine new surgeries were possible with five on the ground floor as well as disabled and staff parking. It did need gutting and internal rebuild which would cost around £200k' he says.

With the help of a local businessman who wanted to invest in the venture, Dr Davies went ahead with the move. The businessman bought the premises, which the practice then rented, which gave them time to plan for the new space.

When thinking about the 'patient journey' to the practice, a lot of thought was put into difficulties that a disabled patient might encounter. For example, a portion of the reception counter was lowered so that it could give access to a wheelchair user.

Oasis Dental provides eye level access for wheelchair users

'Since the move to the new premises, the practice has had positive feedback from patients with disabilities.'

There was access to a disabled toilet, and the waiting room also had room for a wheelchair to manoeuvre, as did the surgeries themselves.

Dr Davies says, 'While infra-red loops can be used for those hard of hearing, they can be confined to one room and patient confidentiality is potential problem. One answer would be to train the staff in sign language in order to overcome this, and for staff to lower their masks when talking to the patient so that they can lip-read.'

The surgery had contrasting coloured walls in each room as well as contrasting architraves so that the partially sighted could differentiate between them. Signage should also be large, and braille inserts could help partially sighted people get around the practice more easily. Large print information and patient leaflets were made available in the waiting room.

He added, 'One sobering thought is that were one of the staff ever to become disabled, would the surgery be able to accommodate them? For this reason the staff spaces were well thought out to have as much room as possible.'

According to Dr Davies, since the move to the new premises, the practice has had positive feedback from patients with disabilities. 'We have also has a large increase in the number of disabled patients seen,' he says.

Guidelines suggest that it is advisable for the dentist to know what would be deemed reasonable and justify a refusal to comply with the provisions of the DDA. Although there are guidelines set out in the codes of practice issued by the Disability Rights Commission, ultimately the definition will be a matter for judicial decision when cases are brought to court. It is recommended that an access audit is carried out before any structural alterations are performed. Some of the guidelines for reasonableness include the type and nature of service provided, the size and resources of the service provider and the effect that a refusal would have on the disabled person.

In some cases, practices may wish to take steps to comply with the remaining duties in relation to physical features as they come into force in 2004, that is altering or removing a physical feature so that it no longer has the effect of making it impossible or unreasonably difficult for disabled people to use the services of the dentist (including providing an auxiliary aid which involves an alteration to the physical fabric of the building).

For example, when planning and executing building or refurbishment works to practice premises, such as an extension or making structural alterations to an existing building, it would be advisable to consider the removal or alteration of physical features which create a barrier to access for disabled people or the provision of a reasonable means of avoiding the physical feature, even though the law does not yet require this.

The Disability Rights Commission in partnership with BT, has developed an online interactive Self Appraisal Toolkit for small and medium sized businesses to enable them to identify areas where business development could help them respond positively to the requirements of the Act which can be visited at www.disabilityaware.org

The Code of Practice for the DDA is available from any branch of the Stationery Office or through the Government's mail order line 0870 600 5533. The Act is available at http://www.legislation.hmso.gov.uk/acts/acts1995/1995050.htm.

See page 54 for a list of practical steps practices can take to comply with the Act.

PRACTICAL STEPS

Improving access for disabled patients

From October 2004 service providers will have to make reasonable structural alterations to accommodate disabled patients. **Peter Fyne** looks at some practical steps dental practices can take.

The following simple, practical measures can help disabled users to access dental services. The steps follow a patient's pathway to and through your practice.

Are patients able to find the entrance easily?

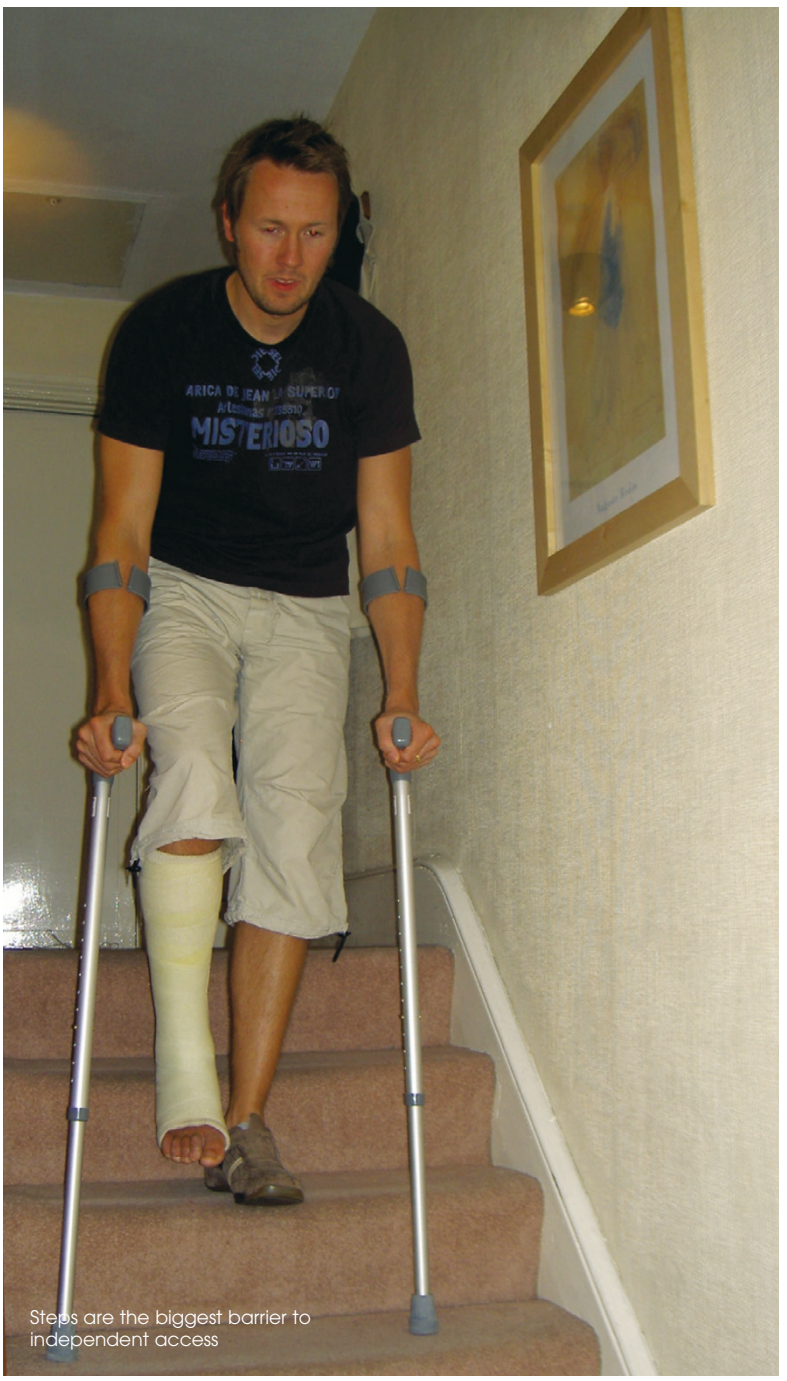
The entrance should be easy to find from the street, car park or other routes to the building. Possible adjustments include:

- Adding clear directional signs with the street name, number and telephone number.
- A hanging sign above the entrance, if planning permission allows
- Painting the door frame a contrasting colour helps
- Relocate the main entrance where it is easily identifiable
- A rear or side entrance nearby might be an accessible entrance for wheelchair users.
- Improved external lighting
- Extra-wide parking bays for the disabled,
- Surfaces should be free of trip hazards, firm and not slippery.

External steps

Steps are the biggest barrier to independent access. Try:

- Raising a section of the pavement to the level of the door; this may be difficult, so negotiate with the local authority
- An external ramp, preferably permanent, if there is sufficient space
- An internal ramp if there is sufficient space
- Temporary ramps, available from commercial suppliers, need to be firm and secure and stored somewhere when not in use



Steps are the biggest barrier to independent access

- Handrails should be fitted for disabled persons who do not use wheelchairs and steps clearly marked
- Paint a strip of colour on the edge of steps, which contrasts with the main part of the step, and
- Improve the lighting.

Call bells

A call bell or entry phone system, at a suitable height for wheelchair users, could be installed to alert staff. For those with visual impairment, there should be a visible indication, eg a flashing light, to show that the call has been answered or the door catch released.

Doors

- Door thresholds should be flush. The recommended maximum is for a 13mm lip
- Doors should be wide enough to clear double buggies and wheelchairs
- Door handles should be at a convenient height
- Entrance mats should be flush
- Glazed doors should have clear safety markings
- Door closers should be regularly maintained .

Emergency exits

Practices should have a strategy to enable disabled patients to escape from the building eg flashing light alarms and special aids such as evacuation chairs to carry people downstairs:

- Keep exits free of obstruction
- Ensure all alarm systems are in working order and procedures are in place and tested regularly
- Ensure that new staff are trained with attention to assisting patients with visual or mobility impairments.

Layout of the practice

The internal structure design, the location of shelves, display cabinets and reception desks should meet the requirements of patients with disabilities.

For example:

- Floors, walls, ceilings and door frames can be distinguished by using contrasting colours
- Signs should be easily located, simple, short and easy to read
- Reception desks should be positioned away from windows and part of the desk should be at a level where a patient sitting in a wheelchair can enjoy face-to-face communication with the receptionist and lean on to sign cheques etc. To help those who lipread, the desk should be where staff members will not be put in shadow by bright sunshine
- In cases where it is not possible to create the physical conditions in which customers with different disabilities can move around easily and safely, it would be reasonable to provide staff assistance.

If it is not possible to make reception desks or display cabinets fully accessible, it may be possible to alter working practices. Staff could come out from behind the desk to meet a wheelchair-using patient and carry out transactions in this way. They could get items down from inaccessible cabinets or shelving for patients to look at.

It is important that there is adequate space for wheelchair users to manoeuvre through aisles and corridors. The recommended width is 1200mm.

- Keep aisles, corridors, areas near doors and other circulation space as uncluttered as possible.
- Fit handrails where there is one or more internal step or internal ramp.
- The edges of internal steps could be clearly marked with a contrasting colour
- Poorly fitted mats should be relayed and uneven junctions of floor surfaces should be repaired
- Surfaces should retain their slip resistance.

Waiting areas and seating

Provide a mixture of seating with and without armrests and at a range of heights. Consider the positioning of furniture in the waiting areas so that there is space for a wheelchair user to pull up alongside a seated companion. Announcement systems should be both visible and audible so that they can be understood by customers with hearing and visual impairments.

Lighting

- Highlight hazardous areas with additional lighting in places like stairwells or changes in floor level
- Maximise light by ensuring windows, lamps and blinds are kept clean and used light bulbs are promptly replaced
- Where there are large surfaces of white or highly reflective finish, glare and reflection could be a problem for patients with partial sight. It is advisable to adjust or relocate the lighting to reduce those effects, and
- Lights should not cause undue glare or reflections, so avoid glass where possible.

Communicating with staff

Improvements to enhance communication for people with hearing impairments can be undertaken. Some are simple, such as induction loops, whilst others are more complicated, such as infrared systems. Keeping background noise to a minimum helps. You might consider putting in sound insulation and avoiding too many hard surfaces. A member of staff may learn sign language.

- Improve lighting conditions to allow patients to lip read easier
- Use alternative means of communication where induction loops are not possible eg a voice enhancement system or exchange of written notes. Sometimes it may be necessary to provide a British Sign Language interpreter for the patient
- Look straight at patients and be careful not to cover your mouth when speaking. Allow extra time and repeat back to the patient to check accuracy and understanding
- It may be possible to separate quiet and noisy areas by planning the use of practice space to benefit all patients, particularly those with hearing impairments.

Publications

The Disability Rights Commission provides the following publications free of charge:

Making Access to Goods and Services Easier for Disabled Customers: A Practical Guide for Small Businesses and Other Service Providers

Good Signs - Improving Signs for People with a Learning Disability

Improving the services dentists provide to disabled people

Contact the Disability Rights Commission, www.drc-gb.org or phone 08457 622 633.

The test of reasonableness underpins the rules. Some suggestions may not be possible if, for example, your practice is a listed building. If your dentist is a BDA member advice on this is available from BDA Professional Services, phone 020 7563 4154.