Increasing Accessibility in Healthcare Delivery for Persons with Vision Loss: Companion Guide

Module 3: I've got this!

Unit 1: Building Positive and Respectful Relationships

Please note:

This Companion Guide is a resource created to complement the online modules.

This module was developed by a group of community members, healthcare providers, educators, and vision loss and blindness organizations in collaboration with the Queen's University Course Development team within the Office of Professional Development and Educational Scholarship. This project is made possible with funding by the Government of Ontario and through eCampus Ontario's support of the Virtual Learning Strategy. To learn more about the Virtual Learning Strategy visit the eCampus Ontario website.

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Table of Contents

Introduction....5
Improving the learner experience....5
Accessibility tips and disclaimers....5
Introduction to Unit 1....6
A note on language....6
Introduction to Module 3....8
Module 3 learning outcomes....8
Course icons....9
Media features....9
Download your answers and feedback to questions....10
Case: I've got this!....12
Video: Introduction to the case....12
Case question: Observations....13
Decreased visual function: A few examples....14
Video: Vision loss simulations....16
Visual perceptual or processing difficulties....18
Video: Visual perception and processing....19
Signs of possible vision loss....22
Signs of possible vision loss: Reactions to spaces and materials....23
Signs of possible vision loss: Social interactions....25
Signs of possible vision loss: Emotional responses....26
Case question: Quinn's experience....28

Feedback: Quinn's experience 29
Case question: Dan's experience 29
Feedback: Dan's experience 29
Patronizing behaviours 30
Infantilization 31
Elderspeak 33
How do people judge patronizing behaviour? 34
Possible impacts of patronizing language 36
Reflection activity: Impact of patronizing behaviour 37
Video: Interview with Quinn 38
Video: Interview with Dan 39
Case question: Factors influencing the healthcare scenario 40
Feedback: Factors influencing the healthcare scenario 40
Case question: Reimagining Quinn's experience 42
Feedback: Reimagining Quinn's experience 42
Case question: Creating change 43
Feedback: Creating change 44
Video: Quinn shares what works for him 45
Video: Dan shares what he learned 46
Video: Case with a better outcome 47
Module Conclusion 49
Module 3: Summary 49
Credits 49
Contributors: Content Curation 50

Contributors: Case Videos 51

Feedback 51

Introduction

Please see the online learning module for the full experience of interactions within this document.

Improving the learner experience

This content was retrieved from Introduction Slide 2 of 9 of the online learning module.

This module has undergone accessibility testing, with a specific focus on screen reading software testing and how the module responds to visual changes. While the modules should work for screen reader users, we have come across a few unexpected compatibility issues that we will be looking into further.

Continue to learn about some accessibility tips and disclaimers.

Accessibility tips and disclaimers – *Refer to pages 5-6*

Accessibility tips and disclaimers

Subpage of Introduction Slide 2 of 9 – Accessibility tips and disclaimers 1/1

1. While the module appears compatible with standard screen readers, there are some compatibility issues with ZoomText screen magnifier's App Reader function.
2. The slides do not respond to all inverted colour schemes.
3. The zoom controls built into your device/browser may seem to be counterintuitive. For example, the keyboard shortcut for increasing the zoom (CTRL – PLUS SIGN) will make menu text larger, which will result in a smaller slide. Similarly, the keyboard shortcut to decrease the zoom (CTRL – MINUS

SIGN) will make the menu text smaller, and then make the slide larger.

Note: Additional resources to support your accessibility were made available together with this module in eCampus Ontario's Open Library. Please check in with your instructor/teacher who is sharing these modules and/or check out the website to discover more resources.

Introduction to Unit 1

This content was retrieved from Introduction Slide 3 of 9 of the online learning module.

Welcome to the **Building Positive and Respectful Relationships** unit of 'Increasing Accessibility in Healthcare Delivery for Persons with Vision Loss.'

In this unit, you will explore some basic principles to apply during initial interactions with people with blindness or low vision. Each module in the unit includes a case that illustrates key ideas. You will be guided to reflect on interactions between a person and a healthcare worker that are captured in case videos. You will also get a chance to explore new information to support your learning. The reflection questions in each module were created to help you identify strategies that you can apply in day-to-day interactions with all clients.

While you can choose the order in which you go through the modules, the modules have been organized in an order we feel will best support learners who are new to these topics.

A note on language

This content was retrieved from Introduction Slide 4 of 9 of the online learning module.

You will see a variety of terms used to refer to the experience of blindness or partial sight. Terms include vision loss, sight loss, low vision, blindness, and partially sighted. Deafblindness and dual sensory loss will be used when deafness or hearing loss is also present.

Continue to learn more about the language we chose to use in the modules.

“Vision loss" terminology

The single umbrella term “vision loss” will sometimes be used to represent blindness, low vision, and other types of vision loss. However, we know someone born with low vision or blindness may not have “lost” their vision so may not personally use the term “vision loss.” As such, the language in the module will sometimes switch between terms to find a balance between readability and representing different perspectives.

Language use and disability

In the modules, person-first language (person with blindness, person with vision loss) will be used instead of disability-first language (blind person, deafblind person, partially sighted person). Person-first language is used to recognize that everyone is a person first, not solely defined by blindness or vision loss.

However, clients you meet could use either approach. Disability-first language (“As a blind person, I …” versus “As a person who is blind, I …”) is often used to recognize disability as an aspect of diversity worthy of recognition.

Introduction to Module 3

This content was retrieved from Introduction Slide 5 of 9 of the online learning module.

In Module 3 you will observe a man with vision loss and the reception he gets when he enters a health clinic for an appointment. Content of this module includes an introduction to different ways vision loss may look to the person with vision loss, some behaviours and emotional responses that could be clues to possible vision loss, and patronizing behaviour and the effect it can have.

You will get a chance to reflect on a case scenario to identify ways to offer assistance while respecting personal agency, and approaches to prompt change in your organization.

Module 3 learning outcomes

This content was retrieved from Introduction Slide 6 of 9 of the online learning module.

By the end of this module, you will:

- Identify different ways vision loss may look for people with different conditions
- Distinguish between visual function and visual perception
- Describe some of the behaviours and emotions that could suggest a person has vision loss, as well as what environments or interactions might prompt these responses
- Define infantilization and elderspeak (examples of patronizing behaviour and communication)
- Analyze a case scenario to identify possible improvements to improve patient care

- Identify change strategies to apply to your own work

Course icons

This content was retrieved from Introduction Slide 7 of 9 of the online learning module.

As you navigate the 'Increasing Accessibility in Healthcare Delivery for Persons with Vision Loss' modules, you will come across these course icons.

Continue to learn about each tools role in the course.

References: This icon lives in the sidebar of the slide. Selecting it will reveal the references for content and/or images on the slide.

Definition: When you encounter a word that is bold with an indicator symbol, navigate to/select the word to reveal a definition. Select the 'X' to close the definition layer.
Example Definition*

Audio clip: This icon indicates the presence of an audio clip on the slide. To play the audio clip, select the play button. Full transcripts and closed captions are available.

Definition*:

Example Definition: This is an example of how the definition will appear on the slide.

Media features

This content was retrieved from Introduction Slide 8 of 9 of the online learning module.

Video and audio will be used throughout the modules.

Continue to learn about the different media features available to you.

Play/pause

Select this button to play or pause the media.

Timestamp

The timestamp indicates how long the media has been playing.

Volume

Select this button to change the audio volume.

Closed captions

Select this button to turn on closed captions.

Playback speed

Select this button to open the media in a new smaller window in the bottom right of the screen.

Pop-out layer

Select this button to open the media in a new smaller window in the bottom right of the screen.

Fullscreen

Select this button to expand the video to fullscreen.

Transcript

Transcripts are available for videos and audios. In some cases, you may need to select the indicated button to view the transcript.

Download your answers and feedback to questions

This content was retrieved from Introduction Slide 9 of 9 of the online learning module.

You will be asked questions throughout this module that will test your learning of module content and invite you to reflect on the videos in the case and healthcare scenarios in your work.

At the end of each module, you will have the opportunity to download your answers and feedback to the questions. Because many questions are designed to give you the chance to brainstorm ideas for application in your personal practice, you are encouraged to download your answers to questions for future reference.

Case: I've got this!

Video: Introduction to the case

This content was retrieved from Section 01 Slide 2 of 30 of the online learning module.

In this case, you will explore an interaction between Quinn, a client, and Dan, a healthcare provider, interacting in a waiting room.

Watch the video to explore the case scenario.

Please see the online learning module to view this video.

As you watch: Consider the interaction from the perspectives of both the client and the healthcare provider.

Also, consider how the situation might be challenging for someone with vision loss, either because of how the environment is set up, the behaviour of other people, or what is expected of the client in that setting.

I've got this!: Introduction to the case

Start of Video Transcript:

[Dan] Oh, hey! Are you okay? Here, do you know where you are going?

[Quinn] Yeah, I'm here, aren't I?

[Dan] Yeah. Here why don't I show you to this seat here.

[Quinn] It's okay man. I can see the seat. It's alright.

[Dan] Okay. Oh, sorry just this chair will sometimes slip on the floor. I just...

[Quinn] It's okay. Just take it easy, alright. I'm all good.

[Dan] Okay.

[Quinn] Can you please let Dr. Khan know that his 10:00's here, please?

[Dan] Yeah. Yeah, I'll let him know.

[Quinn] Thanks.

[Jamie] What's with that guy?

[Dan] Not sure, but he has an appointment with Dr. Khan.

[Jamie] Why's he so frustrated?

[Dan] I don't know. I tried to help him but he's just not having it.

End of Video Transcript.

Case question: Observations

This content was retrieved from Section 01 Slide 3 of 30 of the online learning module.

Answer the question by reflecting on the interaction presented in the video.

Case question 1 of 6: What do you notice about Quinn? Do you think he wants help or not, and how can you tell? Are there visual cues that he may need assistance?

Feedback:

Because of his white cane, you can assume Quinn has vision loss. He can see the chair, so isn't fully blind. He sweeps the cane across the ground in front of him, suggesting some skills using the

cane as a navigational tool (though this could be hard to tell if you aren't familiar with cane use). He pauses briefly at the door, but does not bump into anything or indicate he wants assistance.

Decreased visual function: A few examples

This content was retrieved from Section 01 Slide 4 of 30 of the online learning module.

Low vision and blindness look different depending on the eye or brain condition that causes the vision loss.

Continue to compare some common types of vision loss. These are only examples of how vision might look.

Decreased visual acuity example

Central visual field loss example

Patchy visual field loss example

Tunnel vision plus glare sensitivity example

Tunnel vision with more significant peripheral field loss example

Loss of half of the visual field example

Reference:

National Eye Institute, National Institutes of Health (NEI/NIH). (2019). Eye disease simulations. Retrieved December 2022 from https://medialibrary.nei.nih.gov/search?f%5B0%5D=category%3A8#edit-imagelink

Video: Vision loss simulations

This content was retrieved from Section 01 Slide 5 of 30 of the online learning module.

For your interest, watch the video to see brief simulations of the common types of vision loss from the previous slide.

As you watch: Think of examples in your healthcare setting where the environment would present challenges for someone with each type of vision loss.

Visual Simulations - www.visionaware.org

Start of Video Transcript:

[Audio description] Title Vision Simulations. People with visual impairments using assistive devices.

[Narrator] For people with normal sight, it can be difficult to fully comprehend the experience of the visually impaired. One frequent

comment from those with vision loss is: "if you could see what I see, you'd understand what I'm going through." In this section, we have created a series of simulations for the most common causes of vision loss. We hope that by viewing them, you will gain a better appreciation for vision loss and improve your ability to assist and communicate with those who have low vision.

[Audio description] Title Macular Degeneration. A blurred image with dark spot in the center.

[Narrator] Macular degeneration is the leading cause of vision loss among older people. It is a condition that affects the center portion of the eye. That's the part responsible for central vision and seeing detail.

[Audio description] Title Cataracts. A sharp focused image becomes blurred.

[Narrator] A cataract is a cloudy area that forms in the lens of the eye. Cataracts cause an overall blurring and haziness of vision. If you have cataracts, it often appears as if everything is out of focus. People with cataracts tend to be very sensitive to bright light and glare.

[Audio description] Title glaucoma/Retinitis Pigmentosa. A blurred image with a sharply focused area in the center.

[Narrator] While very different conditions, both glaucoma and retinitis pigmentosa result in a loss of peripheral vision often described as tunnel vision. People with a certain type of glaucoma can also experience nausea, headaches, and halos around bright lights.

[Audio description] Title Diabetic Retinopathy. A blurred image with dark spots throughout.

[Narrator] When diabetes damages the tiny blood vessels in the retina, this condition results in overall blurred vision and blind spots from bleeding in the eye. The conditions can produce patchwork images, where portions are completely blocked out.

[Audio description] Title Hemianopsia: Stroke-Related Blindness. Image of a refrigerator left side blurred, right side focused.

[Narrator] The result of a cerebral stroke, brain tumor, or trauma – hemianopsia -- is the loss of vision in half the visual field. Look at how difficult it is to see the water and ice dispenser on the left. People with this condition can benefit from learning new techniques to scan their environment.

End of Video Transcript.

Page Link:

https://www.youtube.com/embed/DwtH1mO4eE0

Visual perceptual or processing difficulties

This content was retrieved from Section 01 Slide 6 of 30 of the online learning module.

The last two slides showed examples of visual function loss. Visual function includes how well you see and how much you see. However, to make sense of what you see, your brain must also process and interpret visual information.

Some conditions change how people recognize or understand what they see. For example, an individual might not recognize what they are seeing (or might confuse it with something that has similar features).

For someone with object **agnosia***, a drawing of a fan may be seen as a basketball hoop if some features of the drawing match the features of a basketball hoop they have stored in their visual memory (such as the base, pole, and circle with mesh-like pattern).

Definition*:

Agnosia: As defined by the National Institute of Neurological Disorders and Stroke, agnosia is a “neurological disorder characterized by an inability to recognize and identify objects or persons using one or more of the senses."

References:

National Institute of Neurological Disorders and Stroke. (n.d.). Agnosia. Retrieved February 2023 from https://www.ninds.nih.gov/health-information/disorders/agnosia

Tietjen, M. (2017). What do you see? Online webinar + PPT presentation. Retrieved February 2023 from https://www.perkinselearning.org/videos/webinar/what-do-you-see-cvi-tvi

Video: Visual perception and processing

This content was retrieved from Section 01 Slide 7 of 30 of the online learning module.

Someone with **simultagnosia*** will struggle to interpret the whole scene at once.

Watch the video to view a simulation of simultagnosia as part of **cortical visual impairment (CVI)***.

While this seems similar to tunnel vision, someone

with tunnel vision controls their focus and where they are looking.

For someone with simultagnosia, their vision is reactive to the environment. What they see and how much they see can be affected by their interests, experience, or distractions in the environment (visual motion, noise). Their focus and vision may jump from one object to another, outside of their control.

CVI-SIM Progress (3:19)

Start of Video Transcript:

[Narrator] Welcome to another CVI-SIM progress video. Our classrooms now have children in them and a teacher. This classroom seems quite busy with all the movement. But look around, there is nothing on the walls, shelves, or floor. This classroom is empty.

Our next classroom is still pretty clear and tidy, although there are posters on the wall and books and files on the shelves. The children have brought their bags and hung them on their chairs, or put them on the floor by their feet. Our cluttered classroom is really filling up now with things hanging from the ceiling, posters all over the walls, shelves piled high with books, and of course the children and their bags and their teacher all shuffling around and moving. There is something else of course… Noise! [background noise] Classrooms can be noisy! Lots of children chatting away can make it very difficult to hear the teacher.

[background noise fades]

[class teacher's voice] "Three… if something is not visible to us, we can't learn from what it looks like."

[Narrator] That's better. When all the children are quiet everyone can hear the teacher better. But what about children with CVI? Many can only see one thing at a time. The filter we have now applied to what you can see is how vision has been described to us by people with CVI. This window through the surrounding unconscious fog, can change. We've been told it can move around and be difficult to control, driven more by what is being seen than where the child with CVI may really want to look.

Let's try and find our chair. It's easy to knock into people or trip over things. And it's very hard to find the teacher, and even harder to stay focused on the teacher. And even harder to try to give attention and listen to what the teacher is saying. This must be so difficult and stressful for many children with CVI. Let's move to a different room.

What you see now has the same CVI simulation filter being applied as in the last busy, noisy, cluttered classroom. But what has happened to the window of vision and the surrounding fog? The child's brain has much less to constantly give attention to and map and re-map to create vision. And so the fog clears and the window of vision opens. We call this room the tent room. The tent room is inspired by the work of specialist teacher, Suzanne Little. Where would you rather be to see well, and hear well, and learn?

End of video Transcript.

Definitions*:

Simultagnosia: As defined by CVI Scotland, simultagnosia refers to "difficulty in putting together and seeing the whole image simultaneously."

Cortical visual impairment (CVI): As defined by the CVI Perkins School for the Blind, cortical visual impairment is a "brain-based visual impairment caused by damage to the visual pathways or visual processing areas of the brain."

Page Link:

https://player.vimeo.com/video/509674094?h=dc4d0b79e9

Signs of possible vision loss

This content was retrieved from Section 01 Slide 8 of 30 of the online learning module.

White canes, guide dogs, and explicit signs or labels are the clearest indicators of blindness or vision loss. However, you can sometimes pick up on clues by noticing a person's movements and social responses. These clues may suggest the need for interaction or subtle observation before presuming vision loss is definitely present.

You will explore behaviours that you may see if the environment or situation doesn't match someone's level of vision over the next few slides.

Note: Many of these behaviours also happen for other reasons. Also, people with vision loss may display no behaviours that catch your attention.

Reference:

Cupples, M. E., Hart, P. M., Johnston, A., & Jackson, A. J. (2012). Improving healthcare access for people with visual impairment and blindness. British Medical Journal, 344, e542–e542. Retrieved December 2022 from https://doi.org/10.1136/bmj.e542

Signs of possible vision loss: Reactions to spaces and materials

This content was retrieved from Section 01 Slide 9 of 30 of the online learning module.

Some signs of possible vision loss include a person's responses to the physical environment.

Continue to learn about these signs.

Leaning closer

Leaning close to material or signs: Getting closer to objects is a common strategy when information is smaller than someone can see. This strategy is also used to reduce the amount of information seen at one time (getting closer means you see fewer items or words at once).

Avoiding light/glare

Avoiding or blocking out bright light or glare: Many people with vision loss are sensitive to light and glare. They may wear dark glasses or caps with brims even indoors. Squinting or looking away from light sources and shiny surfaces are also common reactions.

Slower light-dark transitions

Difficulty transitioning from light to dark or dark to light: Many people experience their eyes "adjusting" when coming inside on a sunny day or when they turn off the light at night. For people with vision loss and blindness, often vision takes longer to adjust. Some people may pause or take more time before moving

when coming inside (or going outside). This may be obvious, or like in the case video, it might be more subtle.

Changes in lighting levels between areas of a building can present a barrier for this reason.

Bumping into things

Bumping into people or objects: Obstacles may not be as visible to those with visual field loss or those who struggle to see low contrast scenes (for example, a white table in a white room). Mobility canes are used to identify objects, but not everyone has learned white cane skills.

Someone who cannot identify obstacles is more likely to bump into or struggle to find something (for example, a chair). Some people avoid obstacles but move very cautiously. Safe navigation is strongly influenced by design decisions (for example, the colour, shape, and placement of furniture).

Stumbling

Tripping over steps, curbs, or subtle changes in the ground/surface: Most surface changes are only visible by noticing subtle changes in colour, shading, or texture (for example, a concrete curb by its shades of grey). Visually detecting steps and surface changes can be difficult for people with poor contrast detection or missing their lower visual field. Because of this, trips, falls, and cautious movement are more common in the vision loss population.

Using contrast and texture to highlight steps and surface changes helps reduce trips and falls.

Reference:

Cupples, M. E., Hart, P. M., Johnston, A., & Jackson, A. J. (2012). Improving healthcare access for people with visual impairment and blindness. British Medical Journal, 344, e542–e542. Retrieved December 2022 from https://doi.org/10.1136/bmj.e542

Signs of possible vision loss: Social interactions

This content was retrieved from Section 01 Slide 10 of 30 of the online learning module.

Some signs of possible vision loss are more noticeable during an interaction.

Continue to learn about these signs.

Less eye contact

Someone who is not looking at you while you are speaking may not have enough vision to direct their gaze – especially if you don't face them when talking. Separately, someone's eye movement or alignment might make it seem like they are not looking at you.

People with central vision loss often learn over time to use their side vision. In this case, they may look left, right, above, or below your face in order to focus on you with their available vision.

Keep in mind that many other reasons may explain lack of eye contact (for example, cultural norms, past trauma).

Lack of response

Someone who has very poor vision or visual field loss may not notice you passing them an item (like their health card), or may not look to where you are pointing.

Because such a large part of communication is non-verbal, people with certain types of vision loss are likely to miss your actions or gestures.

References:

Cupples, M. E., Hart, P. M., Johnston, A., & Jackson, A. J. (2012). Improving healthcare access for people with visual impairment and blindness. British Medical Journal, 344, e542–e542. Retrieved December 2022 from https://doi.org/10.1136/bmj.e542

Steuwe, C., Daniels, J. K., Frewen, P. A., Densmore, M., Pannasch, S., Beblo, T., Reiss, J., & Lanius, R. A. (2014). Effect of direct eye contact in PTSD related to interpersonal trauma: an fMRI study of activation of an innate alarm system. Social cognitive and affective neuroscience, 9(1), 88–97. Retrieved December 2022 from https://doi.org/10.1093/scan/nss105

Signs of possible vision loss: Emotional responses

This content was retrieved from Section 01 Slide 11 of 30 of the online learning module.

Someone with vision loss may appear confused, hesitant, or even angry and demanding, especially when confronted with stigma, missing information, or other accessibility issues.

Continue to learn about these signs.

Confusion

Everyone gets confused when they don't have the information they need to figure out what to do next. Confusion could result for someone with vision loss if visual information is not clear (for example, signs are too small or don't stand out, crosswalk

markings are faded) or if the information does not work for them (for example, someone giving directions by pointing to landmarks that someone can't see).

If you notice confusion, try to get more information about the situation to determine what information someone might be missing. This will help you provide the information in a way that works for them.

Hesitance

Humans hesitate for many reasons (for example, uncertainty, lack of confidence).

People with vision loss often encounter situations where information is provided in a way that doesn't work for them. Not having enough information may reduce an individual's confidence or make them hold back.

People also differ in how comfortable they are asking others for help. Stigma and society's lack of vision loss knowledge can further complicate things. Some individuals may be uncomfortable saying they have vision loss or feel their question will sound "silly" or "obvious." Embarrassment or guilt might happen because they anticipate judgment or fear they will be a burden.

Frustration

Frustration or demanding behaviour could come from being confused or judged. Social interaction can play a large role in prompting frustration.

Many people have difficulty picturing what someone with vision loss is experiencing and may default to stereotypes about vision loss. This can lead to intentional or unintentional behaviours from fully sighted people that are patronizing, judgmental, or unhelpful, resulting in frustration for people with vision loss. Sometimes, a frustrated response might seem like an overreaction to something small, but consider that some people with vision loss may have a build up of these experiences and the subsequent frustration that the behaviours are happening over and over again.

Reference:

Cupples, M. E., Hart, P. M., Johnston, A., & Jackson, A. J. (2012). Improving healthcare access for people with visual impairment and blindness. British Medical Journal, 344, e542–e542. Retrieved December 2022 from https://doi.org/10.1136/bmj.e542

Case question: Quinn's experience

This content was retrieved from Section 01 Slide 12 of 30 of the online learning module.

Answer the question by reflecting on the interaction presented in the video.

Case question 2 of 6: What do you think Quinn was experiencing during the interaction (this can include feelings, thoughts and memories, physical sensations, etc.)? Is there anything about how the assistance was offered that was notable, and if so, how might this impact Quinn's experience?

Feedback:

Navigate to the next slide for feedback on this question.

Feedback: Quinn's experience

This content was retrieved from Section 01 Slide 13 of 30 of the online learning module.

Quinn seems to be initially confused when Dan asks if he is okay. His responses have a somewhat dismissive tone in subsequent responses. Is it possible he is frustrated or experiencing some other reaction to the interaction with Dan?

What sort of emotion was conveyed in Quinn's response? Do you think there might be other emotions behind that the tone and response?

Consider the tone and phrasing by Dan. Did it sound like he was treating Quinn like a competent adult? What are some emotions people might feel if they think they are being patronized or treated like they are not competent?

Case question: Dan's experience

This content was retrieved from Section 01 Slide 14 of 30 of the online learning module.

Answer the question by reflecting on the interaction presented in the video.

Case question 3 of 6: What do you think Dan was experiencing during the interaction (this can include feelings, thoughts and memories, physical sensations, etc.)?

Feedback:

Navigate to the next slide for feedback on this question.

Feedback: Dan's experience

This content was retrieved from Section 01 Slide 15 of 30 of the online learning module.

Dan seems to start the interaction with some enthusiasm and concern, but over the course of the interaction, seems to be more hesitant in his speaking as he provides additional offers of help or explanations of his reasoning.

His face at the end seems more serious. When going into the office he sighs and communicates uncertainty to his colleague. It is unclear if he is confused, dismissive, or some other combination of emotions.

Consider that most people have good intentions and, if their offers of help are declined, it could be surprising or generate some emotional reaction.

Patronizing behaviours

This content was retrieved from Section 01 Slide 16 of 30 of the online learning module.

Because of common stereotypes held by society, people with vision loss often report being patronized by others. You may have witnessed this, learned about it at school, and possibly even spoken or behaved this way at times, whether towards someone with vision loss or towards others in your life or work.

Continue to explore different definitions related to patronizing behaviours.

Infantilization – *Refer to pages 31-33*

Elderspeak – *Refer to pages 33-34*

References:

Stevenson, J. L., Harp, B., & Gernsbacher, M. A. (2011). Infantilizing Autism. Disability studies quarterly, 31(3), dsq-sds.org/article/view/1675/1596. Retrieved December 2022 from https://doi.org/10.18061/dsq.v31i3.1675

Cox, C., & Fritz, Z. (2022). Presenting complaint: Use of language that disempowers patients. British Medical Journal (BMJ), e066720. Retrieved December 2022 from https://doi.org/10.1136/bmj-2021-066720

Wang, K., Silverman, A., Gwinn, J. D., & Dovidio, J. F. (2015). Independent or ungrateful? Consequences of confronting patronizing help for people with disabilities. Group Processes & Intergroup Relations, 18(4), 489–503. Retrieved December 2022 from https://doi.org/10.1177/1368430214550345

Shaw, C. A., & Gordon, J. K. (2021). Understanding elderspeak: An evolutionary concept analysis. Innovation in Aging, 5(3), igab023. Retrieved December 2022 from https://doi.org/10.1093/geroni/igab023

Infantilization

Subpage of Section 01 Slide 16 of 30 – Infantilization 1/1

Infantilization is the treatment of an adult as if they were a child. This could include condescending language, tone of voice, and behaviours (for example, patting someone on the head).

When someone infantilizes a person with a disability, it is considered discrimination because it suggests that the person is incapable or needs to be taken care of.

A frequently shared example from white cane users is that while they are standing at an intersection, a sighted person will insist on helping them cross the street or tell them they shouldn't be out alone.

Infantilization examples

Start of Audio Transcript:

Hi there, I'm part of the support team here. Are you lost? Can I help you? Sure, I can help you get there. Did you get to the clinic all by yourself? Oh, wow! You walked here? I wouldn't have thought it was safe for you to walk by yourself across that intersection out there. Why didn't you bring anyone with you to help you?

End of Audio Transcript.

References:

Stevenson, J. L., Harp, B., & Gernsbacher, M. A. (2011). Infantilizing Autism. Disability studies quarterly, 31(3), dsq-sds.org/article/view/1675/1596. Retrieved December 2022 from https://doi.org/10.18061/dsq.v31i3.1675

Cox, C., & Fritz, Z. (2022). Presenting complaint: Use of language that disempowers patients. British Medical Journal (BMJ), e066720. Retrieved December 2022 from https://doi.org/10.1136/bmj-2021-066720

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Elderspeak

Subpage of Section 01 Slide 16 of 30 – Elderspeak 1/1

Elderspeak is a way of speaking and choice of language that is similar to baby talk. It is sometimes used with older adults, especially those with dementia and other cognitive changes.

For example, a provider might say in a high pitched voice "oh honey, are you lost?" when encountering an older adult trying to read a sign in a more removed wing of a hospital.

While not technically "elderspeak," the same type of communication is often used with people with disabilities and vulnerable populations, especially in healthcare settings.

Elderspeak examples

Start of Audio Transcript:

[High pitched voice] How are we doing today? Oh honey, are we feeling frustrated? Here, let me get that for you. No? Oh, you got it. Good job!

End of Audio Transcript.

References:

Stevenson, J. L., Harp, B., & Gernsbacher, M. A. (2011). Infantilizing Autism. Disability studies quarterly, 31(3), dsq-

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How do people judge patronizing behaviour?

This content was retrieved from Section 01 Slide 17 of 30 of the online learning module.

A study by Wang and team examined participant responses to videos depicting either **patronizing discrimination*** or **hostile discrimination*** towards a person who is blind.

Sighted participants were more forgiving of patronizing behaviour than blind participants. Sighted participants were also more likely to negatively judge when the person with blindness confronted the patronizing behaviour (less judgmental when hostile behaviour was confronted)

Definitions*:

Patronizing Discrimination: In the video showing patronizing treatment, the sighted person stated it was too dangerous for the person who is blind to be walking on her own, grabbed her arm without her consent, and insisted on taking her to her destination.

Hostile Discrimination: In the video showing hostile treatment, the sighted person stated it was too dangerous for the person who is blind to be walking on her own and told her to go home, all while refusing to answer her question.

References:

Stevenson, J. L., Harp, B., & Gernsbacher, M. A. (2011). Infantilizing Autism. Disability studies quarterly, 31(3), dsq-sds.org/article/view/1675/1596. Retrieved December 2022 from https://doi.org/10.18061/dsq.v31i3.1675

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Shaw, C. A., & Gordon, J. K. (2021). Understanding elderspeak: An evolutionary concept analysis. Innovation in Aging, 5(3), igab023. Retrieved December 2022 from https://doi.org/10.1093/geroni/igab023

Possible impacts of patronizing language

This content was retrieved from Section 01 Slide 18 of 30 of the online learning module.

Patronizing language contributes to discrimination within healthcare. While behaviours are done by individuals, policies and decisions at the organizational level play a big role (for example, how people with disabilities are referred to or spoken about in clinical documents and staff training).

Continue to learn about some of the impacts of patronizing language.

Psychological impact

Within single interactions, patronizing language and behaviours can present as hostility and create anxiety and discomfort. While unintentional, it can have psychological consequences (for example, implying someone cannot take care of themselves, much like a child, can hurt someone's self concept, especially if this message appears frequently).

Emotional impact

Language can also make the recipient feel like they are being talked about (rather than spoken to). It can also make them feel like an object of the healthcare worker's action. An example would be a person with vision loss feeling like they are only "a pair of eyes" when they visit the eye doctor.

Choosing language and your approach wisely is important in creating interactions where individuals feel safe and respected. Paying attention to the policies, practices, social messages, and

documents within your organization could also help you give feedback to your team on areas for improvement.

References:

Stevenson, J. L., Harp, B., & Gernsbacher, M. A. (2011). Infantilizing Autism. Disability studies quarterly, 31(3), dsq-sds.org/article/view/1675/1596. Retrieved December 2022 from https://doi.org/10.18061/dsq.v31i3.1675

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Shaw, C. A., & Gordon, J. K. (2021). Understanding elderspeak: An evolutionary concept analysis. Innovation in Aging, 5(3), igab023. Retrieved December 2022 from https://doi.org/10.1093/geroni/igab023

Reflection activity: Impact of patronizing behaviour

This content was retrieved from Section 01 Slide 19 of 30 of the online learning module.

Reflection activity: Consider a time that you were patronized. How did you feel and what did you do in response, if anything?

Discuss with a colleague or peer to identify a time one of you used elderspeak, infantilization, or were even subtly patronizing with a client. Consider:

- Does your voice change when you speak to people with disabilities or older adults?
- When you adjust your wording, are there times you may have unintentionally oversimplified because the person had a disability or was older?
- What might you do differently in the future? If the person needed some sort of assistance, is there another way you could have phrased it?

Video: Interview with Quinn

This content was retrieved from Section 01 Slide 20 of 30 of the online learning module.

Watch the video to learn about the interaction from Quinn's perspective.

Please see the online learning module to view this video.

As you watch: Think about whether there is anything that surprises you or that you didn't anticipate.

Keep in mind, this video is a possible experience only. While the scenario is informed by real life experiences, different individuals may respond or feel differently.

I've got this!: Interview with Quinn (0:23)

Start of Video Transcript:

[Quinn] I can't stand it when people talk to me like I'm a child. I try to have a good humour about it, but honestly the tone of voice – Ugh. When people say things like "Oh, hey! Can we help you out there? Oh, here's a chair!" Ugh. Honestly, I try to be a good sport about it, but on the inside I kind of just want to curl up into a ball and hide.

End of Video Transcript.

Video: Interview with Dan

This content was retrieved from Section 01 Slide 21 of 30 of the online learning module.

Watch the video to learn about the interaction from Dan's perspective.

Please see the online learning module to view this video.

As you watch: Think about whether there is anything that surprises you or that you didn't anticipate.

Keep in mind, this video is a possible experience only – different healthcare providers might feel differently or behave differently in the same situation.

I've got this!: Interview with Dan (0:23)

Start of Video Transcript:

[Dan] I don't understand why some people are so rude and unappreciative. Sometimes, it just ruins my day. I was just trying to be helpful. That's why I'm in healthcare. It's not even like I did anything wrong. He didn't have to snap like that. But I guess he didn't want the help and all I can do is offer, right?

End of Video Transcript.

Case question: Factors influencing the healthcare scenario

This content was retrieved from Section 01 Slide 22 of 30 of the online learning module.

Many different factors can influence interactions between a client and their provider. This may include the knowledge, experiences, and situations of **people directly involved** (client, family, support or healthcare workers) and **people not directly involved** (managers, decision makers, society), as well as **the environment and systems** (such as the physical space, funding, policies and procedures).

Answer the question by reflecting on the interaction presented in the original video and considering the interviews with Quinn and Dan.

Case question 4 of 6: What are some possible factors that are influencing the situation?

Feedback:

Navigate to the next slide for feedback on this question.

Feedback: Factors influencing the healthcare scenario

This content was retrieved from Section 01 Slide 23 of 30 of the online learning module.

Learn about the factors that may be influencing the situation.

Societal stereotypes

Because the general population's understanding of vision loss is relatively poor, Dan may have limited knowledge on the possible

skill sets used by people with vision loss. He may think that all or most people with vision loss cannot travel independently.

Past experiences

Quinn and Dan's past experiences might impact their reactions.

For Quinn, this may be one of many times that someone responded in an overprotective way when he didn't need any help.

Dan may have had experiences that influence how determined and quick he was to offer assistance. For example, he may work with a lot of people who are at risk of falling and be very conscious of preventing falls.

Training

Dan may have had little training or exposure to examples of people with vision loss and the skills that people can use to be independent in the community.

He may also have not had training that focuses on certain parts of the communication dynamic. For example, training on what infantilization, elderspeak, and other patronizing interactions sound like and what to do instead.

Healthcare norms

Healthcare focuses on providing excellent care to clients and patients. Along with this comes helpfulness and good customer service. Trying to be as helpful as possible often aligns with good care. There is nothing wrong with trying to be helpful, though depending on the situation, it might take away a person's agency or feelings of competency. What is helpful in any given moment

changes quickly, and sometimes it is most helpful to just be available.

Reflection activity: Do any of these apply to your setting? Did you come up with other examples of factors that may affect this scenario?

Case question: Reimagining Quinn's experience

This content was retrieved from Section 01 Slide 24 of 30 of the online learning module.

Answer the question by reflecting on the case and what you have learned so far.

Case question 5 of 6: If you were Dan, what might help you respond differently in the moment to improve these situations and Quinn's (or another client's) experience in the waiting room?

Feedback:

Navigate to the next slide for feedback on this question.

Feedback: Reimagining Quinn's experience

This content was retrieved from Section 01 Slide 25 of 30 of the online learning module.

There are many possible actions one could do in the moment to help ensure a positive interaction.

Continue to learn about a few actions you could consider.

Pause and observe

When there is an immediate safety risk, a quick response is often needed. However, sometimes people react quickly when they falsely identify a safety risk, experience discomfort, or do not know how to respond.

If Dan had taken a moment to pause and observe, he may have noticed more details – that Quinn moved relatively confidently and demonstrated no obvious signs of confusion or discomfort that would suggest he was lost or struggling to navigate. This may have allowed him to change his approach.

Choice of language/tone

Paying attention to language and tone helps you check if you are using your natural speaking voice and not going to a higher pitch or patronizing tone simply because someone has a disability, is older, or for some other reason.

How assistance is offered

Assistance can be offered in many ways – sometimes in ways that imply the person is incapable. Also, some people are sensitive to offers of assistance for various reasons (for example, if a society strongly values independence, people may not feel independent if they ask for or accept assistance).

Preparing in advance can help you have ways to offer help in a way that empowers the other person ("I'm available if you need anything") or normalizes assistance ("Would you like some direction getting back to the lobby? This building is a maze.").

Case question: Creating change

This content was retrieved from Section 01 Slide 26 of 30 of the online learning module.

Answer the question by reflecting on the case and what you have learned so far.

Case question 6 of 6: If you were Dan, what changes might you suggest within the healthcare facility or system so that other service users have a better experience? What could you do to advocate for change in the workplace environment, policies, procedures, and/or culture?

Feedback:

Navigate to the next slide for feedback on this question.

Feedback: Creating change

This content was retrieved from Section 01 Slide 27 of 30 of the online learning module.

Creating change sometimes goes beyond individual actions.

Continue to explore some actions you could take to make things better in the future.

Get feedback

Your colleagues may be able to notice things about how you communicate with people with disabilities that you might otherwise miss. Ask for feedback on your language and/or tone to determine if it changes unintentionally

Request education and training

A good starting point would be requesting additional education on skills used by people with vision loss. Training delivered by

people with vision loss who use these skills would give you even more exposure to the capabilities.

Additional training and mentorship help you practice speaking in a more natural voice in situations where you might have developed the habit of speaking with a higher pitch than usual or with more patronizing language.

Address accessibility barriers

Addressing any obvious accessibility barriers in the environment may help in general to prevent falls. This is useful in general for client safety, but may also help providers feel more at ease that there are fewer safety risks they have to monitor (for example, if the chairs do truly have a habit of sliding unpredictably, perhaps this is an issue that needs follow-up). Sharing specific safety concerns back to a manager is a starting point.

Seek input

Ask if clients who are blind, deafblind, and partially sighted have been part of any consultation and planning processes undertaken for quality improvements or staff training provided in your setting. Suggest they be included.

Video: Quinn shares what works for him

This content was retrieved from Section 01 Slide 28 of 30 of the online learning module.

Watch the video to explore Quinn's perspective and to learn about some strategies that work for him in this kind of situation.

Please see the online learning module to view this video.

As you watch: Consider how these ideas might apply to your work with clients in the healthcare system.

I've got this!: Dan shares what he learned (0:31)

Start of Video Transcript:

[Quinn] When accommodation starts with conversation, it makes it so much easier for me to step into a situation that I'm unsure of. I don't deal with doctors on a daily basis. So, when it starts with questions like "how can we help you?" versus "do you need help?", it allows me to answer questions in a way that I feel comfortable rather than yes, no, or maybe. And I feel that is very important when it comes to comfort with medical care.

End of video Transcript.

Video: Dan shares what he learned

This content was retrieved from Section 01 Slide 29 of 30 of the online learning module.

Watch the video to explore Dan's perspective after he had more information about the situation and thought about what things he could do to improve it.

Please see the online learning module to view this video.

As you watch: Think about what you and Dan have learned and how it could impact clients.

I've got this!: Dan shares what he learned (0:34)

Start of Video Transcript:

[Dan] So our team has been doing some communication training lately and I've been trying it out and it seems to really work. I don't even realize I'm doing it… my partner calls it my "kindergarten teacher voice" and I guess sometimes I slip into it when I'm trying to offer help. Half the time I get it right and sometimes I get it wrong. But I'm doing better. I also try to remember how I hate it when someone tries to help me with something I already know how to do. Maybe that's what I sound like when I try to offer help. So, I just try to keep that in mind.

End of Video Transcript.

Video: Case with a better outcome

This content was retrieved from Section 01 Slide 30 of 30 of the online learning module.

Watch the video to explore how the scenario could have gone if Dan was more aware of his tone and behaviours.

Please see the online learning module to view this video.

As you watch: Think about how this might apply to your setting – are there any situations that might be similar and benefit from new approaches?

I've got this!: Case with a better outcome (0:30)

Start of Video Transcript:

Dan] Hello, how are you today?

[Quinn] I'm good! How are you?

[Dan] Good, thank you! If you tell me your name, I'll get you checked in.

[Quinn] Oh, my name is Quinn Ambrose. I have an appointment with Dr. Khan at 10.

[Dan] Perfect. I'll get you checked-in and my name's Dan just let me know if you need anything today.

[Quinn] Nice to meet you Dan. I appreciate it.

[Dan] You as well.

End of Video Transcript.

Module Conclusion

Module 3: Summary

This content was retrieved from Conclusion Slide 2 of 7 of the online learning module.

In this module, you explored a clinic waiting room interaction between Quinn, a client, and Dan, a healthcare provider. You reflected on what the experience may have been for each of them.

Vision loss can present in many different ways for different people and you explored simplified examples of what this may look like. You were also introduced to different potential signs of vision loss you might notice by observing a person's movements and emotional responses.

You learned about the different impacts of patronizing language and discrimination towards people with low vision or blindness. You reflected on how it feels to be patronized and where there might be instances where you have unintentionally been patronizing.

You returned to the case scenario to explore some strategies for responding in a more positive way.

Credits

This content was retrieved from Conclusion Slide 4 of 7 of the online learning module.

This module was developed by a group of community members, healthcare providers, educators, and vision loss and blindness organizations in collaboration with the Queen's University Course

Development team within the Office of Professional Development and Educational Scholarship.

This project is made possible with funding by the Government of Ontario and through eCampusOntario's support of the Virtual Learning Strategy. To learn more about the Virtual Learning Strategy visit the eCampus Ontario website.

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Contributors: Content Curation

This content was retrieved from Conclusion Slide 5 of 7 of the online learning module.

This project would not have been possible without a large team of people who shared their experiences, expertise, and time.

Members of the community were involved at all levels of the project providing their insight and expertise or sharing their experiences of navigating the healthcare system as someone with blindness, deafblindness, low vision, or other types of vision loss.

Healthcare providers, healthcare students, and educators were also involved at all levels of the project sharing their own learning experiences and learning preferences, their expertise with this population, and/or insights into content delivery.

A full list of project contributors is available with these modules in the eCampus Ontario Open Library.

Contributors: Case Videos

This content was retrieved from Conclusion Slide 6 of 7 of the online learning module.

The case scenario is a work of fiction. However, the scenario comes from real life experiences shared during the development of these modules, and from experiences published in the literature. The following people played a key role in creating the case videos for this module.

Actors:

- Quinn: Jarod Gregorio
- Dan: Simulated patient
- Unnamed healthcare provider: Dan Walmsely

Creative team:

- Lead script writer: Gillian Davis
- Assistant script writing: Project team members and actors
- Videography: Media Services Team, Queen's Faculty of Health Sciences Information Technology
- Director: Dan Walmsely
- Creative Directors: Julia Foster, Rosemary Lysaght

Feedback

This content was retrieved from Conclusion Slide 7 of 7 of the online learning module.

We are interested in your feedback on how we can support you and other learners in going through this content and applying what you learn to practice. If you would like to provide any feedback on your experience of going through this module as it

relates to learning preferences or accessibility, please send us some information via our survey.

Continue to provide feedback on the learning experience and accessibility of this module.

Feedback Survey

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