



# Evaluation of Access for All – Disability Awareness for Mainstream Health Providers

15 August 2023



Assessment and Evaluation Research Centre  
Melbourne Graduate School of Education

# Evaluation of Access for All – Disability Awareness for Mainstream Health Providers

Prepared for CheckUP

15 August 2023

## **ACKNOWLEDGMENT OF TRADITIONAL OWNERS**

The University of Melbourne acknowledges the Aboriginal and Torres Strait Islander traditional owners of the unceded land on which we work and learn. We pay respect to the Elders, past and present, and the place of Indigenous knowledge in the academy.

## Acknowledgements

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## Context

### **The University of Melbourne**

The University of Melbourne has over 160-years of history of leadership in research, innovation, teaching and learning. It is the highest-ranked research university in Australia. Our researchers are at the forefront of international scholarship in a diverse range of fields.

### **Assessment and Evaluation Research Centre**

The Assessment and Evaluation Research Centre (AERC) (formerly the Centre for Program Evaluation and the Assessment Research Centre) at the University of Melbourne is the premier academic organisation for transdisciplinary evaluation and assessment education and practice, and the only academic evaluation research and training centre in Australasia. We advance equity through collaboratively creating clarity of purpose, rigor in methods, transparency in reasoning and reporting, and actionable results. AERC is situated within the Melbourne Graduate School of Education at The University of Melbourne, which is also home to the internationally recognised Centre for Wellbeing Science.

AERC brings together evaluation, assessment, and measurement across sectors to advance all three in terms of i) theory and methods; ii) teaching and learning; and iii) practice (for individuals, teams and organisations).

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## List of Abbreviations

**Table 1: List of Abbreviations**

Abbreviation	Full text
AERC	Assessment and Evaluation Research Centre
COVID-19	Coronavirus Disease 2019
CPD	Continuing Professional Development
CPE	Centre for Program Evaluation
MGSE	Melbourne Graduate School of Education
NDIA	National Disability Insurance Agency





## Report Structure

This report presents the findings and recommendations of the evaluation of Access for All – Disability Awareness for Mainstream Health Providers, conducted by the Assessment and Evaluation Research Centre (AERC). The document is structured as follows:

### **Section (i) Executive Summary**

**Section 1 Introduction** provides a background to the project, the purpose of the evaluation and the key evaluation questions.

**Section 2 Methodology** presents the rationale and design of the evaluation, the sampling, data collection, and analytical methods.

**Section 3 Results** presents the data collected as part of the evaluation.

**Section 4 Discussion** provides a discussion of key findings in relation to the evaluation questions.

**Section 4 Conclusion** is an overview of key findings.

**Section 5 Recommendations** provides an overview of recommendations based on the analysis and discussion of key findings.

# Executive Summary

## The Evaluation

The Assessment and Evaluation Research Centre (formerly the Centre for Program Evaluation) was contracted by CheckUP to implement a process and impact evaluation of 'Access for All', CheckUP's online training on disability awareness for mainstream health providers. 'Access for All' was developed in consultation with people with lived experience of disability, healthcare providers (with and without disability), Aboriginal and Torres Strait Islander consumers and health care workers, and disability advocates. Access for All was funded by the Australian Government Department of Social Services (DSS).

The aim of this evaluation is to examine the implementation of the Access for All training program and its initial impact on mainstream health providers' awareness and knowledge of barriers experienced by people with disability as well as their intention to implement changes to practice that promote inclusivity and accessibility.

## What We Did

We analysed the following survey data:

- Participant registration & survey data collected by CheckUP;
- Survey information from non-completers collected by CheckUP;
- Follow-up surveys developed and distributed by The University of Melbourne

We followed up some of the participants with online interviews (conducted by The University of Melbourne).

## What We Found

The satisfaction rates for the course were very high, and relatively few respondents suggested any changes to the course. However, some participants suggested including more material on working with people with an intellectual or communication disability, and possibly more tips on how people working in the allied health area could work better with those with a disability. Other suggestions for improvement revolved around accessibility issues of the platform used to deliver the online training and the registration process. This aspect of the online platform was mentioned not only by training participants, but also by those who did not complete the training package.

Most participants felt the material covered in the course was relevant to their particular roles. The most commonly identified area of skills and knowledge which respondents wished to improve on was their understanding and awareness of experiences faced by people with disability. The second most frequently identified area was an interest in improving service accessibility for those with disability or clients from remote areas.

The vast majority of respondents provided general positive feedback, including stating that they enjoyed the course, thanking the course designers, or provided other broad statements in support of the course overall. Participants also suggested that more people should undertake the course. A number of participants suggested that the course should be mandatory for people working in the disability sector. It was also suggested that the course be Australia wide, with each State providing content. Another suggestion was that the course be provided at tertiary level as an introductory course.

The most common comment from participants was that the training helped them to understand other people and different cultures better. The respondents also identified a range of attitudinal shifts which they had experienced as key areas of learning. Other key learnings identified by participants related to skills and knowledge that are foundational to person-centred care, such as empathy, awareness of the needs of people with disability, and communication strategies that account for the needs of people with disability. They also identified a shift in their mentality and approach to engaging with people with disability. Participants self-reported disability awareness increase before and after completing the training and was found to be statistically significant. It is also noted that in the follow-up survey, the majority of respondents reported an increased awareness of the need for disability training.

A number of participants commented that they were looking at their practice policies and procedures as well as acknowledging that they need to coordinate more with allied services who were serving the same client.

Some respondents also spoke about difficulties they had had with support staff who could not understand that the extra time spent with certain clients would produce better outcomes for that client in the long run. It was also pointed out that there are also physical barriers for some clients, particularly in private practices where it is difficult to make any changes to the physical environment..

A summary of the key findings will be found on page 53.

## **1. Recommendations**

Recommendations are based on key findings and participants' suggestions for improvement and are structured around the following areas: implementation and scaling up the training; content and accessibility; also further evaluation of the training.

### *Training implementation and potential expansion/scaling up of the training*

It is recommended that CheckUP continues promotion of the training using online communications with healthcare providers and via professional organisations. Access for All training could be promoted to all staff in an organisation as a way of promoting practice change at the organisational level. CheckUP could further promote the online training at professional and academic conferences (e.g. Australasian Society for Intellectual Disability conference). CheckUP could also contact tertiary education providers to promote the online training among students in health sciences and allied health disciplines.

It is recommended that the Access for All online training course be adapted for Australia wide delivery. This may involve consideration of policies and legislation specific to other Australian states. CheckUP could also consider dividing the online training package into individual and independent modules (similar to micro credential courses) to reduce time investment for participants interested in the training but unable to commit the time. We also recommend that opportunities for participants to choose which modules to complete, based on their previous knowledge or specific learning needs, are integrated in the training package.

### *Training content and accessibility*

It is recommended that although members of the neurodivergent community are already involved in the Advisory Group, that more of that community be involved in discussing the accessibility of the training program and offering suggestions for change, as well as utilising further testing activities. These further trials will allow CheckUP to collect valuable information on how the training is completed and what issues are experienced in real time.

A recommendation related to course content is to include other topics such as more material on working with people with an intellectual disability or complex communication needs, as well as providing additional information on working with a person with disability and Indigenous peoples.

We recommend that CheckUP investigates accessibility issues in the online training package, in particular, issues with video captioning, length, structure and design of the training may have influenced the discontinuation with the modules. Although it is understood that an accessible version of Access for All was available, it is suggested that clearer instructions be made available on how to access that version.

### *Evaluation of the training*

Further evaluation of the training could include consideration of level 4 indicators in Kirkpatrick's model. This involves collecting data on how healthcare practitioners and professionals are implementing changes to their practice that reflect increased disability awareness, knowledge of barriers to access, addressing barriers related to the physical environment, attitudes, communication and services/procedures, and evidence of use of person-centred care approaches that address the needs of people with disability. We recommend doing a follow up on a sample of training participants or healthcare providers to understand what practices are being implemented, what impact they are having on people with disability, and what contextual and organisational factors are enabling or hindering practice change. We suggest employing success case methodology using a sample of participants/providers across demographic and other factors of interest (e.g. remoteness of practice provider, size of the organisation). These case studies would involve gathering the views of people with disability (e.g. via short interviews), documenting practices, and surveying or interviewing healthcare providers and professionals.

We also recommend defining some of the terms used in the evaluation (e.g. enabler) by providing examples to participants, or providing a list of common barriers and enablers to practice change for evaluation participants to select, followed by an open-ended question for participants to expand on their responses. This approach will allow for the collection of both quantitative data on the presence and prevalence of specific barriers and enablers, as well as qualitative information on how these enablers and barriers are experienced by participants in their workplace.

## 2. Introduction

### 2.1. Access for All online training

The Assessment and Evaluation Research Centre (formerly the Centre for Program Evaluation) was contracted by CheckUP to conduct a process and impact evaluation of 'Access for All', an online training package on disability awareness for mainstream health providers. CheckUP is a not-for-profit based in Queensland, Australia, that provides a number of health services and training packages related to the health industry.

The Access for All training aims to improve accessibility and inclusivity for people with disability when accessing mainstream health services by raising awareness of disability and access needs among healthcare providers. The online training, available to all mainstream health providers (including medical, dentistry, nursing, allied health, Aboriginal and Torres Strait Islander health workers and health students), can be completed by both practitioners and administrative staff/management. The training is self-paced and divided into short modules, taking approximately two and a half hours to complete. Those who complete the training can claim Continuing Professional Development (CPD) points.

Development and delivery of the online training was funded by the National Disability Insurance Agency (NDIA) Information Linkages and Capacity Building - Mainstream Capacity Building Program. Access for All was developed in consultation with people with lived experience of disability, healthcare providers (with and without disability), Aboriginal and Torres Strait Islander consumers and health care workers, and disability advocates.

### 2.2. Evaluation Aims

The aim of this evaluation was to examine the implementation of the Access for All training program and its initial impact on mainstream health providers' awareness and knowledge of barriers experienced by people with disability, as well as their intention to implement changes to practice that promote inclusivity and accessibility. To this end, the evaluation was underpinned by Kirkpatrick's (Kirkpatrick & Kirkpatrick, 2006) model of evaluation of professional development and learning activities, whereby the effectiveness of the training is assessed through a series of levels or stages that evolve from initial participants' reactions (e.g., satisfaction, perceptions of relevance) to the application of what they have learned to their practices and outcomes for end users. Evaluation questions related to each level in Kirkpatrick's model are described in the next section. It should be noted that the fourth level (results or outcomes for end users of the training) is beyond the scope of this evaluation due to the limited timeframe of this project. This evaluation report focuses on findings related to participants' reactions to the training, awareness and knowledge of barriers experienced by people with disability and intention to implement practice changes. Suggestions on how CheckUP could extend the evaluation of this online training to examine the impact on end users are included in the Recommendations section of this report.

### 2.1. Evaluation Questions

The following evaluation questions were refined in consultation with CheckUP. As detailed below, they are aligned with the first three of Kirkpatrick's proposed levels of professional development evaluation: reaction, learning, and behaviour. The fourth level, results, is beyond the scope of the current program stage and therefore beyond the scope of the evaluation, though factors to consider for evaluating results in future will be noted in the discussion and recommendations.

### 2.1.1. Process Evaluation Questions

How has the program been implemented and what elements of the training program could be modified to maximise the intended outcomes?

How were the promotion strategies implemented and how effective were they?

### 2.1.2. Initial Impact Evaluation Questions

**Level 1. Reaction** - *How participants feel about the program. Comments about the training content, materials, instructors, facilities, delivery methods, etc.*

How satisfied were participants with the training program?

How relevant was the material covered in the program to the participants and their role?

What opportunities can be identified to improve the training for the future?

**Level 2. Learning** - *“The extent to which participants change attitudes, improve knowledge, and/or increase their skills as a result of attending the program” (Kirkpatrick & Kirkpatrick, 2006, p. 22)*

Has involvement in the program increased awareness of the need for training?

Is there an increase in knowledge and awareness of the needs of people with disability?

What skills and knowledge have been learnt and what gaps in knowledge, if any, remain?

What learnings or strategies do participants intend to implement?

**Level 3. Behaviour** - *How has behaviour changed as a result of the training?*

To what extent have the skills and knowledge presented in this course been applied in the workplace?

Do participants intend to change their practice when working with people with disability?

What practice changes have been made by participants?

What enablers and barriers are envisaged in the process of practice change?

### 3. Methodological approach

This evaluation employed a mixed methods pre/post design with a focus on assessing changes in awareness and intention to implement inclusive practices for those completing the online training course. This approach allowed the evaluation team to gain a more in-depth understanding of the impact of the training on participants' awareness and understanding of barriers to accessing mainstream health services, and their ability to implement strategies to improve accessibility in line with course objectives.

The following evaluation activities were undertaken:

Analysis of participant registration and survey data collected by CheckUP (pre and post training completion survey data) to measure change in participants' disability awareness, initial learnings, intentions to change practice, and potential barriers/enablers in the workplace.

CheckUP also provided survey data to the University of Melbourne from a short survey of participants who did not complete the training, in order to gauge contributing factors to this decision.

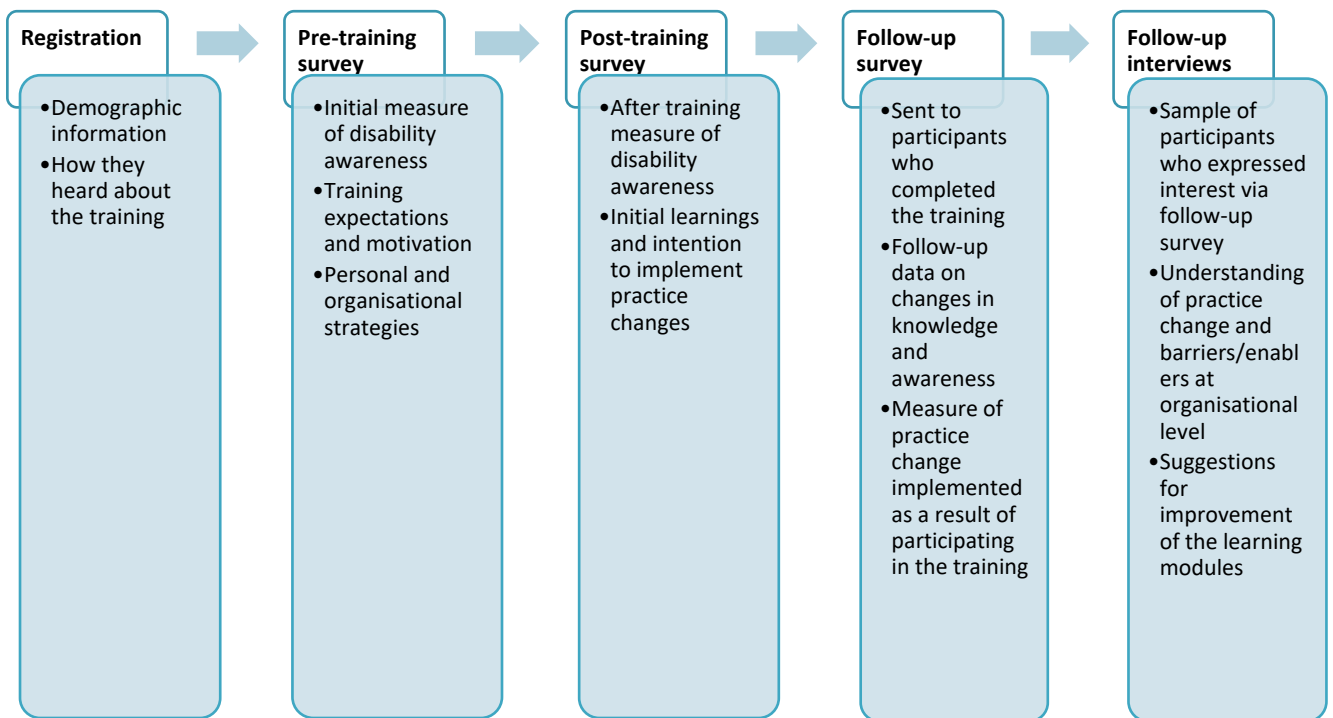
Follow-up surveys conducted by University of Melbourne researchers, to examine participants' views on the usefulness and applications of the online training modules, changes in knowledge and awareness of barriers to accessing healthcare for people with disability, practice changes implemented as a result of participating in the training, and future strategies to continue implementation of accessible practices in the workplace.

Follow-up interviews with a sample of participants to gain a better understanding of the impact of the training course on their practices and barriers/enablers at the organisational level, and as well as their views on usefulness and relevance of the training resource, their use of resources provided through the training modules, and any recommendations on how to improve the resources provided.

Where relevant, additional contextual information on the process and rollout of the training has been obtained from CheckUP staff.

Participants completed the registration and pre and post surveys as part of their participation in the online training modules. Follow-up surveys were sent to those who completed the training and pre- and post-surveys. Participants expressed interest in taking part in a follow-up interview via the follow-up survey. These interviews were arranged and conducted by The University of Melbourne and were completely independent of CheckUP.

The figure below is an overview of the sequence of the data collection process:



**Figure 1. Overview of Evaluation Design**

Given the mixed-methods nature of the evaluation, multiple quantitative and qualitative data were collected in order to address the evaluation questions. This approach allowed the evaluation team to examine multiple sources in relation to each question. A summary of key constructs measured through each data collection activity is presented below:

**Table 2: Access for All: Evaluation Crosswalk**

Evaluation area	Key Evaluation Questions	Registration/Survey Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
<b>Process</b>	How has the program been implemented and what elements of the training program could be modified to maximise the intended outcomes?	*	*	*	*
	How were the promotion strategies implemented and how effective were they?	*			*
<b>Level 1: Reaction</b>	How satisfied were participants with the training program?	*	*	*	*



Evaluation area	Key Evaluation Questions	Registration/Survey Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
	How relevant was the material covered in the program to the participants and their role?	*			*
<b>Level 2: Learning</b>	What opportunities can be identified to improve the training in the future?	*		*	*
	Has involvement in the program increased awareness of the need for training?	*		*	*
	Is there an increase in knowledge and awareness of the needs of people with disability?	*		*	*
	What skills and knowledge have been learnt and what gaps in knowledge, if any, remain?	*		*	*
	What learnings or strategies do participants intend to implement?	*		*	*
<b>Level 3: Behaviour</b>	To what extent have the skills and knowledge presented in this course been applied in the workplace?			*	*
	Do participants intend to change their practice when working with people with disabilities?	*		*	*
	What practice changes have been made by participants?			*	*
	What enablers and barriers are envisaged in the process of practice change?	*		*	

### 3.1.1. Data Collection and Analysis

#### **Registration and Pre and Post surveys**

The Access for All training modules included the registration forms, as well as pre and post surveys. Before accessing the training modules, participants were asked to complete the registration form and the pre-survey. After completing the training, participants filled in the post survey in order to obtain their completion certificate. 405 participants completed these surveys out of 928 training registrations. Data was collected by CheckUP and provided to the University of Melbourne in deidentified format.

All survey responses received to 31 October 2022 (n=309) were provided in the first tranche of data, which was subject to initial analysis in early 2023, including the development of qualitative codes for subsequent analysis. From 1 November 2022, data from new registrations and survey completions was provided by CheckUP in monthly iterations until the end of the survey period (30 April 2023). These data tranches were analysed as they were received, with final revisions following the receipt of the final data tranche. A total of 405 survey responses were received within the period 21 July 2021 to 30 April 2023.

Quantitative data was analysed using SPSS v29 to derive descriptive statistics, including frequency counts. A paired sampled t-test was conducted to examine differences in participants' disability awareness before and after completing the training.

Open-ended responses were coded using an inductive approach that focused on examining key themes and strategies as mentioned by participants. This analysis was informed by a constructivist Grounded Theory approach, using reflexive, iterative inductive coding. (Charmaz 2006; Thornberg & Charmaz in Flick, 2014). This approach identifies "codes", which are central concepts that recur throughout a data set, in order that the frequency of those codes can then be counted across the data set as a whole. Codes are identified through close reading of the data with attention to textual style, cultural context, phrasing, associations such as metaphor, tone, and other qualitative elements of verbal expression which recur across multiple responses. This approach allows qualitative data to be analysed at scale for patterns of representation and expression, and for this data to be analysed and represented alongside more quantitative data.

Initial coding stages identified themes in relevant questions through analysing the first tranche of survey data (n=309), using responses received up to 31 October 2022. Data from respondents who completed the survey between 1 November 2022 and 30 April 2023 (n=96) were coded according to the themes identified in the first tranche.

#### **Follow-up surveys**

An online survey, developed and distributed by The University of Melbourne (with input from CheckUP) was forwarded to all training participants who had completed the training (n = 405). A total of 66 complete responses were received. Survey responses were collected via Qualtrics, an online survey tool.

CheckUP provided email addresses of training participants who had completed the registration and pre and post-surveys. These details were provided separately to the survey data and were not linked. Participants were then contacted by the University of Melbourne and asked to participate in an optional, further follow-up survey administered directly by the University. Due to COVID-related project delays and staffing changes, participants who completed the training from July 2021 to the end of October 2022 were contacted in a single tranche on receipt of that data in October 2022, with participant email addresses provided to The University of Melbourne in monthly updates until the end of the survey period in April 2023. This meant that there was variation in the length of time between survey completion and follow-up for a longer view of changes made to practice, between two weeks and several months. This survey

included closed and open-ended questions. Survey questions covered demographic information, level of awareness of barriers for people with disability (Pre and post training), learnings and any changes to the training program. A full copy of survey questions is provided as Appendix 8.2.

Quantitative survey responses and program data was analysed using Excel and SPSS to provide descriptive statistics and frequency data to illustrate the implementation and outcomes of the program. Open-ended responses were thematically coded using the same approach as the pre- and post-survey, in order to examine participants' views on training effectiveness and their use of strategies to improve accessibility of their practices.

### **Survey: non-completers**

Those participants who registered to do the online training, but did not complete all modules, received a short survey to gain a better understanding of why they had not been able to complete the training. The survey was developed by CheckUP and administered using SurveyMonkey. Survey data were provided to University of Melbourne researchers in deidentified format in May 2023. 34 respondents completed this survey.

### **Interviews**

Interviews were conducted with eleven participants who expressed interest in taking part in the follow-up interviews from June 2022 to April 2023. The interview protocol was devised by University of Melbourne staff in consultation with CheckUP staff, with a focus on understanding the impact of the training on participants' practices and the influence of organisational factors. All interviews were conducted online using Zoom software. The Interviews were audio-recorded (with participant consent) and transcribed prior to analysis. A full copy of interview questions used is provided as Appendix 8.5.

The table below provides a summary of number of participants by data collection method.

**Table 3. Evaluation Participants: By data collection method**

<b>Data collection method</b>	<b>Number of Participants</b>
<b>Registration/ Pre/Post training surveys</b>	n =405
<b>Follow-up survey</b>	n=66
<b>Non-completer survey</b>	n=34
<b>Interviews</b>	n=11

## **4. Results**

The results section is structured as follows:

- Evaluation participants' demographic data;
- Data collected via registration form and pre training survey: personal and workplace strategies to improve accessibility reported prior to completing the training; how they heard about the training;

motivation for undertaking the training and skills, and knowledge participants wanted to improve by completing the training;

- Results by level as per Kirkpatrick’s model of evaluation.

#### 4.1. Demographics

Participants’ demographic data is presented by data collection method below. With the exception of the non-completer survey, participants were able to contribute to multiple forms of data collection.

##### 4.1.1. Training participants

###### Participant professions: by category

A summary of participants’ reported professions, using the list provided by CheckUP, is provided in the figure below. The largest group of respondents was among allied health practitioners (n=139) followed by nurses (n=101). “Other” health sector workers, including a range of healthcare support, technical, community health, and outreach roles, formed the third largest respondent group (n=72) followed by administration officers and receptionists. (n=25).

For analysis purposes, the category of “receptionist”, which appeared in data received after 1 February 2023, has been collapsed into the category of “Administration Officer” which appeared consistently throughout the survey period. The category “medical specialist” did not directly correspond to physician qualification and was used by respondents who qualified their responses in subsequent questions to identify their roles as being specialist practice within other associated medical fields such as allied health. As such “specialist” should not necessarily be interpreted as equivalent to physician qualification.

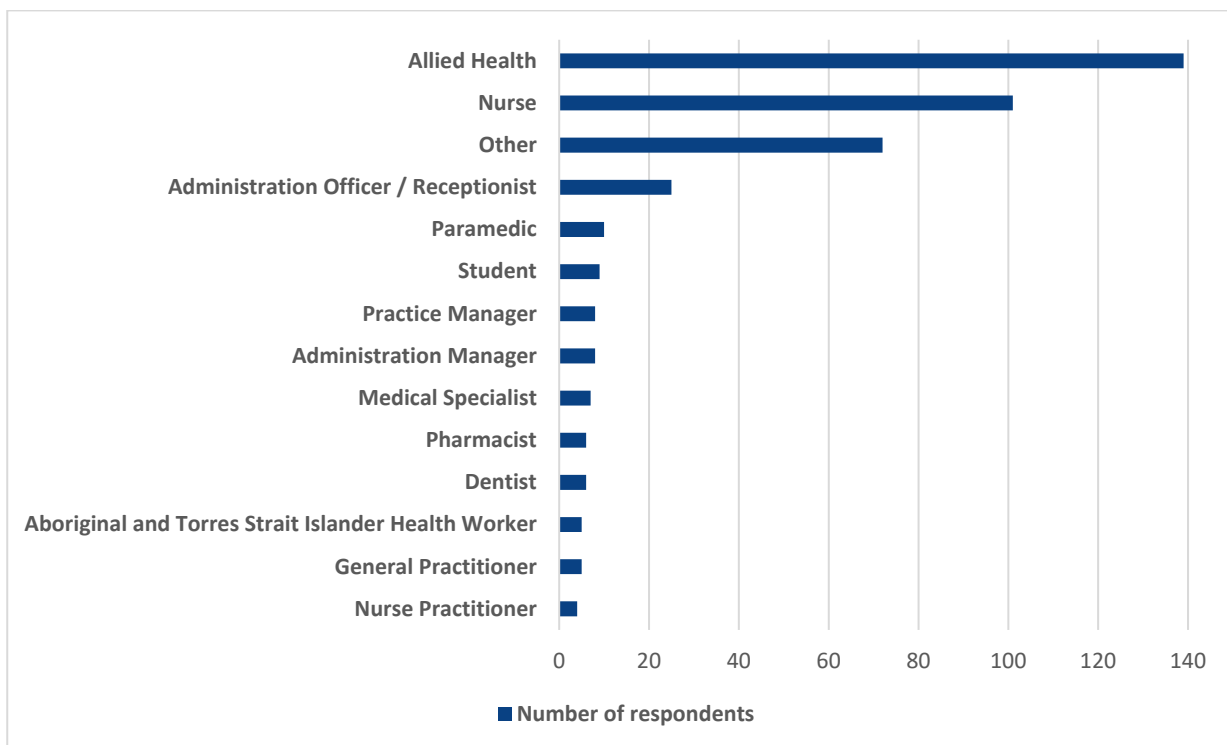


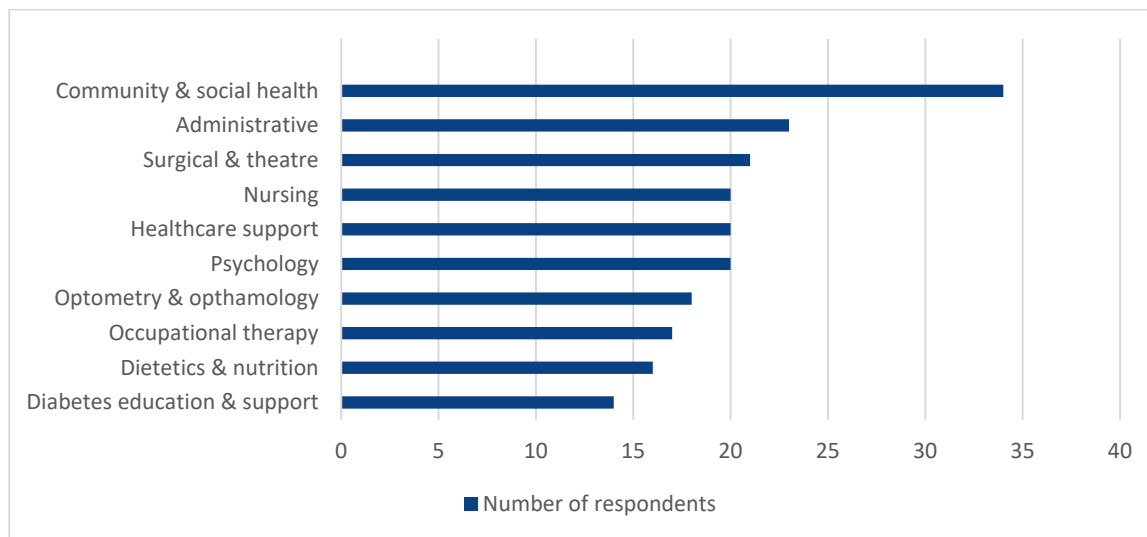
Figure 2: Professions of training participants, using provided categories

###### Participant professions: by open field description

Alongside these larger professional groupings, respondents were provided with the opportunity to describe

their discipline specialty, using an open field. Respondents were not required to use formal job titles. 78 respondents did not utilise this field at all and left it blank.

To account for multiple specialisms and wording variations, responses to this field (n=327) were inductively coded according to broad medical and professional categories. For example, the response “RN, neonatal immunisation” would be coded in three professional categories: nursing; paediatrics & child health; and immunisation. For this reason, the total number of codes represented in the below chart exceeds the total number of respondents.



**Figure 3: Top ten largest categories of disciplinary specialty, coded from open field responses**

The above illustrates the top ten largest categories of disciplinary specialty within the responses. The largest overarching category of specialisation was community and social health, including community health workers, social and outreach workers (n=34). The second largest disciplinary area was administrative roles (n=23). The third most frequently reported specialties were surgical and theatre roles (n=21), including anaesthesiology, theatre technicians, perioperative and recovery nursing. The fourth largest group of specialties reported were nursing (n=20) and healthcare support (n=20), which included technicians, orderlies, and patient services workers.

### Location: by postcode

Participants were asked to provide their postcode; however it was not specified whether this was intended to indicate the postcode in which participants lived; the location of their primary workplace; or other workplace location. Given that healthcare workers frequently work across multiple sites which are not necessarily adjacent to where they live, the postcode data has been represented here in broader state categories rather than attempting finer-grained representations which may not represent accurate geographic spread of living or working patterns. The figure below should therefore be interpreted as an indicative representation of geographic reach of the training across Australia. Even given these limitations, it is significant to note that 66 of 405 participants, approximately 15%, reported postcodes outside of Queensland. It should be added that the funding for this project was only for Queensland.

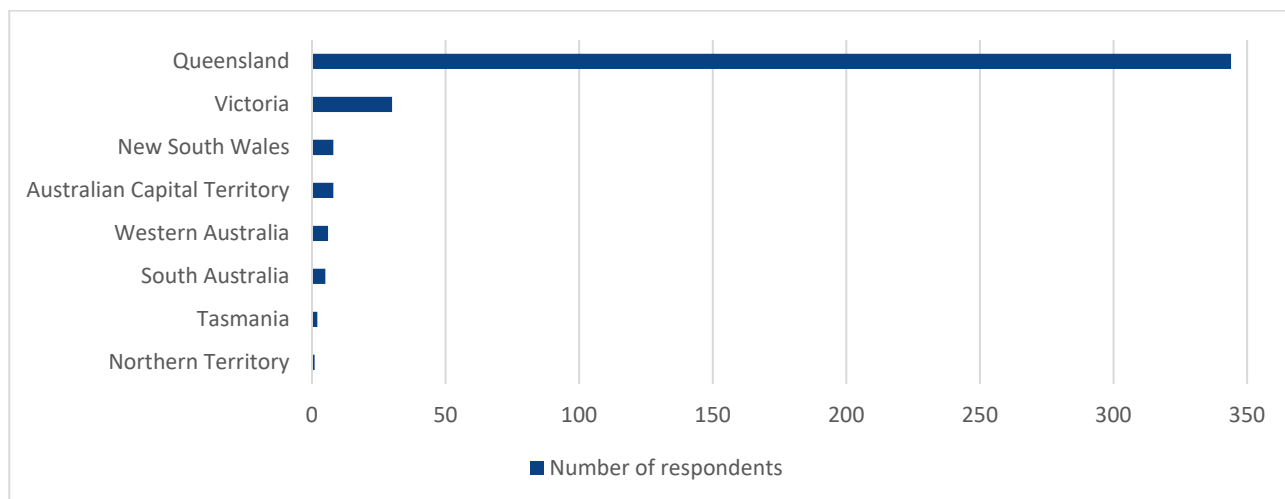
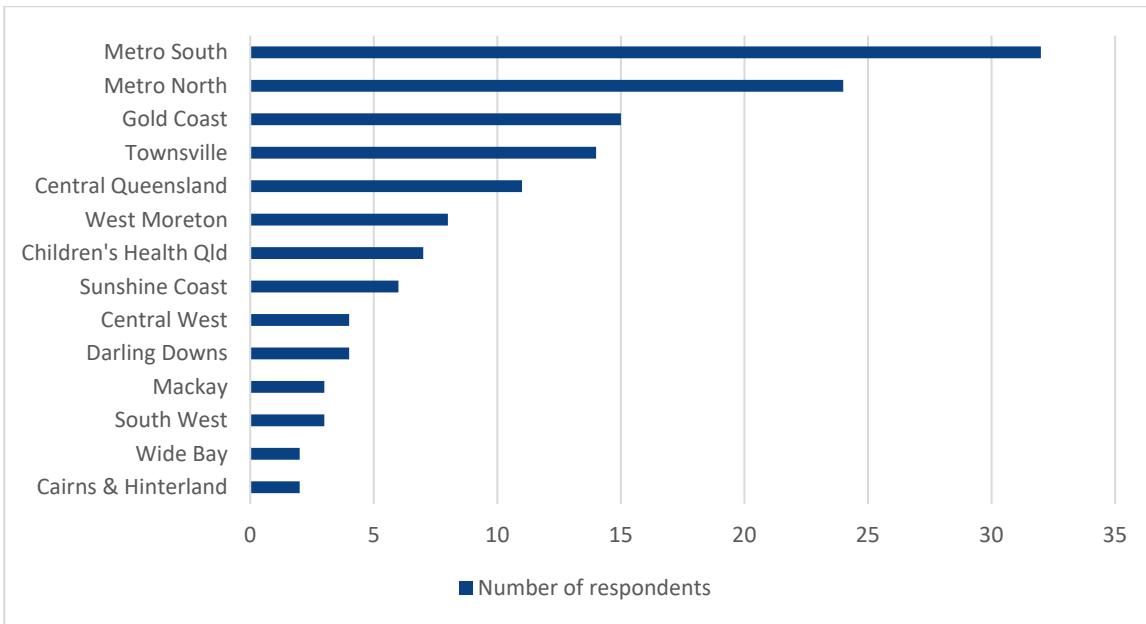


Figure 4: Participant postcode, by state

### Location: Queensland Health employees by HHS

134 respondents named their Queensland Health HHS area, with 271 respondents leaving this field blank. The two largest respondent groups corresponded to the two largest metropolitan HHS areas, Metro South (n=32) and Metro North (n=24). Larger regional HHS were represented in the next largest rankings, with Gold Coast (n=15), Townsville (n=14), and Central Queensland (n=11) completing the top 5 largest HHS participant groups. It should be noted that not all respondents were from Queensland Health, therefore may not have worked within a HHS.

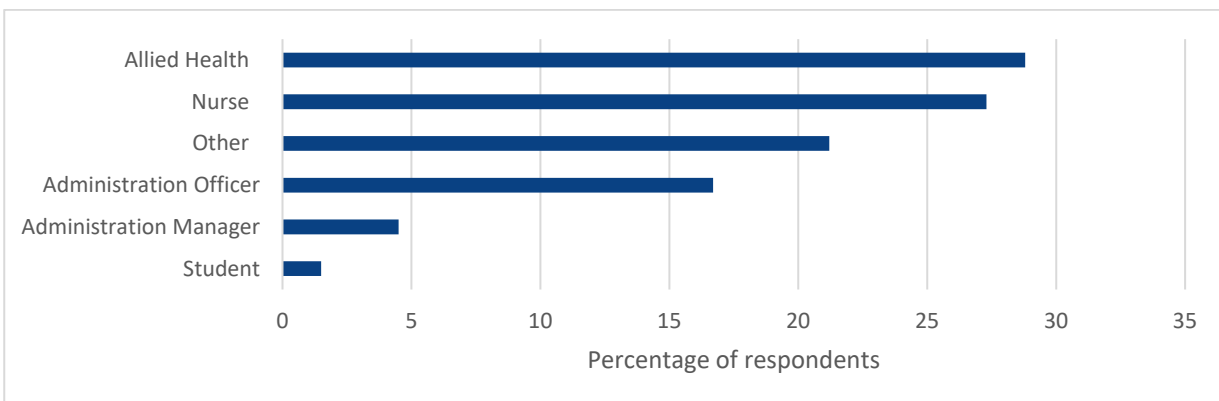


**Figure 5 Location of Queensland Health Employees**

#### 4.1.2. Follow-up survey

##### **Participant professions, by category**

Participants were asked to select their profession from a list of categories which was similar, though not identical, to the categories used by CheckUP in the pre- and post- survey. The majority of follow-up survey participants reported to work in Allied Health professions (28.8% of respondents), followed by nurses (27.3%). Around 21% of respondents selected the 'Other' category in the survey. Most frequent responses included operational services, policy officer, disability liaison officer, optometrist, general manager, and kitchen hand.

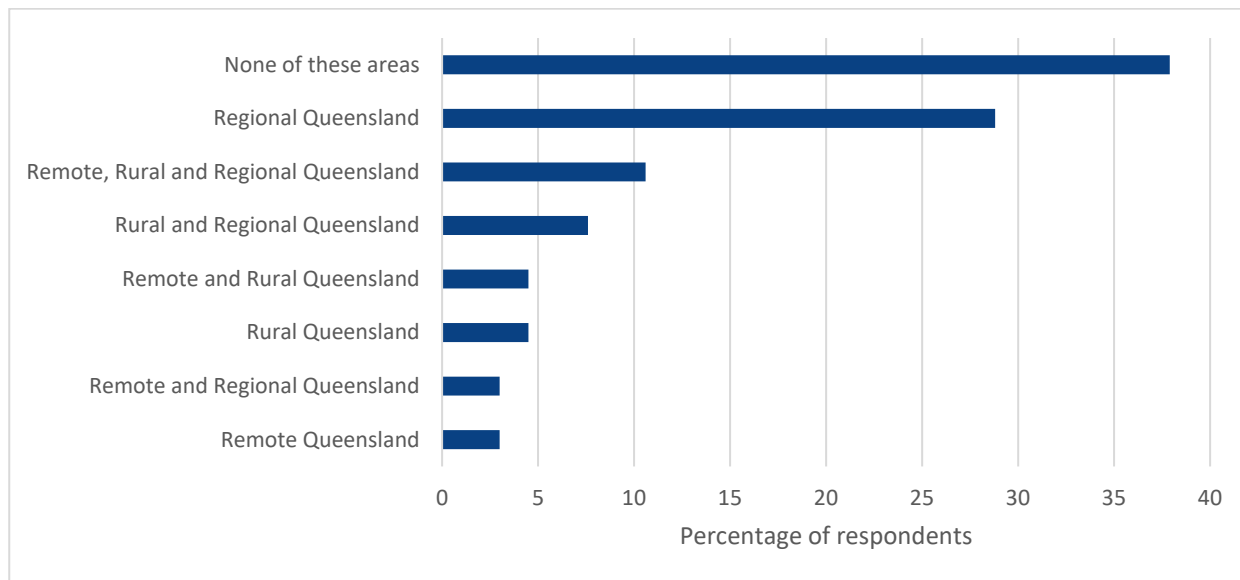


**Figure 6: Follow-up survey professions, by category**

##### **Service locations, by category**

When asked about the region in which they provided services, 28.8% of respondents indicated they worked in regional areas. The survey did not provide definitions for regional, remote and rural categories, and

these can vary in their usage between sectors and disciplines. The survey also did not differentiate between those working in metropolitan areas of Queensland, and all respondents from any other state regardless of area. As such this data provides an indicative overview of the proportion of respondents from outside of metropolitan areas within Queensland, though data from interstate participants and from metropolitan Queensland is conflated in a single category.



**Figure 7: Follow-up survey, participant service locations**

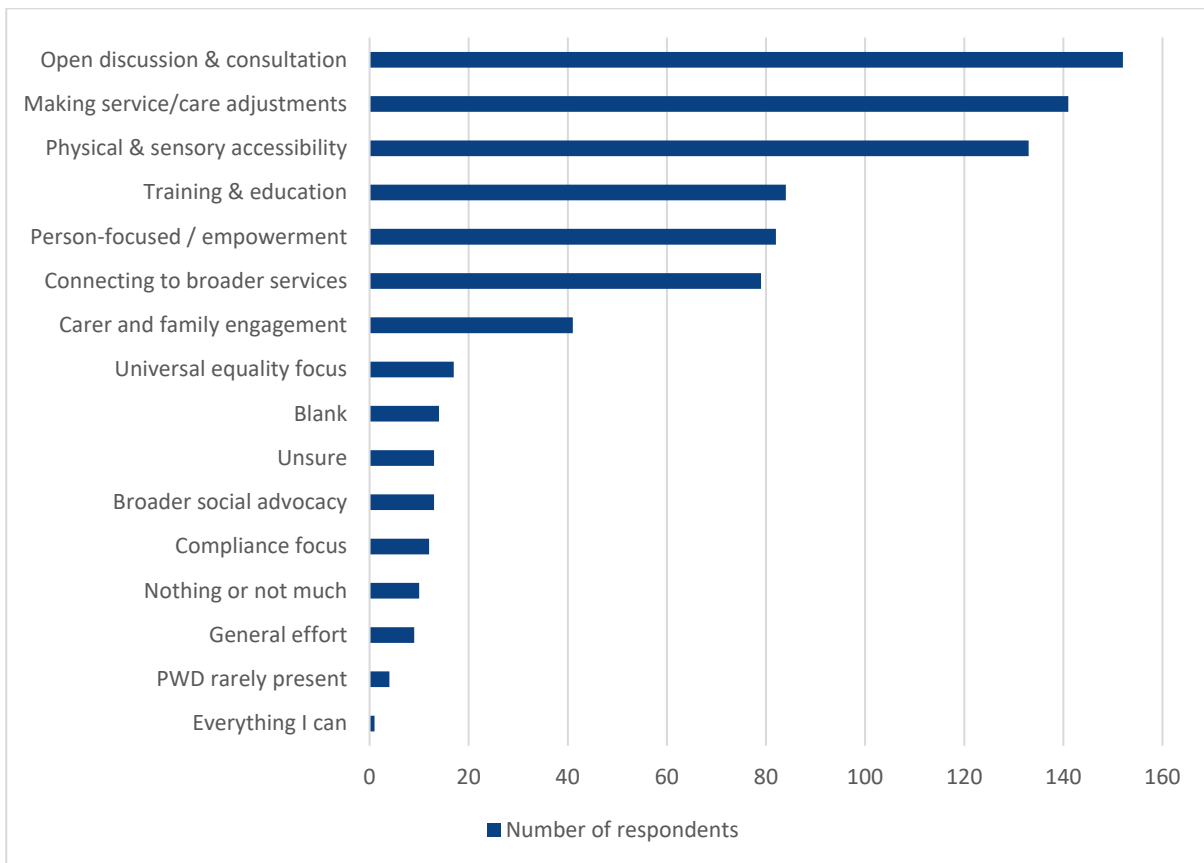
#### 4.1.3. Interview participants

Eleven participants were interviewed during 2022 and the first half of 2023. The participants came from a range of health areas: optometry, nursing, allied health and management. In terms of geographic area of work, the participants worked in Brisbane, regional centres in Queensland as well as far north Queensland. One participant came from the ACT.

### 4.2. Personal and workplace strategies used to support access for people with disability, prior to training

Training participants were asked to list what things they personally do to improve access to their service for people with disability, using an open field. Respondents were asked to list as many as they liked. This data is included here as a qualitative baseline against which later data on the impact of the training can be considered.





**Figure 8: Personal and workplace strategies to support access for people with a disability prior to training, from open field responses.**

14 participants either left this field blank or otherwise did not indicate an answer. The most frequently mentioned personal strategy to support access for people with disability was open discussion and consultation (n=152) followed by making service or care adjustments (n=141). This code included adjustments to behaviours and practices informing interactions with clients or patients, including flexible timing (n=21) and in providing virtual or telehealth consultation options (n=27).

The third most frequently mentioned personal strategy to support access was physical or sensory accessibility adjustments (n=95). This listed physical, concrete or tangible resourcing changes which were intended to support a range of physical or sensory bodily variations, including using assistive technologies.

Survey respondents were asked to list things that their workplace does to improve accessibility for people with disability, using an open field. Respondents were asked to list as many as they liked.

14 respondents left this question blank or otherwise did not provide a response, while 16 were unsure regarding this question, though as one respondent noted, ongoing working from home practices since 2020 may mean that workers are less familiar with their employers' on-site accessibility measures.

A smaller number of overall themes (13 total) emerged through the coding process. The most frequent category of workplace access strategy was physical and sensory accessibility (n=231) which was over twice as many as the second-most frequently mentioned set of measures, which was making service and care adjustments (n=109). In discussing physical and sensory accessibility, most responses did not describe their workplace as broadly catering to this category as a whole, but instead described very specific measures, e.g. listing ramps, railings, pathway accessibility, or lighting. Of these, few physical or sensory accessibility measures exceeded standard best practice for accessibility for publicly accessible buildings.

Training and education (n=92) encompassed individual practitioner research as well as formal education, CPD, and workplace training events. Coordination with external services (n=73) tended to be mentioned in terms wider referral networks, NDIS liaison, or further local services. Codesign, collaboration, and consultation (n=48) described a range of strategies of formal or informal consultation with people with disability, generally reflecting an interest in receiving information from people with disability about practice accessibility and their experiences of healthcare. Examples included involvement in policy design, collaborative groups or committees, or collecting information through surveys.

### 4.3. Awareness of access barriers prior to completing training

Participants were asked to list access barriers which they were aware of prior to completing the training, using an open field. 31 respondents left the field blank. The most frequently identified area of existing knowledge on barriers to access were needs specific to individual conditions and disabilities, with respondents listing specific aspects of accessibility practice (n=12). This included the need for interpreters, awareness of sensory accessibility needs and exertional or energetic load. Due to the smaller size of the respondents for this cohort, these very specific answers were grouped as a single code to highlight that the largest respondent group for this question described their pre-training knowledge as mainly focused on individual details rather than broader or systemic understandings of accessibility in practice. Flexibility in communication and language use was the second-most frequently identified area of prior awareness (n=11).

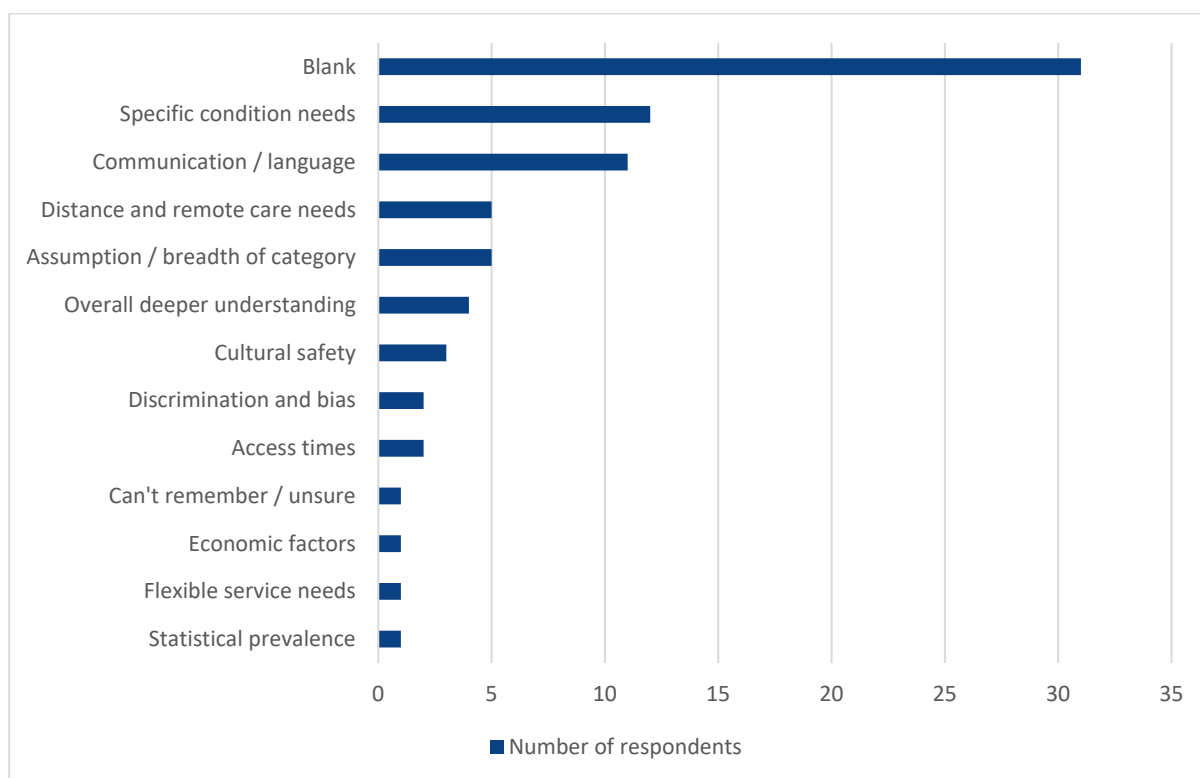


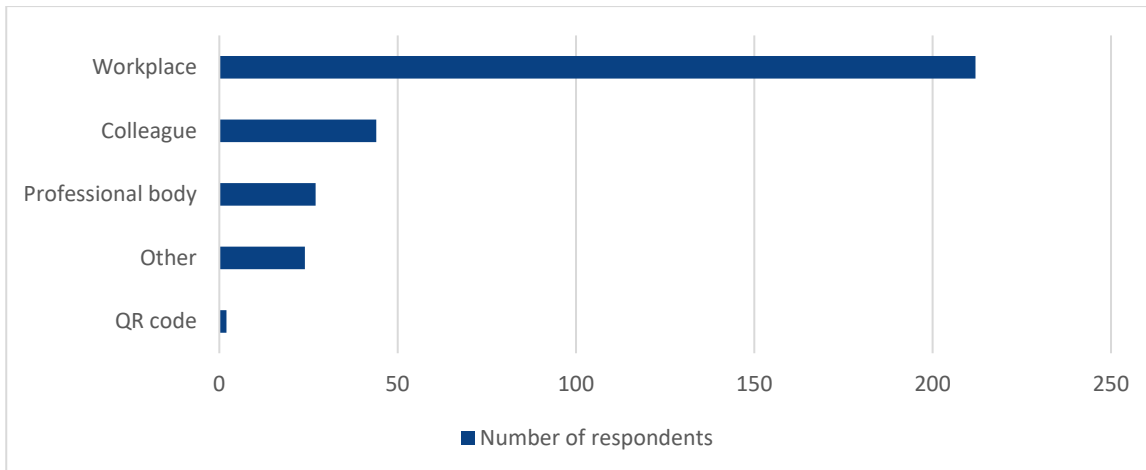
Figure 9: Awareness of access barriers prior to training

### 4.4. How participants heard about the training

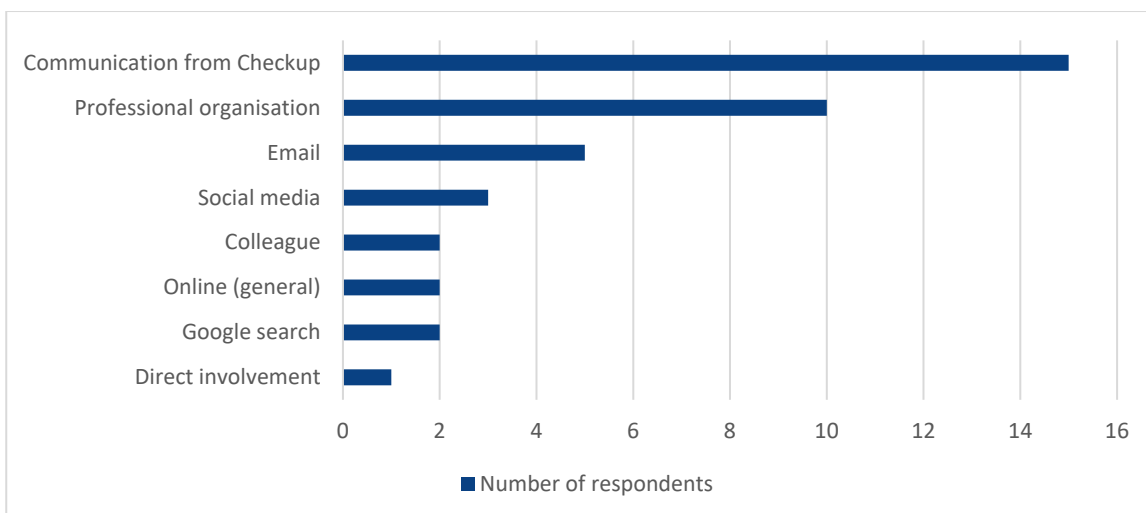
Participants who indicated how they heard about the training had the option to select answers from a fixed list or to use an “other” open field. The largest number of respondents selected “workplace” (n=212), though the main method by which Access for All was promoted at conferences was using a QR code,

therefore “QR code” (n=2) may also overlap with this field. Similarly, the categories “colleague” (n=44) and “professional body” (n=27) may also overlap in practice.

Of those respondents (n=40) who used the “other” field, most (n=15) received information directly from CheckUP, listing their responses as “CheckUP Team,” “email from CheckUP”, “CheckUP Outreach Services”, or simply “CheckUP”. The next largest group (n=10) named a professional organisation, including CRANAPlus, AHPQQ, Optometry Australia, Mental Health Australia, and ADAQ.



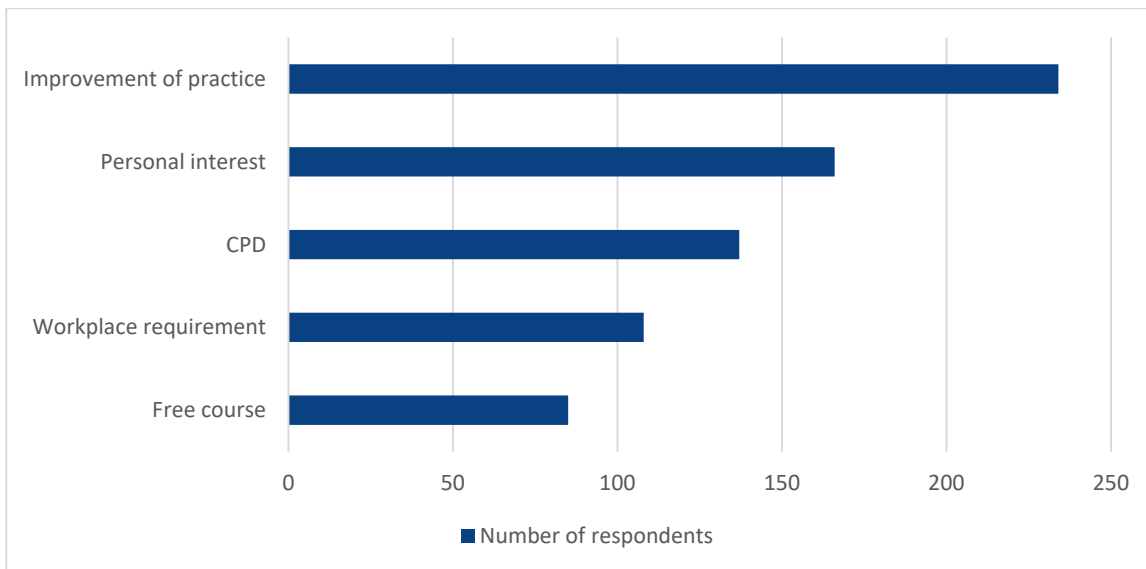
**Figure 10: How training participants heard about Access for All**



**Figure 11: How training participants heard about Access for All, open field**

#### 4.5. Motivations for undertaking Access for All training

Training participants were asked to select their motivation for taking the course from a provided list of five options and were asked to select all that apply. Respondents had the option to choose no options, or otherwise not to answer this question.



**Figure 12: Motivations for undertaking training**

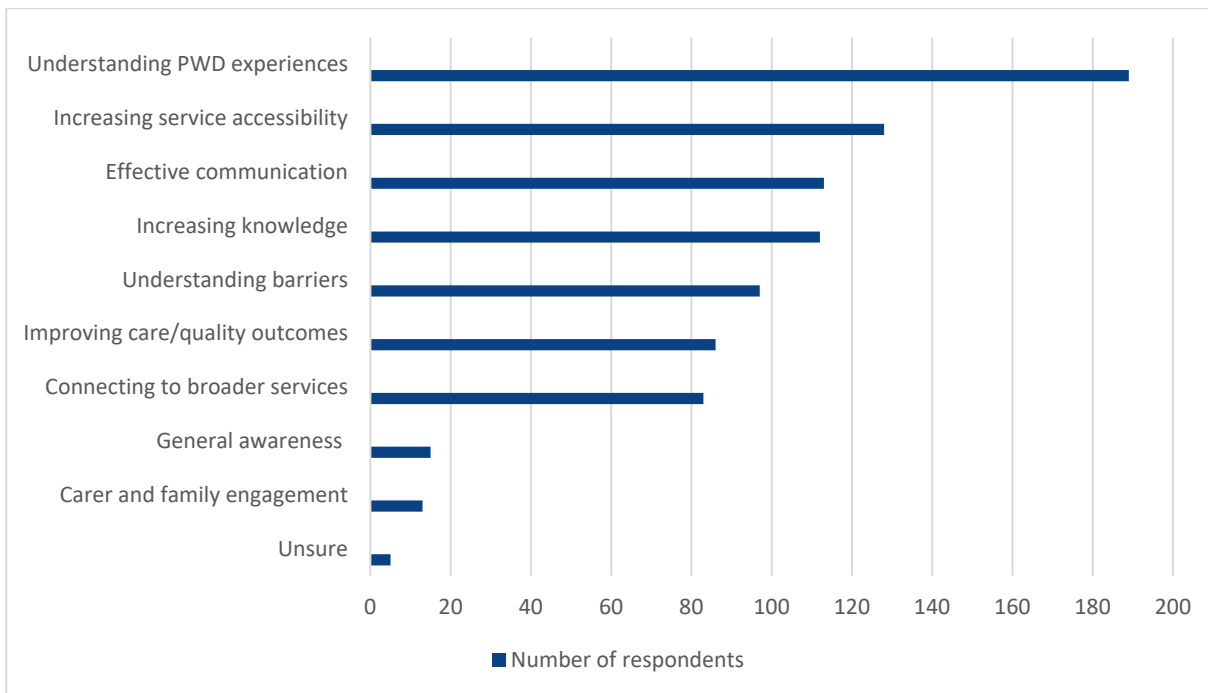
Ninety-one respondents left this question blank. Improvement of practice (n=181) was the most frequently identified motivation for taking the course, followed by personal interest (n=166), continuing professional development (n=137), workplace requirement (n=108), and free course (n=85).

#### 4.5.1. Reasons for Undertaking the Training: Interviews

Interview participants were asked for their reasons in taking the Access for All training, with some participants giving multiple answers. Six participants indicated that they had received recommendations from colleagues or management. Five participants expressed that they wished to upskill or increase their knowledge about disability. Three participants indicated that they “already work in Indigenous areas” [sic] with the implication that they therefore viewed the training as potentially useful to their existing practice.

#### 4.6. Interest in improving skills and knowledge

Prior to completing the training, participants were asked to identify skills and areas of knowledge which they would like to improve upon, providing these answers using an open field. Respondents were asked to list as many areas as they liked. Of the 405 responses to the survey, 8 respondents either left the field blank, indicated “not applicable” or provided an equivalent non-response.



**Figure 13: Skills and knowledge respondents wished to improve on**

11 respondents did not answer this question or left it blank, while 6 were unsure.

Across the entire cohort, the most commonly identified area of skills and knowledge which respondents wished to improve on was their understanding and awareness of experiences faced by people with disability (n=189). The second most frequently identified area was an interest in improving service accessibility (n=128). This emerged as distinct from interest in understanding barriers faced by people with disability (n=97), which was the fifth most frequently identified area. Respondents tended to express the need to understand barriers faced by people with disability in broader terms, whereas improving service accessibility tended to be oriented towards strategic, local-level or practical knowledge relevant to a particular role or clinical setting. Similarly, understanding barriers faced by people with disability was not always expressed as part of a desire to understand people with disability or their experiences directly, and was not always linked to services or any other area.

The third most frequently identified area of skills and knowledge which respondents wished to improve upon was methods and strategies for effective communication with people with a disability, which was named by n=113. This included respondents naming specific communicative skills which they wished to improve, such as communication with people who are non-verbal or those with an intellectual disability. Within this group, 7 respondents were interested in what they consistently termed “correct terminology” or “correct language” to use in communicating with, or about, people with disability. Three respondents indicated that improved communication was important to assist with obtaining consent from clients or patients.

The fourth-most frequently mentioned area of interest for skills development was increasing specialist or practitioner knowledge (n=104). This code referred to factual information regarding disabilities, statistical information, and legal or compliance-based knowledge. This category included the ability to “identify” particular disabilities, or to know more about “different types” of disability. Interest in this category presented as distinct from interest in understanding more about broader service availability and access (n=83) or more strategic forms of information how to improve care quality or outcomes (n=86).

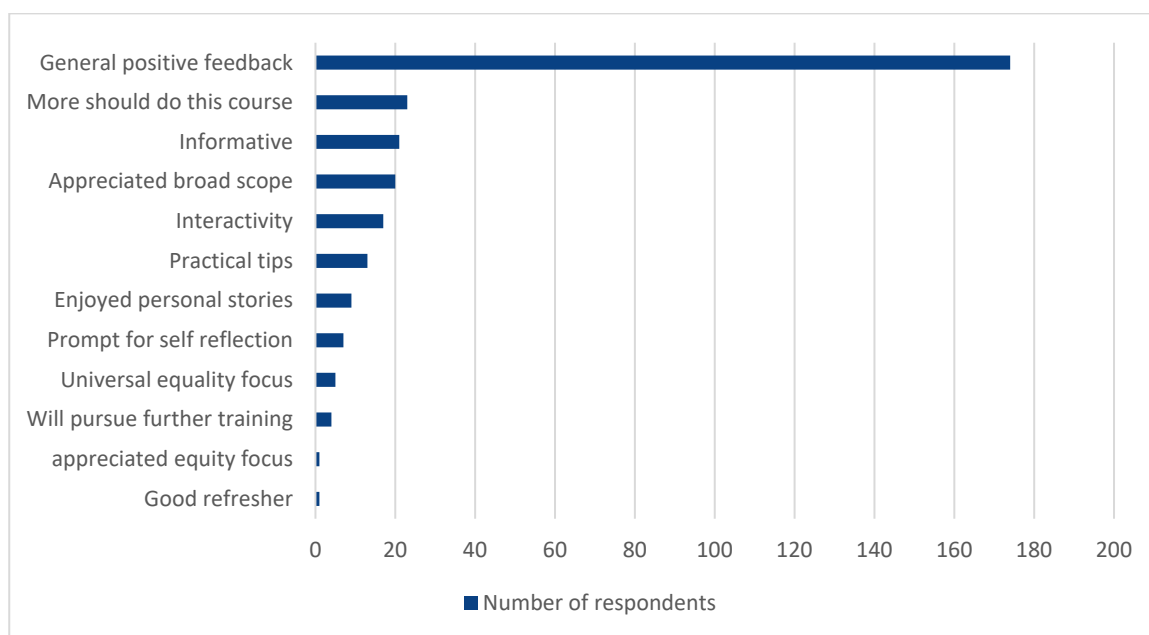
## 4.7. Level 1: Reactions

Findings related to level 1 in Kirkpatrick’s model are included in this section, including satisfaction with the training and participants’ suggestions for improvement, as well as their views on the relevance and usefulness of content and materials. This section also includes non-completers survey data as it provides the initial reactions of those who did not complete the training. The data related to this level has been grouped in terms of the different data collection methods.

### 4.7.1. Satisfaction with training and feedback about the resource

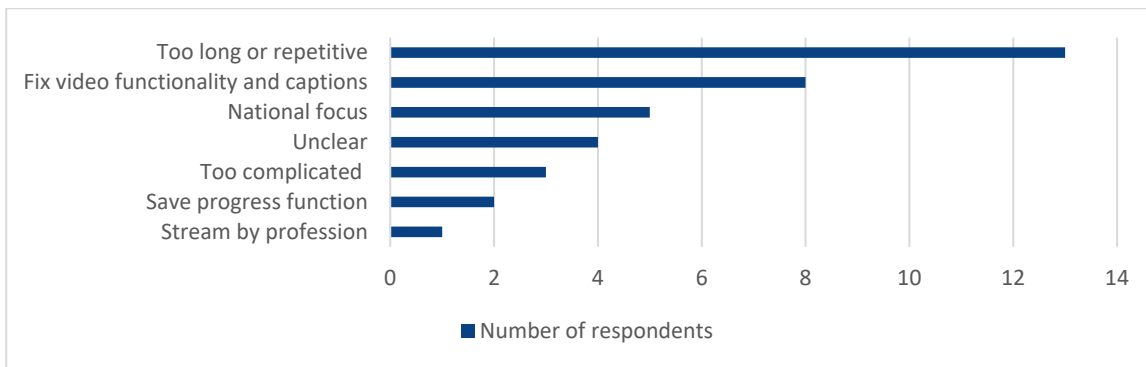
#### Post survey respondents

The post-training survey asked respondents “Do you have any feedback regarding Access for All: Disability Awareness for Mainstream Health Providers?” with the opportunity to respond using an open field. 141 respondents either left this field blank, or otherwise declined to provide feedback.



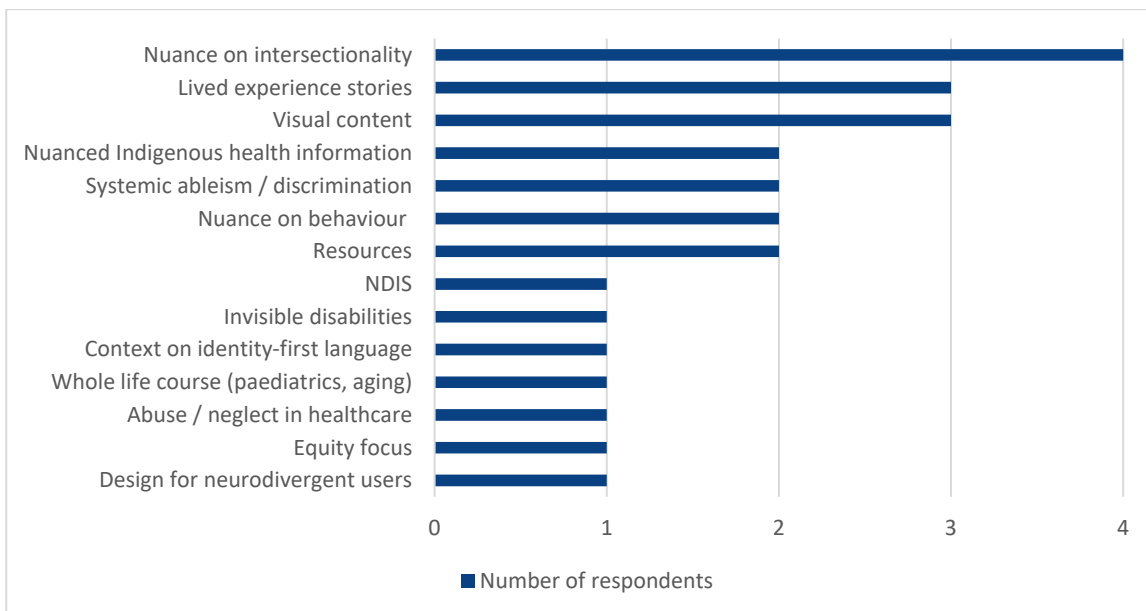
**Figure 14: Qualitative feedback on training modules, post survey respondents**

As illustrated above, the vast majority of respondents provided general positive feedback, including stating that they enjoyed the course, thanking the course designers, or providing other broad brief statements in support of the course overall. Of those who provided more detail, the most common sentiment was that more people should undertake the course [n=23]; a related but separate theme was those who were inspired to pursue further training in this area [n=4]. Areas which were singled out for particular focus were the broad scope [n=20], interactivity [n=17] and practical nature [n=13] of the course.



**Figure 15: Suggested areas for improvement, post survey respondents**

The above illustrates broader feedback which raised particular areas for improvement or amendment. The main themes in these responses were: regarding time commitment, indicating the training was too long or repetitive [n=13] or stating that a clearer ability to save progress would have helped [n=2]; regarding scope, including preference for more national focus [n=5] or streaming by profession [n=1]; and regarding content clarity, including respondents who experienced problems with video functionality and a lack of captions on video content [n=8], those who found the training unclear at times [n=4] or too complicated [n=3].



**Figure 16: Smaller feedback groups, post survey respondents**

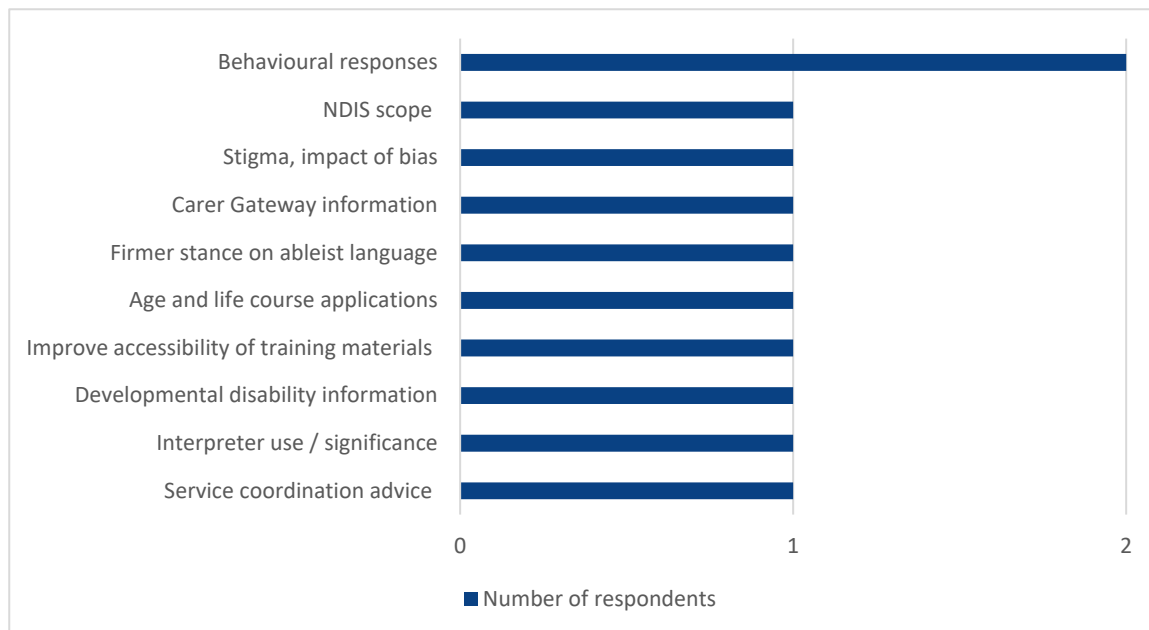
The above illustrates more specific points of feedback which were raised by fewer respondents, but which identified finer details or distinctive perspectives which may not have been noticed more broadly. This is particularly the case as a number of these themes were framed by respondents as either directly affecting them as individuals, or as areas of concern due to their greater familiarity with these areas.

Of these themes, more nuanced exploration of intersectionality, including linguistic, cultural, age, gender, sexuality, and educational factors was the most commonly raised [n=4]. More specific related areas included: more nuance on Indigenous health experiences [n=2]; more consideration of systemic ableism and healthcare’s role within that; nuance on discussion of behavioural labelling; information on invisible disabilities; context on why some people choose to use identity-first language with reference to the social model of disability; consideration of whole-life-course information, including paediatrics and aged care; focus on equity of outcomes; and exploration of abuse and neglect by the healthcare system.

Including a larger number of lived experience stories and perspectives [n=3] was also raised as an area for potential improvement; this was raised separately to the data above which indicated that these perspectives and stories were viewed especially positively by some respondents [n=9].

The accessibility of the course itself was also raised by some respondents, particularly with reference to the clarity and amount of visual content [n=3], and more specifically, design with consideration for neurodivergent users, including awareness of trauma and potential triggers [n=1]. The data above which indicated that video functioning and captions not being available for some videos were concerns for some respondents [n=8] should also be noted alongside these accessibility concerns.

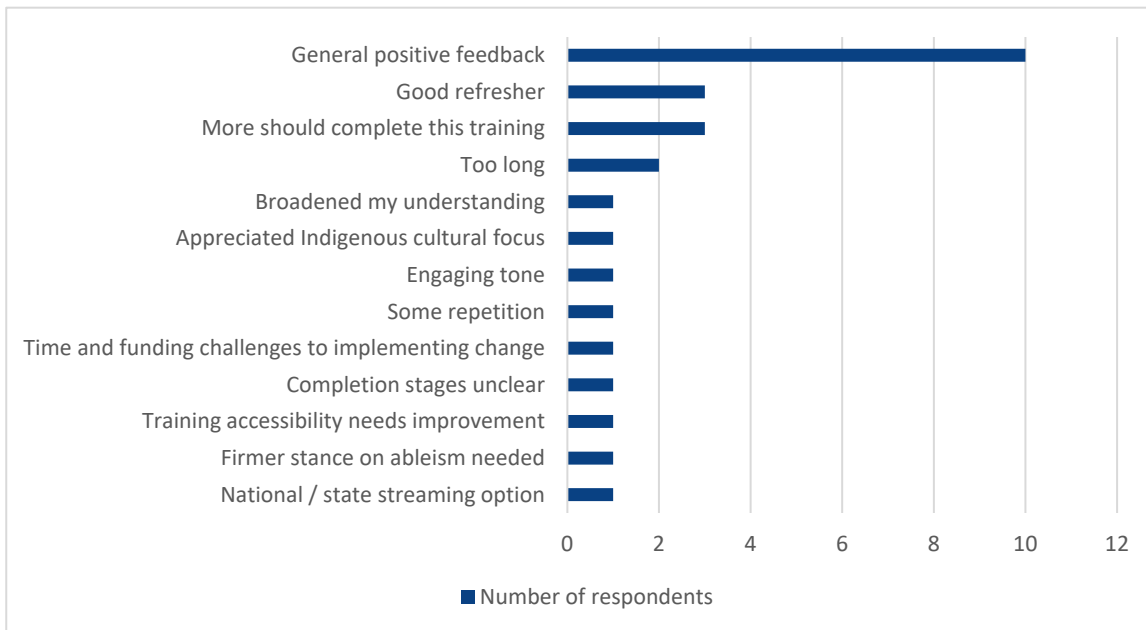
### Follow-up survey respondents



**Figure 17: Additional topics for training, follow-up survey respondents**

Participants were asked if there were other topics which they would have liked to see included in Access for All, using an open field. 37 respondents left this field blank (56.06%), while 15 (22.73%) declined or otherwise stated that they were satisfied with the scope. One respondent indicated that they were unsure. Of the topics mentioned by other respondents, the only topic mentioned more than once was further information on engaging with client/patient behaviour and how best to respond.





**Figure 18: Feedback and comments, follow up survey respondents**

Participants were also asked to provide any further comments, ideas for improvements or suggestions to the training, using an open field. 36 respondents did not answer this question and a further 6 respondents declined to give more detail. Of those who responded to this question, a clear majority (n=10) of responses provided general positive feedback about the training as a whole, with the two next most frequent feedback codes indicating participants who found the training to be a good refresher on their knowledge on these topics and stating that more people should complete this training (n=3 respectively).

More critical feedback tended to be more specific in tone. Similarly, to the post-training survey, two main themes overall shaped these specific comments: feedback on the training design, and commentary on the content. Broadly, the feedback provided to the follow-up survey mirrored the topics identified in the post-training survey, including mention of repetition, structural comments on progress and accessibility, and the potential benefit for streaming by State.

#### 4.7.2. Relevance of training materials and resources

##### **Interviews: perceptions of training materials**

In general, most interview participants were impressed with the course. Several participants felt that the course helped them to understand other people and different cultures better. It was also commented by several participants that it's important to look at the issue of treatment from the client's point of view. One participant provided an example from their clinical experience in caring for a client based in a rural area. This client needed to travel to Brisbane for surgical care. On further questioning it was clear that he had never left his community, and going to the city was a big undertaking:

*“When I did the training, I realised that I need to understand where people are coming from and looking at their situation rather than my preferences. He (the client) when I talked to him further, was more comfortable to wait for surgery, and I realised that suggesting that he goes to Weipa rather than Brisbane was much better for him.” (Interview Participant 1)*

For other participants, the training reinforced what they already knew. The content was spoke of as engaging and useful and although a number of people commented that the information was not new for them, it did reiterate certain ideas and practices. Most participants appreciated having the patient's point of view emphasised (in the videos) and felt that the scenarios shown were very relevant for practitioners working with people with disability as well as for those working in Indigenous communities. The information provided on disability was also seen as useful and helped the participants understand their clients' circumstances and point of view more clearly. A number of comments were given on the possibility of the course being offered as an introductory course at university so that students get a broader knowledge of disability as well as understanding the needs of people in the community:

*"Also, they (practice managers, receptionists) should understand how to structure the diary around people, so they need to understand the needs of people in that situation. So structure business differently if you are dealing with people from communities" (Interview Participant 1).*

A number of participants felt that the Access for All training program could be adapted for an Australia wide distribution.

*"I thought that I had learned a lot from it (the course). I found it easy to follow and use. this course could be Australian wide, gives a really good overview of working in the disability sector." (Interview Participant 11)*

Most participants commented on the videos which gave examples of lived experience, and how useful they were for increasing their awareness of disability. It was also commented that the videos were well structured, informative and engaging with very appropriate content. One participant commented on the usefulness of the accessibility check list. Another participant emphasised that his main takeaway from the training was a greater understanding of participants needs:

*"So, the video helped me to understand that for some clients when they ask me for something I can now understand the importance of this action of this "want" for them" (Interview Participant 8)*

*"I felt that they were excellent learning materials. They met all the standards we work to" interview (Interview Participant 5, hospital staff)*

### **Were there particular activities or resources which you felt were really helpful?**

For most participants the videos where you hear it from the patient's point of view were the most helpful. As was commented by one participant "when you hear it from someone's lived experience, it validates it" (Interview Participant 7):

*"I remember thinking that the revision about the current day philosophies of disability and how we perceive it, social, medical models etc, very relevant. Good perspective and made me feel good about what I was doing. Enjoyed the ap on the website, knowing about different disabilities, good general knowledge about disabilities and being aware" (Interview Participant 10)*

*"I thought that all the accessibility features were good, and had understandable titles there was not loud music playing over the words.... well balanced. Well put together. Very user friendly" (Interview Participant 7)*

### **Were there particular activities which you did not find helpful?**

Most people agreed that they were impressed with the resources and felt that they were helpful. One participant felt that the training was more relevant for the managers and permanent people in his practice. Another participant commented that the content was useful for revision, and it was good to have it confirmed that what you are doing is correct and relevant. In general, all participants felt that the activities were helpful and relevant to their practice,

*“I don’t remember thinking that anything was unhelpful. Good for revision -I have been in the field a long time, so good to have it confirmed that what you are doing is relevant and correct.”  
(Interview Participant 10)*

### **Are there other topics which you would like to see included in the training?**

Generally, this question yielded limited answers. One participant commented that if any more topics were added it could be too much. It was commented by one participant that possibly some more tips on how allied health professionals could work better with those with a disability could be useful. Another person would have liked to see more on working with people with an intellectual or communication disability. Several people suggested that the course should be part of mandatory training for those working in the area of disability.

*“What I would like to include is something for the front-line team. i.e., receptionists, in particular things they need to think about. Also, they should understand how to structure the diary around people, so they need to understand the needs of people in that situation. In other words, you need to structure business differently if you are dealing with people from indigenous communities. Not just the receptionist but the practice manager as well “(Interview Participant 2)*

Another participant who works in Indigenous communities suggested that the social and cultural barriers should be further explained. This participant described their experiences of working with clients and patients where different family members may accompany them to each appointment. Understanding family networks is important and ensuring that the information received at each session is spread to all family members is essential. This participant raised another issue, that of mistrust of health services by some Indigenous peoples.

*“.....but there is a lot of mistrust in health services (was touched on a little in the course), but perhaps adding some strategies people have used to get around it. Perhaps going to see elders, or high up social connections, getting the word up to build trust, sharing yourself and your services – good content to include.” (Interview Participant 7)*

It was commented by one participant that the training had made her think of design in the hospital setting, in terms of sensory issues:

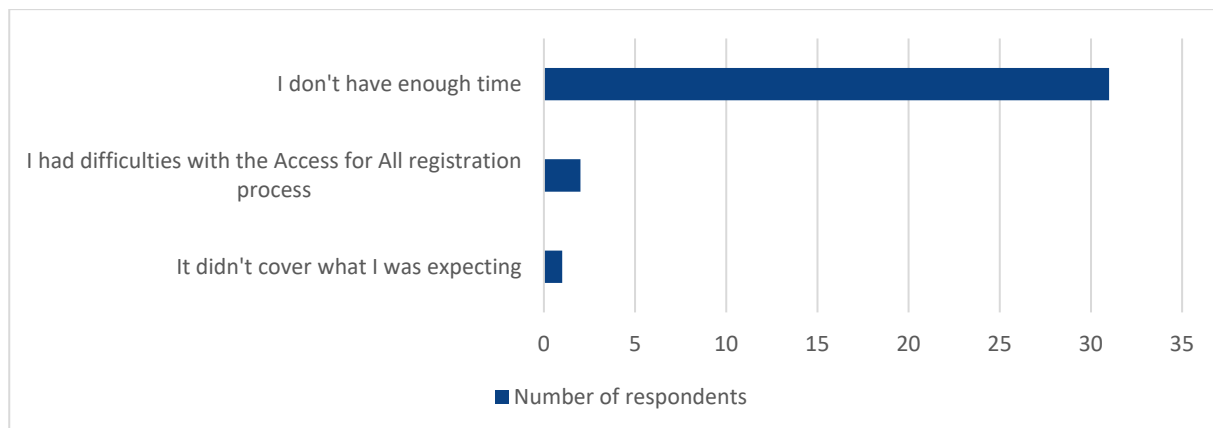
*“Think about lighting and sound in hospitals, often people with a disability find it difficult. We should think more about design.” (Interview Participant 2)*

### **Promotion of the course**

It was commented by a respondent in the ACT that the course was promoted internally as part of disability awareness, and the International Day of Disability. Although the information was Queensland specific, it was promoted as a really good tool which could be adapted for other states.

### 4.7.3. Non-completer survey respondents

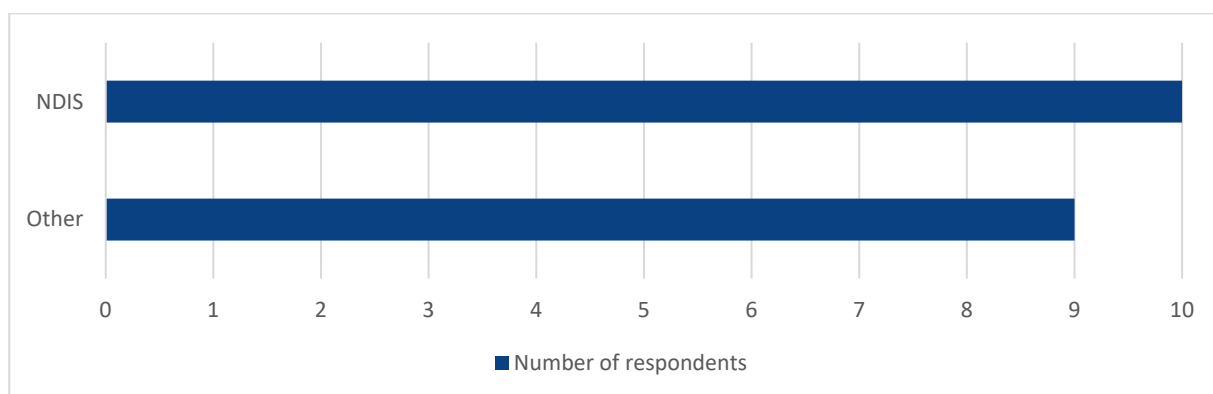
Respondents (n=34) were asked to identify factors that led to their not completing the Access for All training from a provided list. The majority of survey participants who had not completed the Access for All training did so because of a lack of time, cited by 91.18% of respondents (n=31). Two participants identified issues with the registration process, and one participant indicated that the training did not cover what they were expecting.



**Figure 19: Non-completer survey, reasons for non-completion**

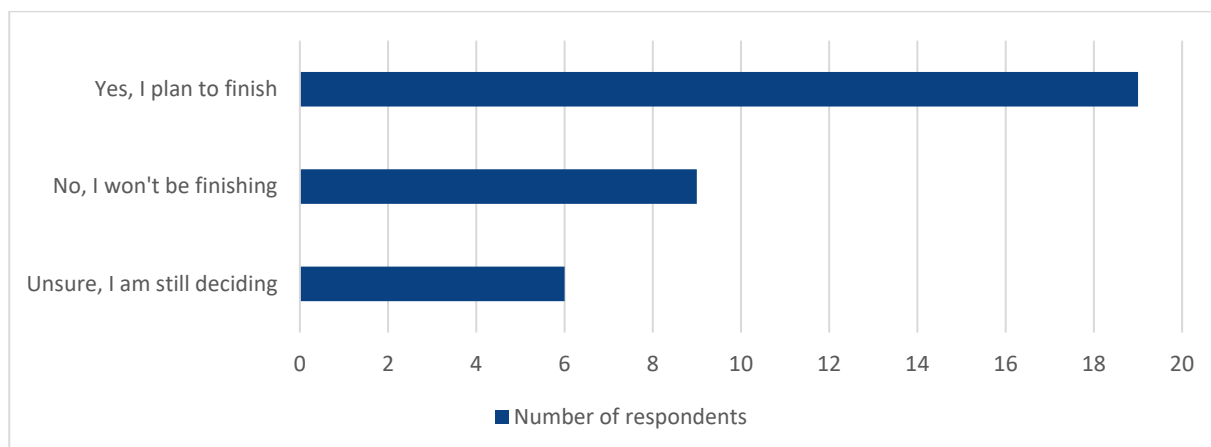
In an open field, participants were asked if they needed help with registration, to please provide their name and contact details. Three respondents instead used this field to provide additional feedback; two participants elaborated on time constraints, and a third participant indicated that they had problems with the registration and therefore were not able to access module one so was unable to progress any further with the training course.

Participants were asked what they “thought the Access for All training was about”, with the option to select “NDIS” or “Other”, and then to elaborate using an open field. Respondents were able to skip or otherwise not to answer this question.



**Figure 20: Non-completer survey, beliefs about training**

Of the 18 responses to this question, over half (n=10; 55.56%) indicated that they believed the training was about the NDIS in some way. Of those who used the “Other” field to elaborate, five participants indicated that they believed the training was about working with people with disability in general. One participant indicated that they believed the training was not relevant for administrative roles; utilising other services; or accessibility issues in general. One further participant was unsure.



**Figure 21: Non-completer survey, plans for completion**

Over half of the non-completer survey respondents (n=19; 55.88%) indicated that they planned to finish the Access for All training in future, with just over a quarter of respondents (n=9; 26.47%) stating that they did not plan to finish the training and the remaining respondents (n=6; 17.65%) indicating that they were unsure. Respondents were asked if they wished their account to be closed or remain open, with a majority of respondents (n=26; 76.47%) indicating that they wished for their account to remain open “just in case”. This indicates that of those who had not been able to complete the training, a sizable proportion of those respondents remained open to the possibility of doing so in future should they be able to do so.

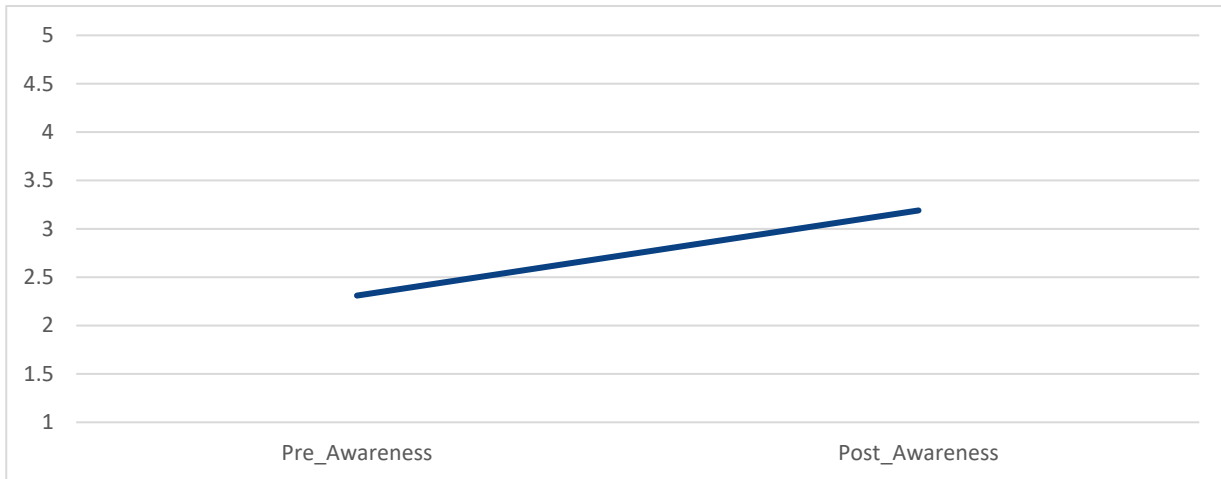
## 4.8. Level 2: Learning

This section includes a summary of results related to level 2 in Kirkpatrick’s evaluation model. These findings relate to participants’ self-reported changes in disability awareness, knowledge of barriers to accessing healthcare services, and what they had learned as a result of completing the online course. Results have been organised by data collection method.

### 4.8.1. Changes in disability awareness and knowledge of access barriers

#### Post survey respondents

Participants were asked to report on their level of disability awareness before and after completing the training, using a numeric scale ranging from 1 (low) to 4 (very high).

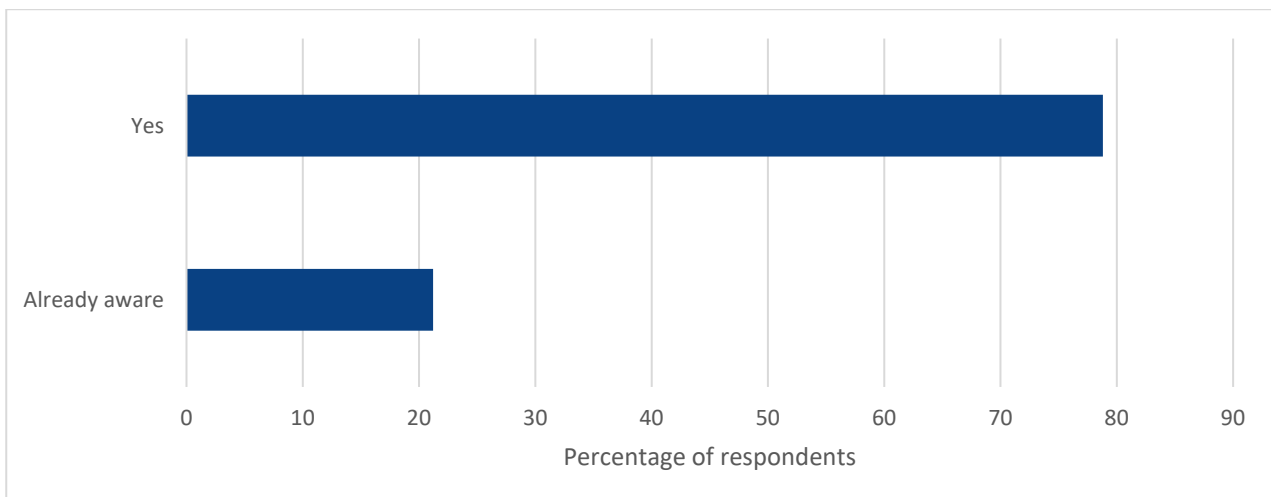


**Figure 22: Mean scores in disability awareness before and after training**

Participants' self-reported awareness increased before and after completing the training (M = 2.31 and M = 3.19 respectively). The increase in disability awareness was found to be statistically significant [t(388)=-20.442, p<.001].

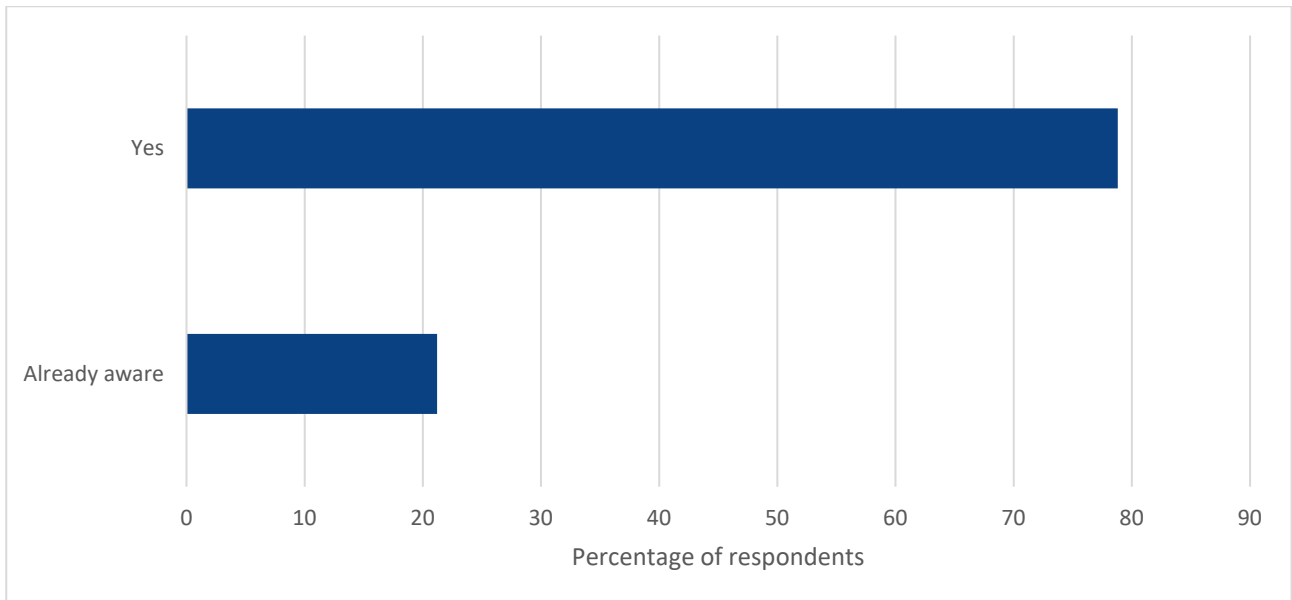
### Follow-up survey respondents

Respondents were asked to report on whether they had increased their awareness for training on accessibility to health care services for people with disability. The majority of respondents reported an increased awareness (66.7%), whilst the remainder of respondents noted that they were already aware of the need for training.



**Figure 23: Awareness of the need for training, follow-up survey respondents**

In addition, participants were asked to indicate whether their awareness of the different types of access barriers that people with disability experience had increased after completing the training. The majority of respondents reported an increased awareness (78.8%), with the remaining participants noting that they were already aware of the barriers experienced by people with disability.

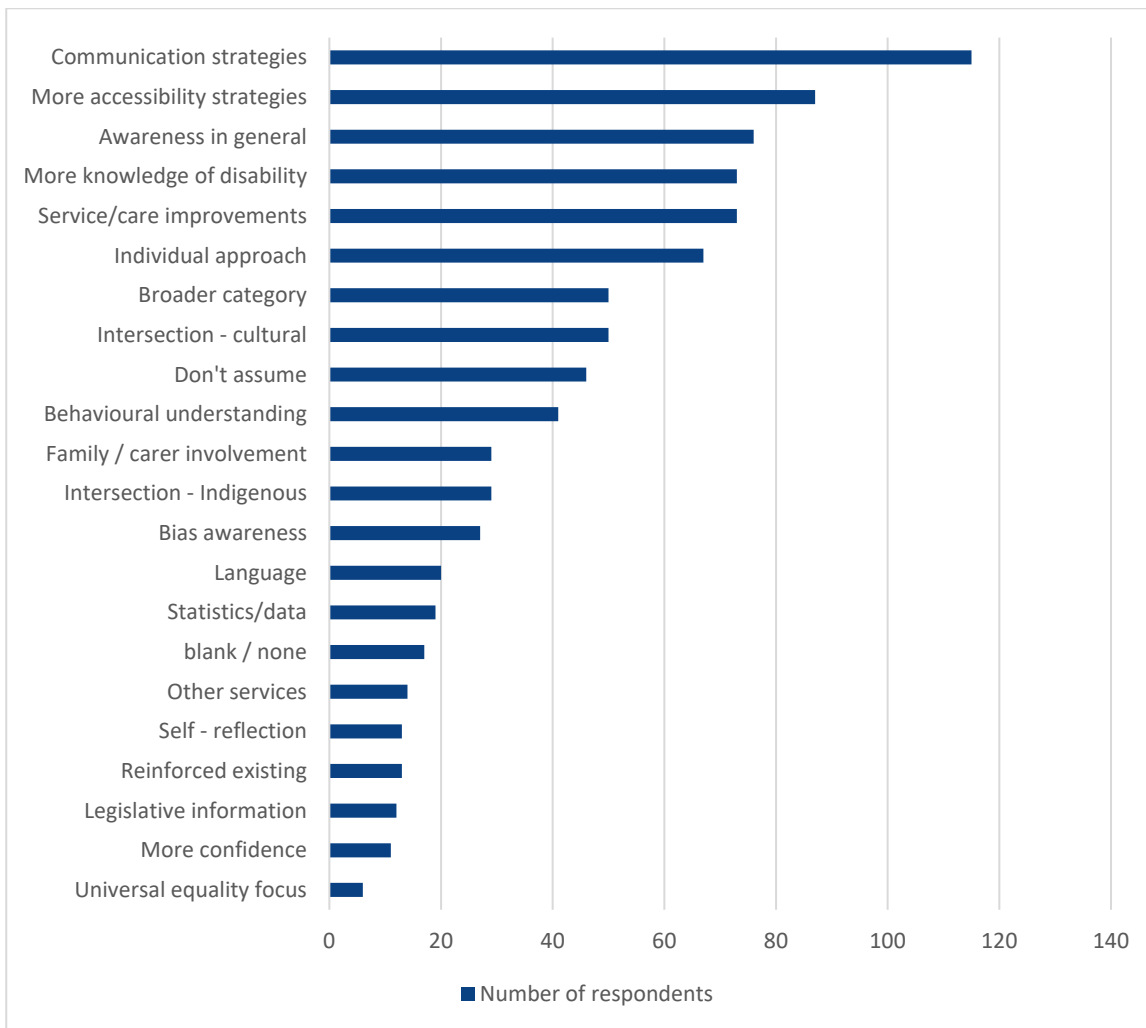


**Figure 24 Changes in awareness of types of access barriers, follow-up survey respondents**

**4.8.2. Learnings from completing the training**

**Post survey respondents**

In the post-survey, participants were asked what they had learned by completing the Access for All training, asked to list as many topics as they would like. Due to the ability to provide multiple responses to this field, response frequency was identified through qualitative coding of responses.



**Figure 25 Learning from completing the training, post-survey respondents**

The most frequently identified area of learning was communication strategies (n=115). Responses frequently described improved communication strategies as being associated with respect and patient-focused care, and identified these in the plural, indicating an awareness that a singular method of communication is an access barrier. Specifically asking patients or clients about their needs was a central element, as was the importance of using interpreters, easy English and accessibility technologies. A related but distinct category was what respondents described as “correct” or “appropriate” language (n=20) which tended to be mentioned in isolation, and referred to specific terminology, and the difference between person-first and identity-first language.

The second most frequently identified area of learning was on accessibility strategies which could be applied in their workplace or practice (n=70). A related area was the fifth most commonly mentioned by respondents, which was knowledge of potential service improvements (n=56). These learnings focused on the way in which services were provided could obtain equitable outcomes for a person with disability. These were differentiated from accessibility strategies, in that these service improvements involved procedural and behaviour adaptations to how the work of healthcare was done, rather than additive technologies or the introduction of additional tools. Service improvements which were listed included adaptations of intake procedures, changing the location or duration of appointments, flexible timing,



increasing telehealth usage, or other consultative approaches which could be communicated about with the person receiving care.

The third largest area of learning was more knowledge of disability (n=73). A number of participants listed becoming more aware of invisible disabilities, neurodivergence, sensory processing issues, and the complexities of disclosing disability in healthcare contexts. Becoming more aware of how disability impacts people's lives, and how that can shape healthcare outcomes, was included in this category. A separate but related category was the seventh-most frequently listed area of learning, which was that disability was a broader category than previously understood (n=43). Within this category, respondents described increased awareness that access was "more than" a ramp (n=6), or that disability were "more than" or "not just" physical (n=10) to describe a heightened awareness of disabilities beyond visible physical impairments. As one respondent noted, "disability issues are more complicated than I previously thought."

A related but distinct category was "don't assume" (n=46), referring to the importance of actively engaging with individual people with disability. This was identified as a discrete code due to the significant uniformity of wording in responses, where almost all respondents reported under this code used the phrasing "don't assume," "always ask not assume", and "never assume". These were mentioned in the context of not assuming what condition a person may have; whether a person has a disability or not; or what their specific access needs are. The consistency of this wording suggests consistent messaging from the training itself.

A distinct category of respondents identified behavioural-specific knowledge, particularly understanding the motivations for what some respondents called "challenging" behaviour (n=35). This tended to be mentioned in isolation from broader knowledge of disability as a category, or of specific conditions, and appeared to be oriented towards understanding patient compliance rather than consent. One respondent noted an increased awareness that they may wish to reconsider involving the police in response to behaviour they found challenging.

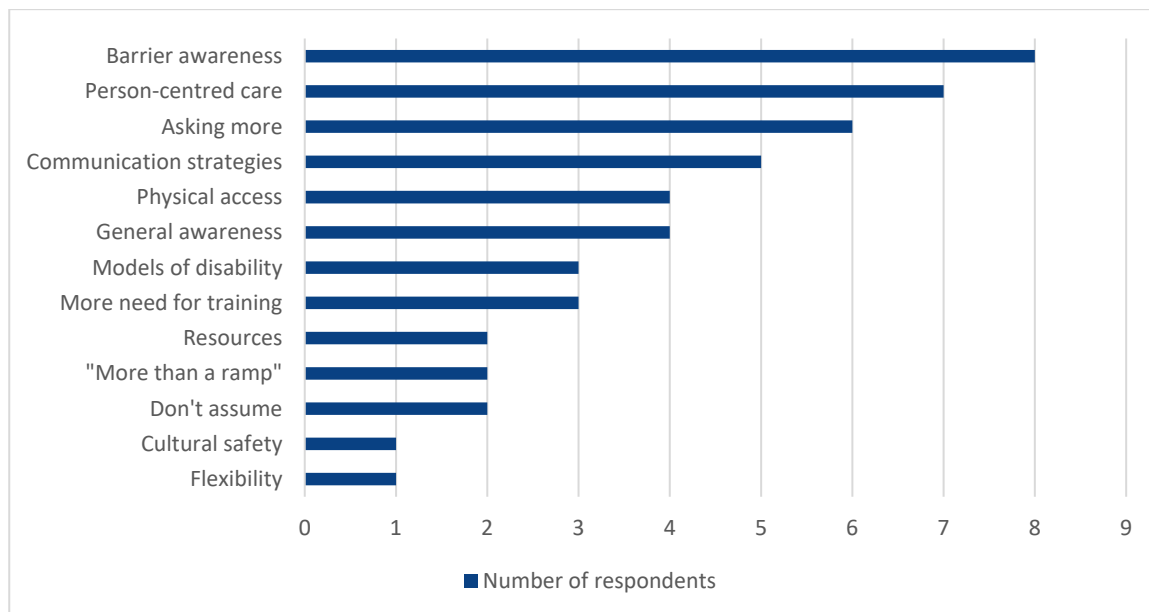
There was also a lower number of responses using language with a universal equality focus in the post-survey responses to this question (n=6) when compared to the pre-survey (n=17 personal strategies; n=12 workplace strategies). Universal equality language included mention of how all people should be treated in the same way, that there should be a focus on ability rather than disability, or that approaches to care should be universal and identical regardless of the patient. The lower number of respondents using this universal equality language in the post survey indicates that the value of specific, differentiated engagement was conveyed by the survey.

### **Pre- and post-survey: comparing personal strategies and subsequent learnings**

While those completing the training indicated a range of strategies they used to support people with disability in the past, responses to the post-survey indicate that there were nonetheless a range of specific practical strategies and broader attitudinal shifts which training participants identified as key areas of learning. The consistency of language use around accessibility being "more than a ramp", the importance of asking more questions and "don't assume", indicates that messaging from the training itself had been clearly received on these topics in particular. A range of related codes indicated that on completing the training, participants viewed disability as a broader and more complex category than they had done previously, including its intersections with other forms of marginalisation. Relatively fewer participants indicated that the training had simply reinforced their existing knowledge, and of those who indicated this, most participants also identified specific additional areas which were newer to them, or which were being viewed from a new perspective.

## Follow-Up Survey

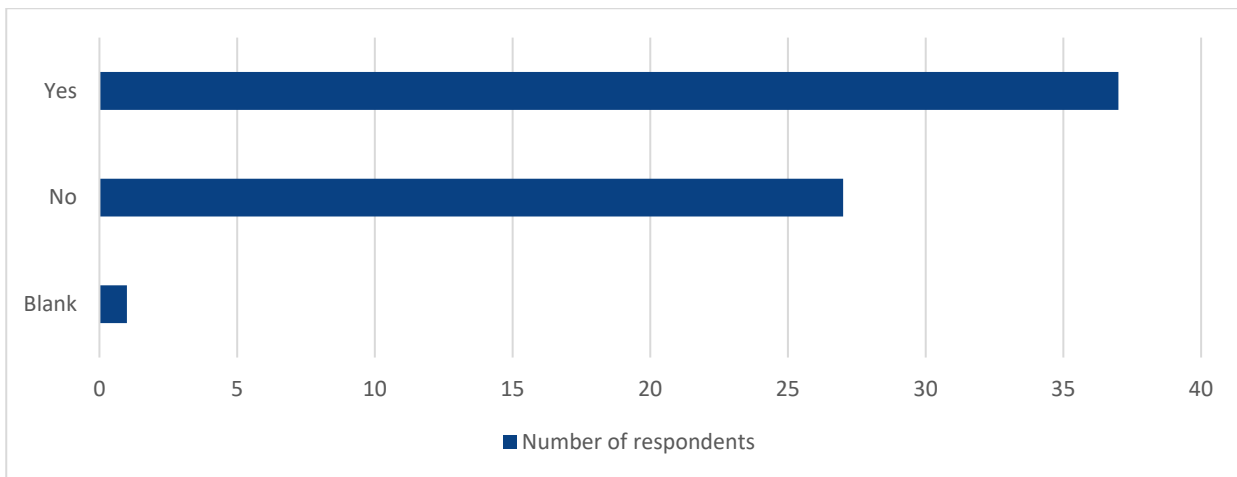
Participants were asked “What learnings have been most useful since completing the Access for All training,” with the opportunity to respond using an open field listing as many learnings as possible. Responses were coded inductively according to principles as used throughout this evaluation.



**Figure 26: Learnings after completing the training, follow-up survey respondents**

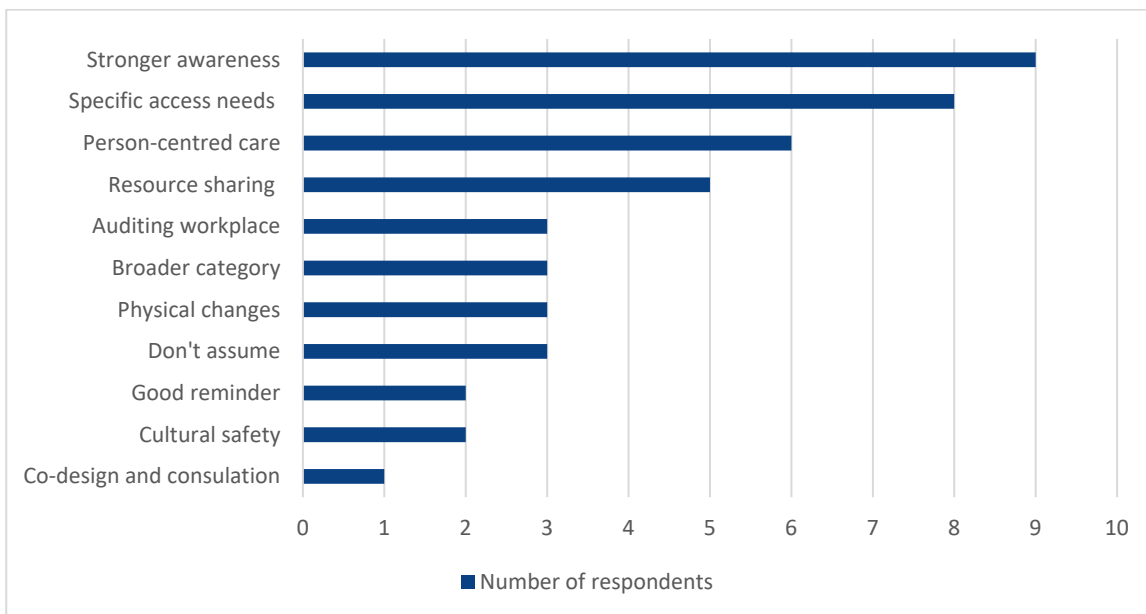
Nine respondents left this question blank. The most frequently mentioned useful area of learning was in awareness of barriers faced by people with disability (n=8), followed by ways to adapt to a more person-centred care approach (n=7) and the need to ask more questions of people with disability (n=6). The topics raised in this field were broadly consistent with those which emerged in the post-training survey cohort, including in the use of consistent terminology around disability being “more than a ramp” and the phrasing of “don’t assume”.

Participants were asked if they had acquired any specific knowledge, awareness or attitudinal shifts which they are considering applying in their practice or workplace, with the option to select yes or no, and if yes to provide more detail in an open field.



**Figure 27: Application of learnings, follow-up survey respondents**

34 of the 37 respondents who responded “yes” to this question used the open field to further elaborate on their response. The below chart illustrates inductively coded responses using this field.



**Figure 28: Application of learnings, open field, follow-up survey respondents**

Respondents to this question in the follow-up survey tended to describe more broader attitudinal shifts, with a number of themes emerging around shifts in mentality and approach to engaging with people with disability. This included consideration of disability as a category which intersects with other forms of marginalisation, the need for person centred care and flexible service delivery, and the importance of not making assumptions. Specific and practical changes or proposed changes tended to focus on information sharing and application, including auditing the workplace and sharing resources with colleagues. Further physical changes to workplaces also emerged as an area for the application of ideas learned during this training.

## Interviews

### What learnings from the course are going to be transferred to the workplace?

Comments from the participants agreed that the training will make them more aware when working with people with disability, or those from Indigenous communities. One participant commented that he has changed his practice already, to make it easier for Indigenous people to get to the city for treatment. Another participant commented that she and her children are all autistic and the course discussed sensory issues – ideas which she has now incorporated into the hospital where she works in Brisbane. It also assisted a lone practitioner to reflect on her practice:

*“It made me revise, not change anything, but made me think about access for people with varying disabilities. I think I have done that, but in a rural space, there is not a lot of options. But I did do an audit of my spaces, and also my website.” (Interview Participant 10)*

Participants were asked if there were changes which they intended to make to their practice after undergoing the training. Most participants commented that they were looking at their policies and procedures as well as recognising that often clients receive multiple services and they needed to coordinate with other services to improve the overall service for people living remotely.

*“One area I have changed, I do go to a more rural areas now, do that once a month, to service NDIS people in a community where there is a need for allied health” (Interview Participant 8)*

One participant talked about access for clients and that their practice is creating pathways for vulnerable clients to make it easier for them to access care:

*“My colleague has said that it is difficult to access care, so we have a pathway in place for our vulnerable clients, by using the disability nurse navigators, or having someone who would contact us and do the booking.” (Interview Participant 3)*

Several participants talked about the course being a reflective practice for them. For most participants the course was useful and relevant. Several participants were going to encourage the staff at their workplace to undertake the training. For most, the experience had made them more aware of some of the difficulties facing those with disability, or those from Indigenous communities. One person suggested that having input from rural and remote people in the design of the course could be useful. In general, the comments from the participants reinforced the message that the course is transferrable everywhere.

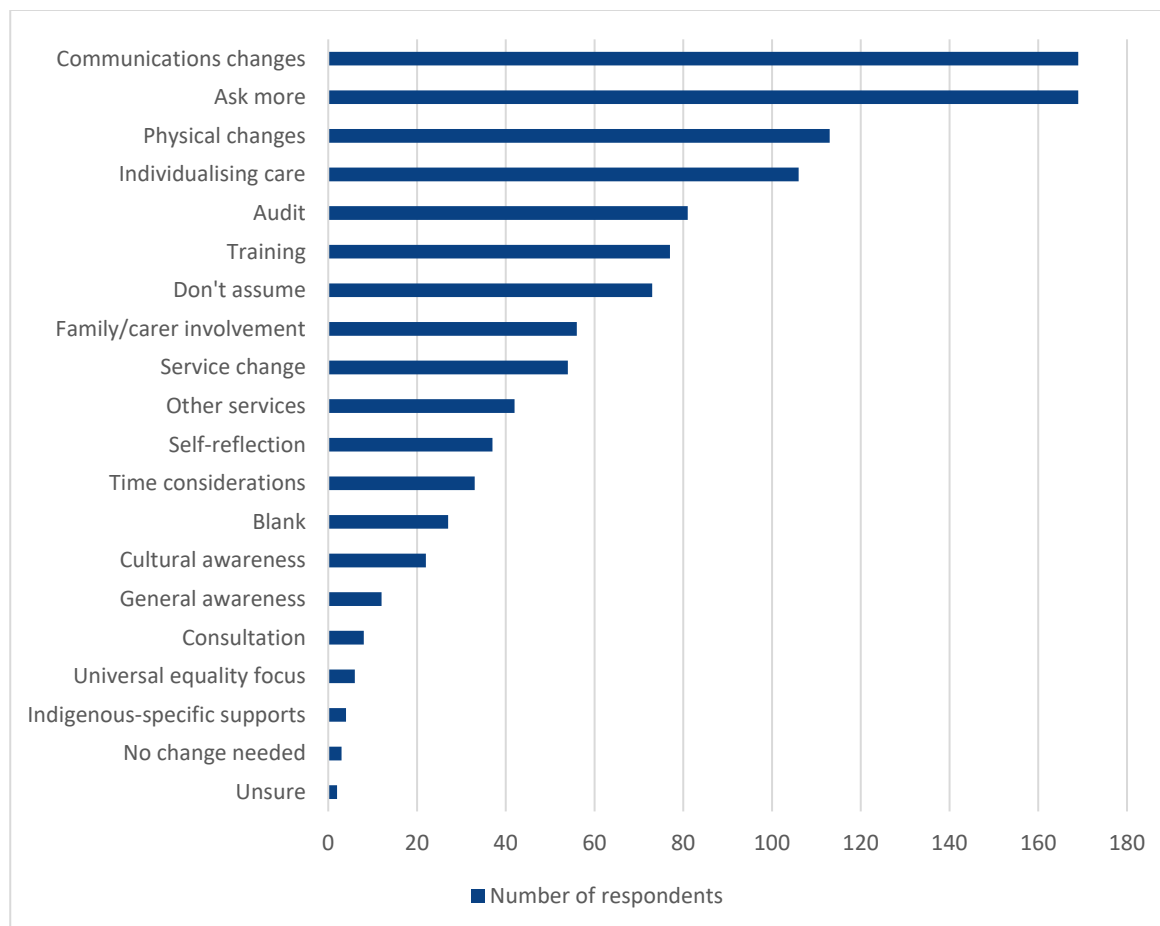
## 4.9. Level 3: Behaviours

This section includes a summary of results related to level 3 in Kirkpatrick’s evaluation model, with a focus on results related to intentions to change practice and barriers/enablers to successful practice change.

### 4.9.1. Intentions to change practice and areas of workplace improvement

#### Post-survey respondents

Participants were asked to identify the three things that they had recorded in their workbook, which they would “now personally do to improve access to the service you provide for people with disability.”



**Figure 29: Intentions to change practice, post survey respondents**

The two strategies which received equal-highest numbers of responses were to ask clients/patients more about their needs; and changes to communication strategies, including written, visual and verbal modes of communication (n=169 each). Physical changes to workplace environments were the third-most frequently mentioned (n=113).

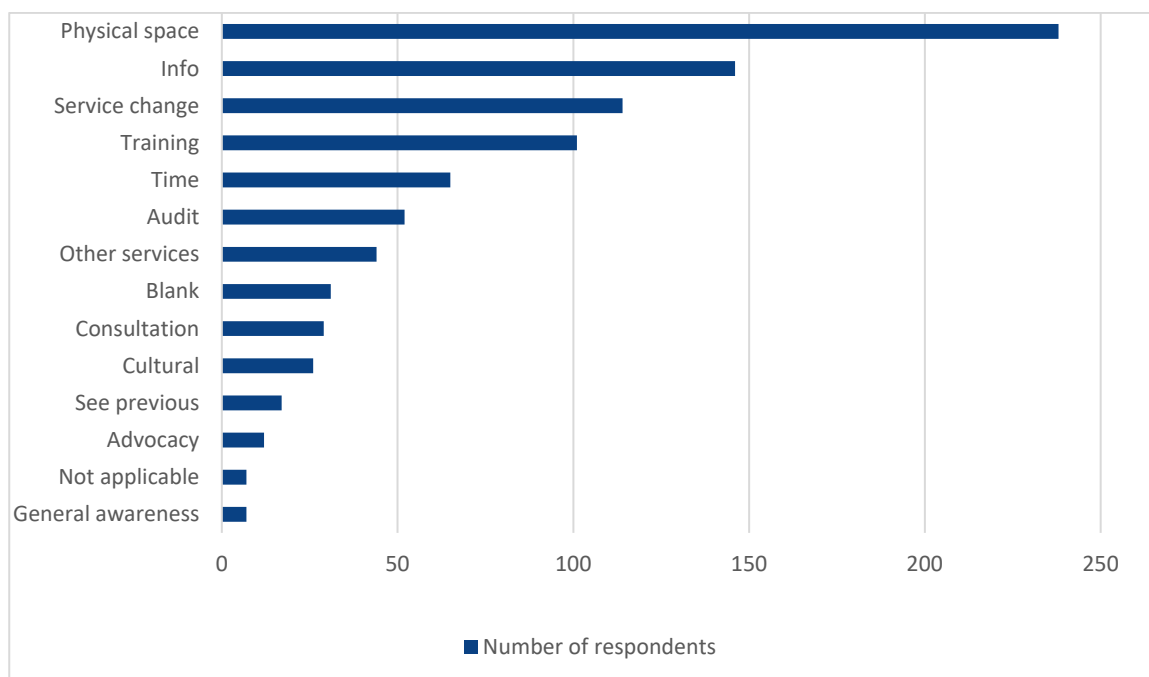
“Don’t assume” (n=73) emerged as a distinct code from “communication changes”, which tended to focus on formal communications such as phone, website accessibility, forms and data collection, and strategic changes to interactions with clients/patients. “Don’t assume” appeared with reference to challenging preconceptions held by the survey participant, e.g. ensuring not to assume that people with disability were not competent, or ensuring to not assume the disability status of an individual, particularly with reference to invisible conditions. “Asking more” as a code emerged as distinct from consultation, which involved formally soliciting input from disabled people for the purposes of service change, whereas “asking more” specifically referred to asking more questions of the client/patient and/or their carers and families where

appropriate. “Asking more” included a range of wordings, while the wording of the “don’t assume” code was extremely consistent, with almost all respondents using this exact phrasing. This code therefore indicates a consistency of messaging from the survey content itself being reflected in survey responses.

Overall, there was a decline in use of universal equality focused framings (i.e. language focused on treating “everyone” identically “regardless” of ability or background) compared to the pre-survey, which combined with the levels of reporting on “don’t assume” and on the need to “ask more”, indicates that the training was effective in conveying the message of the need to differentiate and tailor options suited to individual needs.

27 respondents left this blank or otherwise did not respond. One respondent noted that they did not think that the workbook had been required as a part of the training and that therefore they did not complete it.

Participants were asked to share the three things that they had listed in their training workbook which their workplace could do to improve access for people with disability.



**Figure 30: Areas for workplace improvement, post survey respondents**

Despite the large proportion of pre-survey responses which identified physical accessibility measures as being currently in place in their workplace, physical space changes were the most frequently reported area for improvement in workplace accessibility. This code included a range of specific physical changes, e.g. rearranging waiting rooms and considering sensory input, alongside broader discussions of physical accessibility.

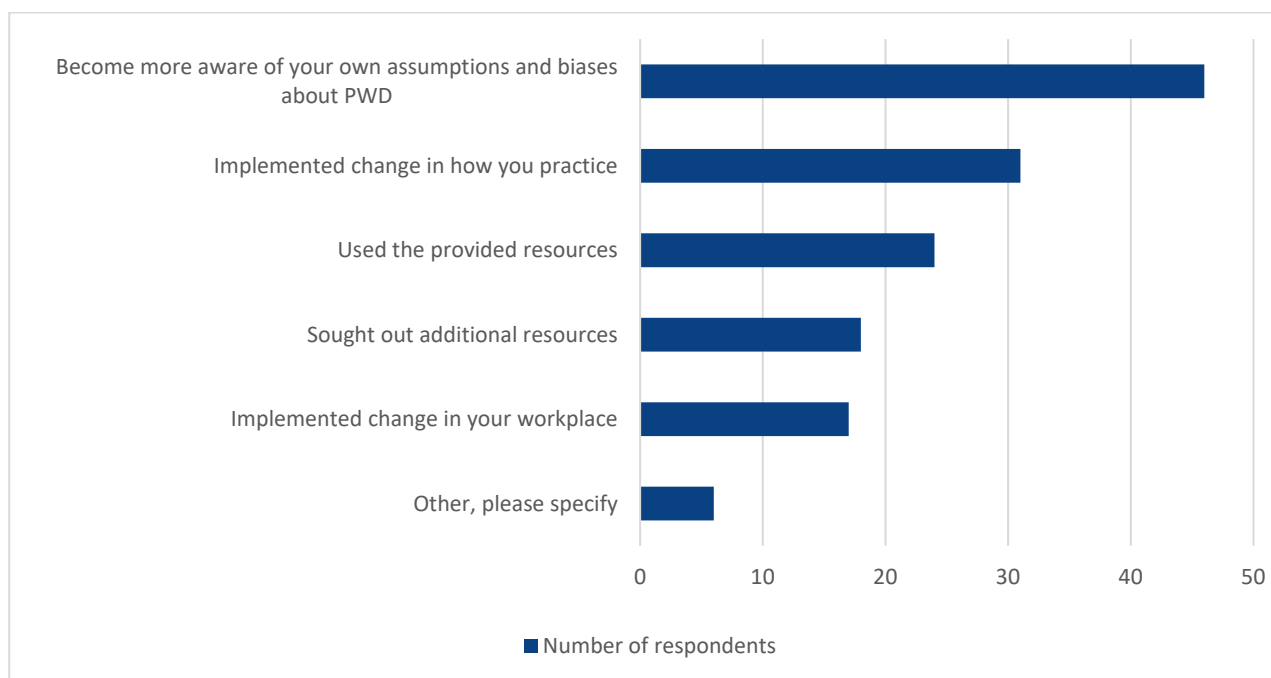
Information changes included a range of changes to information collection and circulation, including soliciting and recording more information from clients/patients with disabilities, use of interpreters (both AUSLAN interpreters and other cultural or language interpreters), use of alternative signage or website accessibility strategies. Training referred to both ongoing training for the survey respondent, or wider training to be undertaken by colleagues or as mandatory training for departments or workplaces as a whole. Time referred to a range of changes to service delivery and client/patient engagement, including

offering prioritised or more flexible appointment times, offering more time overall for consultations, greater flexibility with use of time in individual interactions to ensure that communications were not rushed, and similar flexible approaches to engagement. Audit referred to assessing current physical, operational and policy strategies, not only with a view to ensuring compliance with legal responsibilities, but also to identify areas of improvement. This appeared in the personal strategies survey as well, indicating that this was an area in which many respondents felt equipped to make a direct contribution.

17 respondents indicated that their answer to this question was identical to the previous question; this may indicate those in workplaces where they have significant direct autonomy to inform accessibility policies and practices.

### Follow-up survey respondents

Participants were asked about changes to their practice since completing the training, with the option to select multiple from a fixed list of responses including one open field.



**Figure 31: Changes to practice, follow-up survey respondents**

The most frequently identified change to practice was becoming more aware of their own assumptions and biases (n=46), followed by implementing change in practice (n=31). Of respondents who used the “other” field, two respondents stated that changes were not yet needed, with other mentions of advocating for more training, improving service systems and early need identification procedures, and contacting CheckUP to request a more accessible version of the training itself.

### Interview participants

Participants were asked if there were changes which they intended to make to their practice after undergoing the training. Most participants commented that they were looking at their policies and procedures as well as recognising that they needed to coordinate with other services who service remote people to improve the overall service for people living remotely.

Some respondents commented that they have already restructured their practice when arranging for people living in remote areas to be transferred to the city for treatment. Two participants talked about changes they had made to their booking system to accommodate Indigenous people better.

*“I think I am well on the way to embracing what the course is about. I have learnt to make people feel welcome, and to try to treat staff and clients like family - I enjoy working in this area and feel very accepted by my clients.” (Participant 4)*

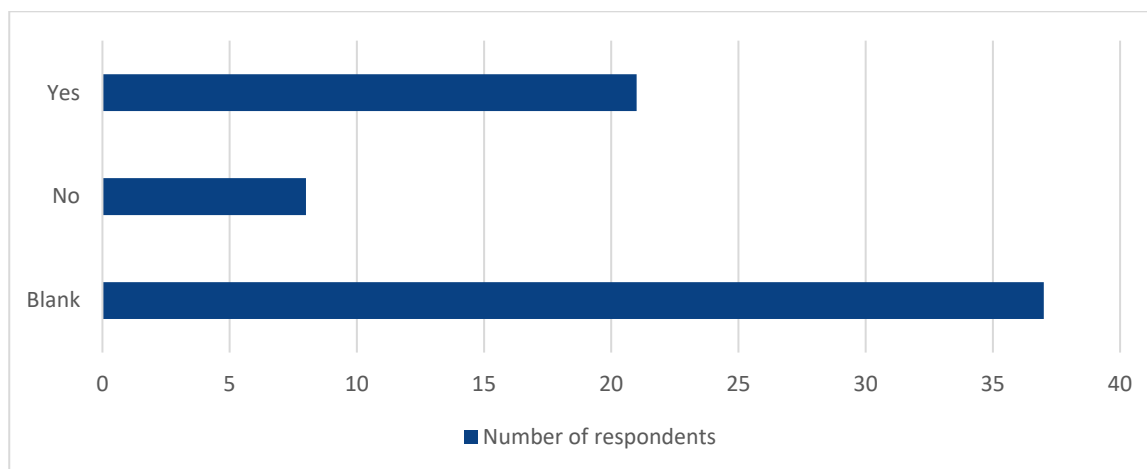
For one participant working in the hospital setting, the course made her think of the sensory aspects of her workplace:

*“Think about lighting and sound in hospitals, often people with a disability find it difficult We should think more about design.” (Participant 2)*

#### 4.9.2. Barriers/enablers to practice change

##### Follow-up survey respondents

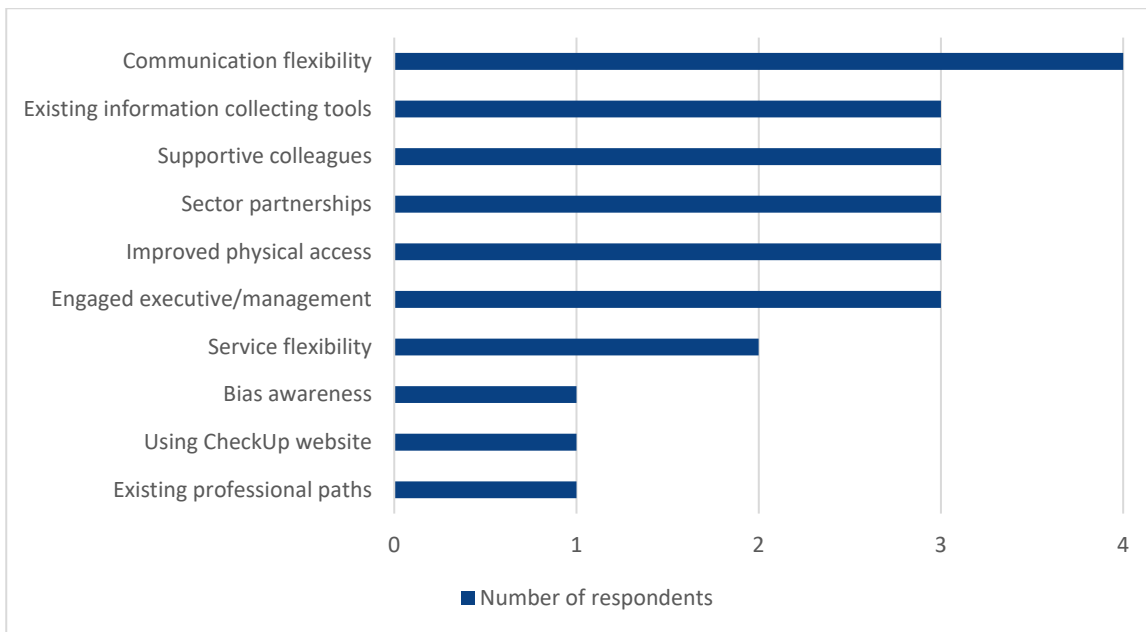
For those participants who reported having made successful accessibility improvements in their workplace, they were asked to report on whether there had been enablers that allowed them to make those improvements. The term “enabler” was not defined for participants, which may be a factor in the largest respondent group being those who left this question blank or otherwise did not respond. Of those who responded, more (n=21, 31.81%) responded yes than those who responded no (n=8, 12.12%).



**Figure 32: Presence of enablers for success, follow-up survey respondents**

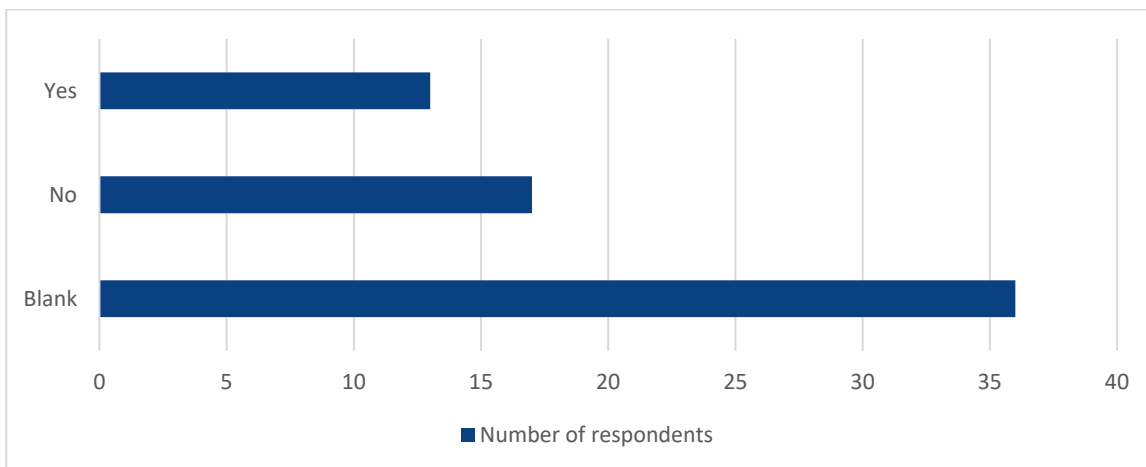
The most frequently identified enabler of successful change was flexibility in modes of communication (n=4), including ability to add other modes of patient or consumer engagement, to take more time. Five enablers of change were equally placed as second-most frequently mentioned; existing information collecting tools (including soliciting, recording and circulating more information); supportive colleagues; sector partnerships; physical space flexibility; and engaged executive and management staff.





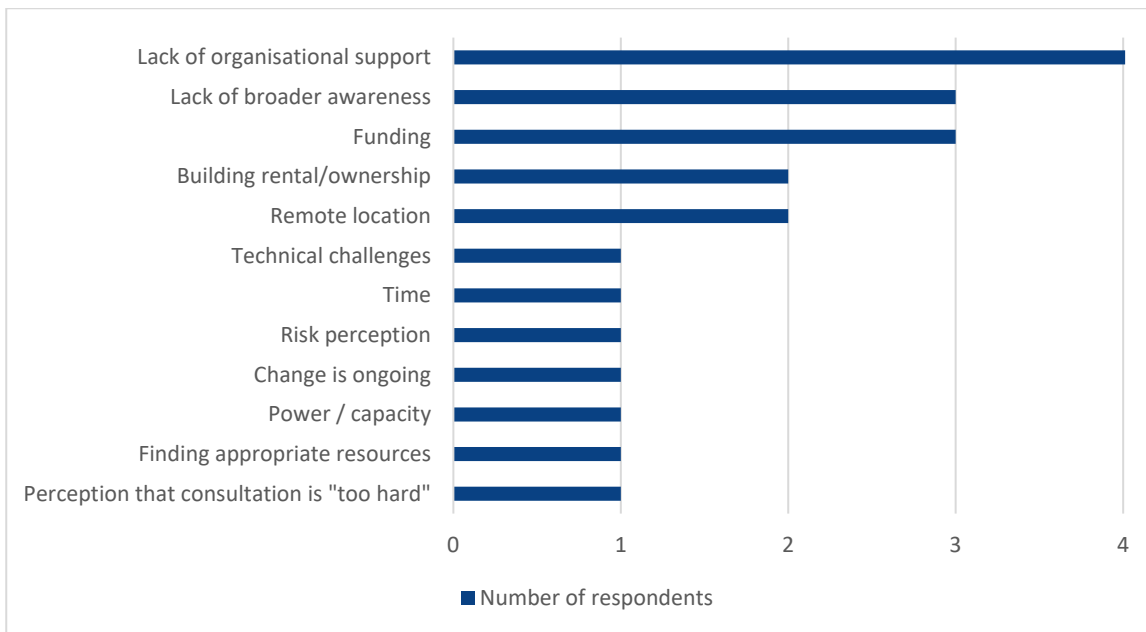
**Figure 33: Enablers for success, open field, follow-up survey respondents**

Participants were then asked if they had been unsuccessful in making accessibility improvements in their workplace, whether they encountered any barriers. The term “barrier” was also not defined for participants, which may have been a factor in the proportion of blank responses.



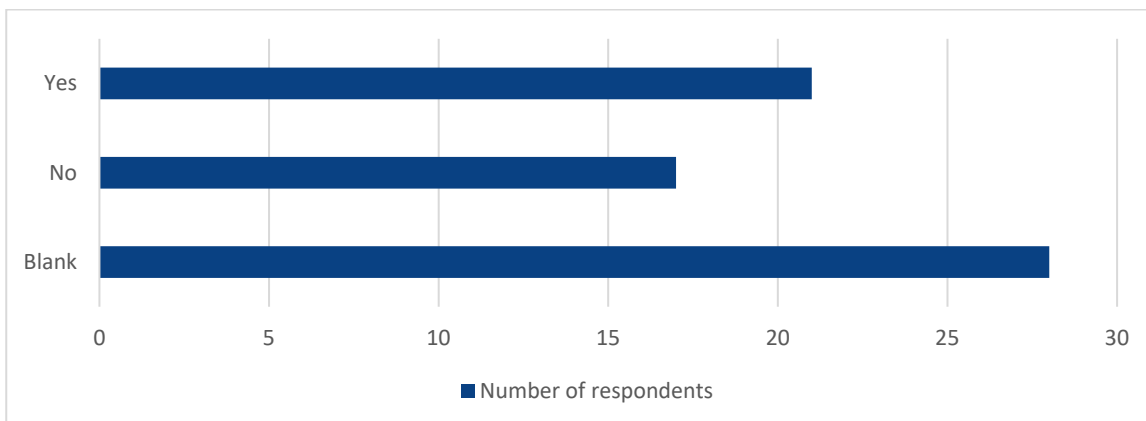
**Figure 34: Presence of barriers to implementation, follow-up survey respondents**

The main barriers experienced by respondents were associated with the extent of their agency over workplace activity relative to other factors, whether these be organisational or other structural forces. Organisational support, broader workplace culture, ownership or authority to make change, ability to access appropriate resources were key factors for respondents.



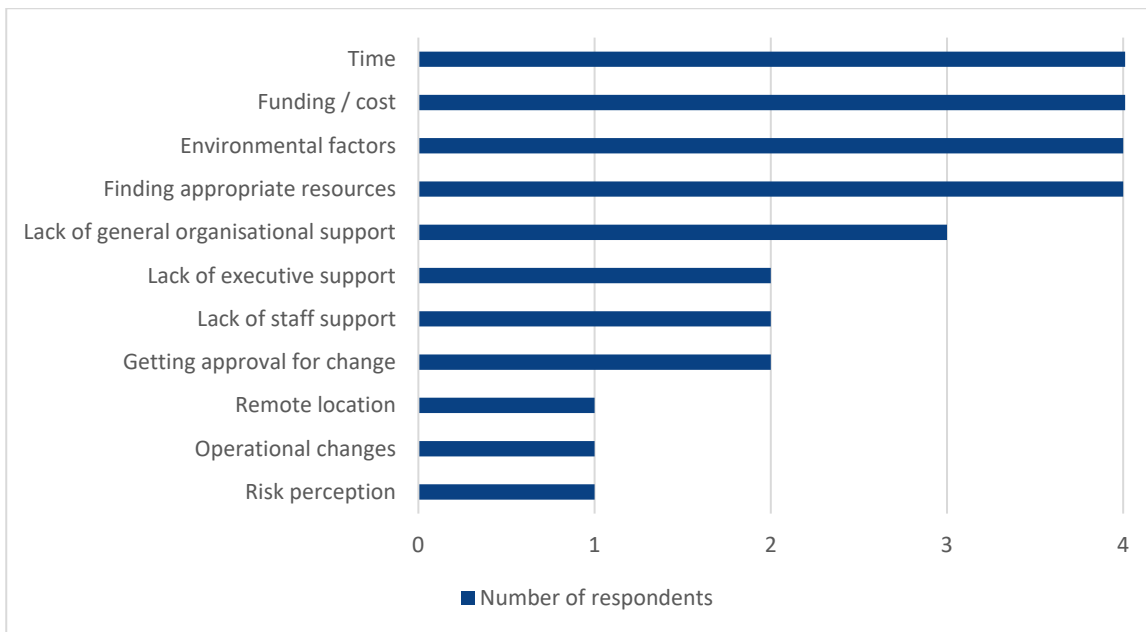
**Figure 35: Barriers to implementation, open field, follow-up survey respondents**

Participants were then asked if they were considering making accessibility changes, whether they anticipated encountering barriers in future. Of those respondents who answered this question, more respondents indicated that they did anticipate encountering barriers (n=21).



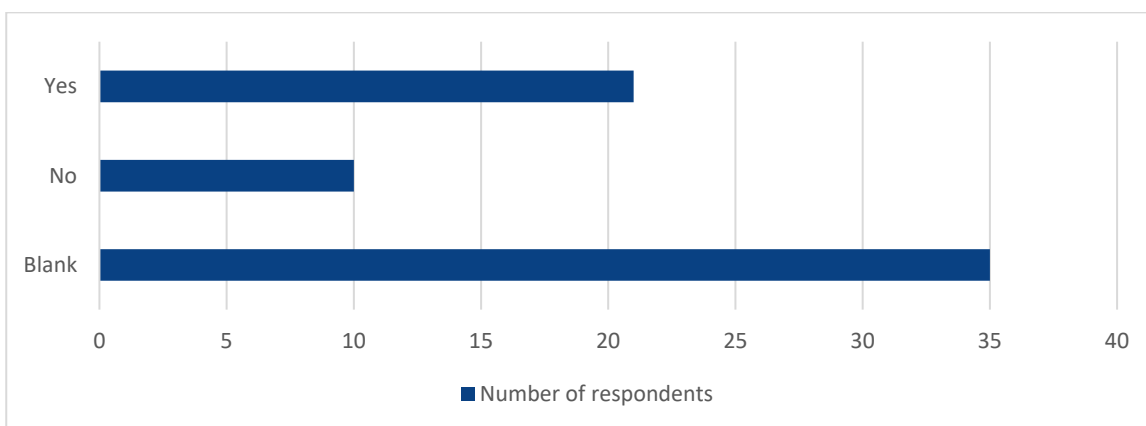
**Figure 36: Anticipated barriers to future implementation, follow-up survey respondents**

Most frequently anticipated barriers included time, funding/costs associated to implementation of accessibility changes, environmental factors related to the workplace, and difficulties in finding appropriate resources to implement changes.



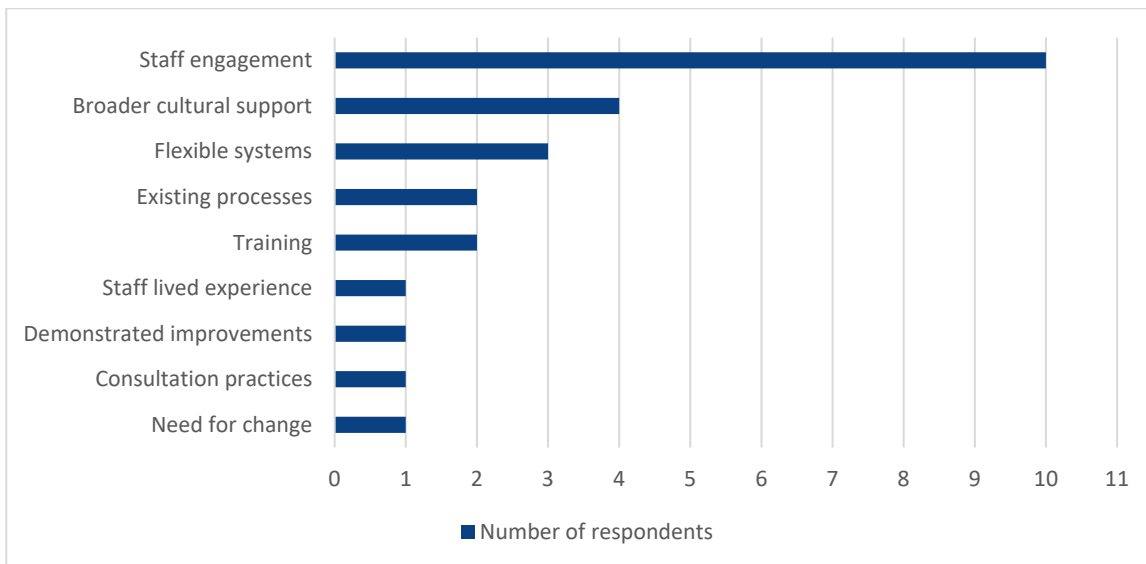
**Figure 37: Anticipated barriers to future implementation, open field, follow-up survey respondents**

Participants were then asked if they were considering making accessibility changes, whether they anticipated encountering enablers to making these changes in future. Of those respondents who answered this question, more respondents indicated that they did anticipate any enablers or barriers (n=21), though the majority of respondents left this question blank (n=35).



**Figure 38: Anticipated enablers of future implementation, follow-up survey respondents**

The most frequently identified enabler anticipated by respondents was engagement by staff and colleagues (n=10). Related topics also emerged as distinct codes, including staff lived experience, the need for change, and demonstrable nature of improvements to systems (n=1 respectively).



**Figure 39: Anticipated enablers barriers for implementation, open field, follow-up survey respondents**

### Interview participants

In terms of whether the participants were envisaging any barriers in the workplace or community some participants felt that they needed to get their staff to do the training so that the awareness within the disability field permeates the workplace. Others pointed to some of the difficulties in practices if they have to spend more time with the clients. For some participants, this brought up the issue of billable time, as increasing time spent with clients increases costs. One participant pointed to the difficulties when some clients have unachievable goals which presents a challenge for the professional who is working with the client. Another participant agreed with the challenges in the health sector at the moment:

*“Yes! Very challenging in the health environment at the moment. Time is one, not just to carve off time, but then to realise the problem, then measure, then try and fix it. But there are a lot of people who are interacting in this space. Need to get them to do the learning, my background is education, but could not fault this course. Need to get the team to do the training. So they understand what it is like to interact with people with disability.” (Interview Participant 11)*

One participant talked about the barrier of “the unknown” when changes are made to practices. He also acknowledged that there were some barriers with their support workers:

*“Real ones (barriers) are with the support workers, (i.e. why are you babying them.) Need to explain that we are making the outcomes smoother, and it will be a better outcome as well as removing anxiety (for the patient)” (Interview Participant 1)*

One participant emphasised the positive aspects of the course design but pointed out a barrier for vulnerable people is calling a call centre to access care:

*“It was really good and culturally appropriate for the area I work. Respectful, right literacy level, Feel it should be part of mandatory training, particular for admin. One of our barriers have to call a centre to access care, this is not doable for about 30% of people, so showing the barriers that people face, makes us understand that we have to find another way” (Interview Participant 3)*

Another participant mentioned time and understaffing which are all barriers in practices. There is never enough time to talk to the patient properly:

*“Trying to provide individualised care – sometimes it is easier to talk to the carer rather than the person with the disability: In an ideal world it would be great.” (Interview Participant 2)*

There are also physical barriers for some clients with disabilities accessing some private practice practitioners where they cannot make any changes to the environment to make it easier for clients to access the treatment areas.

Another participant in the healthcare sector suggested that the course could be geared more towards the acute care area and that getting people to talk about those barriers could be useful. She also pointed out that there are assumptions that people with disability are not in the private sector, and that this assumption should be corrected as clearly disability occurs across the whole spectrum of society.

## **5. Summary of findings**

The table below is an overview of key findings by evaluation question and data collection method. This mode of presentation of findings allows for the identification of convergences and divergences across data sources, as well as the prevalence and strength of findings. Overall, there was a high degree of convergence across data sources, with both survey and interview participants emphasising positive aspects of the training package and providing similar feedback and suggestions for improvement. Data collected from those who did not complete the training package in full point to areas for improvement that align with feedback and comments provided by those who completed the training. A discussion of findings and recommendations is provided in the next section.

## Table 4. Summary of Key Findings

Evaluation area	Key Evaluation Questions	Registration Data, Survey: Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
<b>Process</b>	How has the program been implemented and what elements of the training program need to be modified to maximise the intended outcomes?	Some participants found the training was too long and/or repetitive. Suggestions for improvement included improving course accessibility and including further exploration of intersectionality issues, as well as providing options for participants to complete individual training modules.	Suggestions for improvement revolved around accessibility issues, in terms of physical access as well as accessibility of the Learning Management System (LMS).	Some participants found the training repetitive and suggested improvements in relation to course accessibility.	Participants suggested improvements to training accessibility, as well as extending the scope of the training so it can be rolled out across Australia. Participants suggested adapting the content to better suit the work of practice managers and receptionists.
	How were the promotion strategies implemented and how effective were they?	The course was promoted via communications/emails from CheckUP and professional organisations			Promoted internally through disability awareness events
<b>Level 1: Reaction</b>	How satisfied were participants with the training program?	Participants were satisfied with the course and emphasised that it should be undertaken by more people	Those who did not complete the training reported time constraints as well as issues with the registration process.	Participants were satisfied with the course and found it to be a good refresher on their knowledge.	High levels of satisfaction with course. It helped them understand others' perspectives and increased their awareness of disability.
	How relevant was the material covered in the program to the participants and their role?	Participants stated that content was Queensland-specific and was less relevant to those outside Queensland, but could be adapted or streamed to participants across Australia			Course content was relevant to participants' role and reinforced previous knowledge. Participants emphasised the applicability of content across Australia

Evaluation area	Key Evaluation Questions	Registration Data, Survey: Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
<b>Level 2: Learning</b>	What opportunities can be identified to improve the training in the future?	Participants' suggestions revolved around the scope of the course (preference for national scope), accessibility and interactivity (e.g. issues with video captions, clarity and accessibility) and inclusion of intersectionality content		Participants commented on improvements to course accessibility and functionalities	Participants suggested the program could be adapted for national wide distribution
	Has involvement in the program increased awareness of the need for training?	Many participants stated that the Access for All training should be undertaken by more people and could be made mandatory. They also mentioned that they intended to share strategies they learned in this course with colleagues		Majority of participants reported an increased awareness of the need for training	Many participants emphasised the need for further training and stated that the Access for All training should be included in university courses
	Is there an increase in knowledge and awareness of the needs of people with disability?	Many participants acknowledged there had been an increase in their knowledge and awareness of the needs of people with disability after completing the training		There was a statistically significant increase in participants' disability awareness after completing the course	The majority of interview participants explained strategies that demonstrated an increased awareness and knowledge of the needs of people with disability
	What skills and knowledge have been learnt and what gaps in knowledge, if any, remain?	Key areas of learning encompassed communication strategies, accessibility strategies in the workplace/practice, and knowledge of disability		Key areas of learning included awareness of barriers, person-centred care approaches, and communication strategies such as asking more questions	Increased awareness of how to address the needs of people with disability

Evaluation area	Key Evaluation Questions	Registration Data, Survey: Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
	What learnings or strategies do participants intend to implement?	Ask clients/patients more about their needs, changes to communication strategies (including written, visual and verbal modes) and physical changes to workplace environments		Information sharing approaches, such as auditing the workplace and sharing resources with colleagues, as well as physical changes to workplaces	Reviewing policies and procedures. Coordination with other services to improve overall service for people living remotely
<b>Level 3: Behaviour</b>	To what extent have the skills and knowledge presented in this course been applied in the workplace?			Less than half of survey participants reported having implemented changes to their practice since completing the course	
	Did participants intend to change their practice when working with people with disabilities?	Participants identified areas in need for change in terms of personal and workplace practices		Participants reported intention to implement changes to practice, however, they mentioned the need to improve service systems and early need identification procedures, as well as further training, for these changes to occur	Participants reported intention to make changes to their practice, including revisiting policies and procedures and improving coordination with other services in remote areas
	What changes in practice have been made by participants in the training?			Most frequently identified change to practice was becoming more aware of their own assumptions and biases	Some participants had already restructured their practice to accommodate the needs of people living in remote areas
	What enablers and barriers are envisaged in the process of practice change?	Flexibility in modes of communication was identified as an enabler of successful change. Barriers to change were associated		Enablers included flexibility in modes of communication, existing information collecting tools, supportive	Several barriers were identified, including limited broader awareness, limited agency, funding and time



Evaluation area	Key Evaluation Questions	Registration Data, Survey: Pre/Post training	Survey: Non-completer	Survey: Follow up	Interviews
		to participants' extent of agency, lack of organisational support, limited broader awareness, and access to appropriate resources		colleagues, sector partnerships, physical space flexibility, and engaged executive, and management staff. Barriers were associated to limited agency over workplace changes, organisational support, workplace culture, and access to resources.	issues, understaffing and physical barriers

## 6. Discussion

The discussion section is structured around the evaluation questions, which will guide the discussion of key findings and their implications.

### **Process Evaluation Questions: program implementation and promotion strategies**

The promotional strategies employed by CheckUP appeared to be successful as the majority of participants had heard about the course via direct communication from CheckUP or from their professional association. The participants also had the course promoted in their own organisation both from management as well as colleagues. Similarly, a number of participants who were interviewed, gave as the reason for undertaking the course as a recommendation from colleagues or management. Even though the Access for All online training program was designed and funded primarily for Queensland healthcare practitioners and professionals, a number of training participants came from other states. This finding suggests that promotional strategies reached other participants outside Queensland (perhaps suggested by Queensland training participants), and points to the interest of healthcare professionals in undertaking professional development to increase their disability awareness and ability to employ inclusive practices. The need for such professional development was emphasised by training participants, who suggested on repeated occasions that the Access for All training should be scaled up across Australia, requiring State adaption. It was further suggested that the course could be offered as an introductory course at tertiary level, pointing to existing gaps and limitations in the education of healthcare professionals in relation to disability awareness (Bowen et al., 2020).

Although participants' views on the training course were mostly positive, they found some aspects of the online training delivery challenging or in need of further improvements. Their suggestions for improvement revolved around accessibility issues of the platform used to deliver the online training and the registration process. This aspect of the online platform was mentioned not only by training participants, but also by those who did not complete the training package. The length of the training course was also a factor that may have hindered course completion, with some participants reporting time constraints in their ability to complete the training package in full.

### **Impact questions: satisfaction with the course, suggestions for improvement, learnings, changes to practice and related enablers/barriers**

The majority of participants reported being satisfied with the course content and design, with relatively fewer respondents suggesting areas for improvement. Most participants felt the material covered in the course was relevant to their particular roles and helped them expand their previous knowledge of access barriers experienced by people with disability. The most commonly identified area of skills and knowledge which respondents wished to improve on was their understanding and awareness of experiences faced by people with disability. The second most frequently identified area was an interest in improving service accessibility for those with disability or clients from remote areas.

The vast majority of respondents provided general positive feedback, including stating that they enjoyed the course, thanking the course designers, or provided other broad statements in support of the course overall. Of those who provided more detail, the most common sentiment was that more people should undertake the course, with a number of participants suggesting that the course should be mandatory for

people working in the disability sector. Training participants found the content engaging, useful and relevant to their roles. They also reported that the training helped them expand and consolidate their previous knowledge of access barriers, which suggests that the training package was successful in allowing healthcare professionals with varying levels of disability awareness and knowledge of barriers to extend their previous knowledge and improve their awareness. In terms of possible improvements to the online course, some respondents felt that the course was too long and suggested a more national focus in terms of content. Some respondents had problems with the video functionality and a lack of captioning, and a small number found the training unclear or complicated. In addition to improving the accessibility of the course (both in terms of registration and accessing the online platform), suggestions for improvement also related to course content, with training participants suggesting the inclusion of further material on working with people with an intellectual or communication disability, and possibly more tips on how people working in the allied health area could work better with those with a disability.

There was evidence of increased knowledge and awareness of the needs of people with disability, with participants reporting changes that they had already implemented in their practices. Therefore, training participants were able to apply what they had learned to their practice, either as actions to increase accessibility and inclusivity of their practices or workplace, or as intentions/plans to change their practice or implement further changes in their workplace in the near future. Key learnings identified by participants related to skills and knowledge that are foundational to person-centred care, such as empathy, awareness of the needs of people with disability, and communication strategies that account for the needs of people with disability. The most common comment from participants was that the training helped them to understand other people and different cultures better. The respondents also identified a range of attitudinal shifts which they had experienced as key areas of learning. In particular they identified a shift in their mentality and approach to engaging with people with disability. Some participants also reported an increased awareness of the need to better understand the needs of people with disability and adapt their communication strategies to support them, such as using visual modes of communication. A number of training participants were already engaged in actively improving access to their service for people with disability: namely engaging in open discussion and consultation and making adjustments where necessary to their practice. This finding suggests that the training content was effective in supporting participants to action changes to practice and identify areas in need of improvement in terms of accessibility. Other training participants also discussed their intentions to make physical changes to their premises, although it was acknowledged that for some practitioners, they have little or no influence over accessibility policies and practices.

Participants self-reported disability awareness increased before and after completing the training and was found to be statistically significant. It is also noted that in the follow-up survey, the majority of respondents reported an increased awareness of the need for disability training.

In addition to changes to their practice, training participants identified changes to their workplaces that aligned with the course objectives of addressing accessibility barriers and improve inclusivity of healthcare for all. One key area of change related to workplace policies, with some participants reporting that they were looking at their practice policies and procedures with the intention of improving inclusivity. For example, some participants talked about changes they had made already to their booking system to accommodate Indigenous people from community. A second area of improvement related to workplace practices revolved around the need for better coordination with allied services who were serving the same client, with the objective of providing holistic and person-centred care.

Although there was evidence of changes to practice, both at the individual and workplace level, or intentions to change practice that reflected course content and objectives, there was an emphasis on the existence of barriers to effective practice change that pointed to systemic and external factors. Training participants pointed to the need for organisational support and workplace cultures to implement and sustain changes to practice, as well as adequate resourcing in terms of funding and time. In terms of perceived barriers when implementing changes in their practice participants discussed the importance for all of their staff undertaking the training, so that staff understand what it means to interact with those with disability, or with those living in remote communities.

Another barrier pointed out by several participants was the issue of “billable time”. In the situation of those with a disability or those living in remote setting, practitioners have to spend more time with clients, then the costs increase. It was commented that cost increases to a practice are not always recoverable.

Some respondents also spoke about difficulties they had had with support staff who could not understand that the extra time spent with certain clients would produce better outcomes for that client in the long run. It was also pointed out that there are also physical barriers for some clients, particularly in private practices, where it is difficult to make any changes to the physical environment.

Overall, the Access for All training was successful in improving participants’ awareness and knowledge of access barriers experienced by people with disability. Training participants found the content was useful, engaging, and relevant to their work, however, they reported accessibility issues. There was evidence of application of learning to practice, as well as intention to change practices that demonstrated understanding and application of course content and objectives.

## 7. Recommendations

Recommendations are based on key findings and participants’ suggestions for improvement and are structured around the following areas: implementation and scaling up the training; content and accessibility; also further evaluation of the training.

### *Training implementation and potential expansion/scaling up of the training*

It is recommended that CheckUP continues promotion of the training using online communications with healthcare providers and via professional organisations. Access for All training could be promoted to all staff in an organisation as a way of promoting practice change at the organisational level. CheckUP could further promote the online training at professional and academic conferences (e.g. Australasian Society for Intellectual Disability conference). CheckUP could also contact tertiary education providers to promote the online training among students in health sciences and allied health disciplines.

It is recommended that the Access for All online training course be adapted for Australia wide delivery. This may involve consideration of policies and legislation specific to other Australian states. CheckUP could also consider dividing the online training package into individual and independent modules (similar to micro credential courses) to reduce time investment for participants interested in the training but unable to commit the time. We also recommend that opportunities for participants to choose which modules to complete, based on their previous knowledge or specific learning needs, are integrated in the training package.

### *Training content and accessibility*

It is recommended that although members of the neurodivergent community are involved in the Advisory Group; that more of that community be involved in discussing the accessibility of the training program and

offering suggestions for change, as well as utilising further testing activities. These further trials will allow CheckUP to collect valuable information on how the training is completed and what issues are experienced in real time.

A recommendation related to course content is to include other topics such as more material on working with people with an intellectual disability or complex communication needs, as well as providing additional information on working with a person with disability and Indigenous peoples.

We recommend that CheckUP investigates accessibility issues in the online training package, in particular, issues with video captioning, length, structure and design of the training may have influenced the discontinuation with the modules. Although it is understood that an accessible version of Access for All was available, it is suggested that clearer instructions be made available on how to access that version.

### *Evaluation of the training*

Further evaluation of the training could include consideration of level 4 indicators in Kirkpatrick's model. This involves collecting data on how healthcare practitioners and professionals are implementing changes to their practice that reflect increased disability awareness, knowledge of barriers to access, addressing barriers related to the physical environment, attitudes, communication and services/procedures, and evidence of use of person-centred care approaches that address the needs of people with disability. We recommend doing a follow up on a sample of training participants or healthcare providers to understand what practices are being implemented, what impact they are having on people with disability, and what contextual and organisational factors are enabling or hindering practice change. We suggest employing success case methodology using a sample of participants/providers across demographic and other factors of interest (e.g. remoteness of practice provider, size of the organisation. These case studies would involve gathering the views of people with disability (e.g. via short interviews), documenting practices, and surveying or interviewing healthcare providers and professionals.

We also recommend defining some of the terms used in the evaluation (e.g. enabler) by providing examples to participants, or providing a list of common barriers and enablers to practice change for evaluation participants to select, followed by an open-ended question for participants to expand on their responses. This approach will allow for the collection of both quantitative data on the presence and prevalence of specific barriers and enablers, as well as qualitative information on how these enablers and barriers are experienced by participants in their workplace.

## 8. References

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## 8. Appendices

### 8.1. Program Logic Framework: Access for All (CheckUP)

<p><b>Program aim/vision:</b></p> <p><i>Increase mainstream health providers awareness and knowledge of barriers experienced by people with disability when accessing mainstream health services. Encourage practice change in the delivery of these services in regional, rural, and remote Queensland.</i></p>
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Needs	Inputs	Outputs		Outcomes - Impact		
		Outputs (Activities)	Outputs (Participation)	Short Term	Medium Term	Long Term
<p>Increase awareness and understanding of barriers and challenges experienced by people with disability when accessing mainstream health services</p> <p>Challenge assumptions and biases in mainstream healthcare providers about people with disability</p> <p>Provide healthcare professionals with practical tools and strategies to make health services more accessible to all people with disability</p>	<p>Funding from ILC mainstream capacity building grant</p> <p>Advisory group: input and guidance from stakeholders</p> <p>Technology (LMS)</p> <p>CheckUP staff</p> <p>Resources and content underpinning online course</p> <p>Networks and communication with stakeholder groups in regional and rural Queensland</p> <p>Stakeholder network (includes orgs as well as people with lived)</p>	<p>Online training course for mainstream healthcare providers</p> <p>(Includes suite of resources and training app in development)</p> <p>Promotion of online training course</p> <p>Evaluation activities (internal and external purposes)</p>	<p>Health professionals:</p> <ul style="list-style-type: none"> <li>- GP</li> <li>- Nurses</li> <li>- Specialists</li> <li>- Admin staff</li> <li>- Allied Health</li> <li>- Dental</li> <li>- Pathology</li> </ul>	<p>Health professionals</p> <p>Recognise need for training (key factor)</p> <p>Increased understanding about disability and inclusion</p> <p>Awareness and knowledge of barriers to accessing mainstream health services</p>	<p>Health professionals</p> <p>Increased use of strategies to provide more accessible and inclusive services</p> <p>Ability to encourage and initiate change in their organisations</p> <p>Access to further information and tools to improve practices and increase accessibility of services</p> <p>Willingness to continue</p>	<p>People with disability</p> <p>A lower reliance on carers and disability funding to access mainstream services.</p> <p>People with disability access mainstream services at the same rate as everybody else.</p> <p>Greater choice, independence and autonomy for people with disability in accessing healthcare</p> <p>Healthcare providers/</p>

<p>Encourage systemic change in mainstream health services to become more responsive and inclusive to all patients/clients</p>	<p>experience)</p>			<p>Knowledge of health literacy and service policies</p> <p>Knowledge, development and use of inclusive policies</p> <p>Reflection on current practice in communicating with people with disability</p> <p>Recognition of current knowledge gaps to address with further training</p> <p>Knowledge/realisation of obligation in providing accessible and inclusive health services</p> <p>Demonstrates awareness and understanding of strategies to improve accessibility and inclusivity of services, including reasonable adjustments</p>	<p>learning about access and inclusion</p> <p>Improved communication between healthcare providers</p> <p>Improvements in individual attitudes and service culture</p> <p><b>People with disability</b></p> <p>People with disability engage with mainstream services and staff members.</p> <p>People with disability report positive experiences in accessing mainstream services.</p>	<p><b>systems</b></p> <p>Improved NDIS scheme sustainability.</p> <p>Remove barriers to access to healthcare services</p> <p>Healthcare services become more responsive and adaptive</p> <p>Increased inclusive, relevant, high-quality services</p> <p>Greater involvement of people with disability in service improvement.</p> <p>Development and implementation of accessible and inclusive policies</p>
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				<p>Ability to identify current barriers in organisation, including cultural and linguistic barriers</p> <p>People with disability</p> <p><i>Stakeholders:</i></p> <p>Individuals participating in the program feel their contribution is valued.</p> <p>Individuals feel they have a say on issues that are important to them.</p> <p><i>End users:</i></p> <p>Report positive attitudes in healthcare providers</p> <p>Report positive experiences when accessing mainstream healthcare services</p>		
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### **Assumptions**

- Healthcare staff will be willing to and will have availability to complete the online course.
- Promotion of online course is effective and reaches participants as intended.
- Participants engage with the online course content and activities as intended.
- Participants have the ability to introduce practice change in their organisations.
- Participants are willing to change their practices.
- Organisations are willing to and support practice change.
- Participants prioritise completion of the course
- Organisations are willing/able to pay for completion/provide resources for employees to complete training

### **External Factors**

- Time constraints for participants.
- Other courses available on similar topics.
- Technology access in remote areas.
- Healthcare providers existing policies.
- Funding and resourcing to engage in practice change.
- Restrictions and policies due to COVID-19

## 8.2. Training registration form

FIRST NAME

LAST NAME

EMAIL ADDRESS

USERNAME

PASSWORD

OCCUPATION OR PROFESSION  
Select an option...

Select an option...

DISCIPLINE OR SPECIALITY

POSTCODE

PLEASE INDICATE IF YOU PROVIDE HEALTH SERVICES IN:  
Select an option...

Select an option...

HOW DID YOU HEAR ABOUT ACCESS FOR ALL  
Select an option...

Select an option...

OTHER

QUEENSLAND HEALTH STAFF ONLY - PLEASE SELECT YOUR HHS  
Select an option...

## 8.3. Pre and post training survey questions

### Pre-survey questions

(Q1) Rate your personal level of disability awareness.

- (a) Low - 1
- (b) Medium - 2
- (c) High - 3
- (d) Very high - 4

(Q2) List the skills and knowledge you would like to improve by completing this training. (List as many as you like)

(Q3) What things do you personally do to improve access to your service for people with disability? (List as many as you like)

(Q4) What things does your workplace do to improve accessibility for people with disability? (List as many as you like)

(Q5) What is your motivation for taking this course? (Select all that apply)

(a) Improvement of practice - 1

(b) CPD - 2

(c) Workplace requirement - 3

(d) Free course - 4

(e) Personal interest - 5

### **Post survey questions**

(Q1) After completing the training rate your personal level of disability awareness.

(a) Low - 1

(b) Medium - 2

(c) High - 3

(d) Very High - 4

(Q2) After completing Access for All, could it lead to a change in your practice to improve disability access?

(a) Yes - 1

(b) No - 2

(Q3) What have you learned by completing Access for All? (List as many as you like).

(Q4) In your workbook you were asked to list three things you will now personally do to improve access to the service you provide for people with disability. What were they?

(Q5) In your workbook you were asked to list three things your workplace could do to improve access for people with disability. What were they?

(Q6) Do you have any feedback regarding Access for All: Disability Awareness for Mainstream Health Providers? Please comment below:

(Q7) For Queensland health staff only: is there any specific content you would like to see included in disability awareness training for Queensland health staff? Please comment below

#### 8.4. Follow-up survey questions

Q1 Occupation or Profession

- Aboriginal and Torres Strait Islander Health Worker
- Administration Manager
- Administration Officer
- Allied Health (please state discipline) \_\_\_\_\_
- Dentist
- General Practitioner
- Medical specialist (please state speciality)  
\_\_\_\_\_
- Nurse – RN, EN, EEN, AIN, Midwife, Dental nurse, Practice nurse
- Nurse practitioner
- Paramedic
- Pharmacist
- Phlebotomist
- Practice Manager
- Receptionist
- Student
- Other (please state) \_\_\_\_\_

Q2 Postcode

\_\_\_\_\_

Q3 Please indicate if you provide health services in:

- Remote Queensland
- Rural Queensland
- Regional Queensland
- Remote and Rural Queensland

- Remote and Regional Queensland
- Rural and Regional Queensland
- Remote, Rural and Regional Queensland
- None of these areas

Q4 How many years have you been in your profession?

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Q5 Would you say the 'Access for All' training has increased your awareness of the need for training on accessibility to health care services for people with disability?

- Yes
- No
- I was already aware

Q6 Would you say the 'Access for All' training has increased your awareness about the different types of access barriers people with disability experience?

- Yes
- No
- I was already aware

Q7 Please list the access barriers experienced by people with disability that you were unaware of prior to completing the 'Access for All' training.

- Your comment \_\_\_\_\_
- N/A

Q8 What learnings have been the most useful to you since completing the 'Access for All' training?

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Q9 Has completing the 'Access for All' training increased your knowledge and awareness about the access barriers to your service, experienced by people with disability?

- Yes
- No
- I was already aware

Q10 Since completing the 'Access for All' training, have you? (You may select more than one).

- Become more aware of your own assumptions and biases about people with disability
- Implemented change in how you practice
- Implemented change in your workplace
- Used the provided resources
- Sought out additional resources
- Other, please specify \_\_\_\_\_

Q11 Have you acquired any specific knowledge, awareness or attitudinal shifts from the 'Access for All' training you are considering applying in your own practice or in your workplace?

- Yes - please describe them \_\_\_\_\_
- No

Q12 If you have successfully made accessibility improvements in your workplace, were there any enablers that helped you to do so?

- Yes - please describe them \_\_\_\_\_
- No
- N/A

Q13 If you have tried to make accessibility improvements in your workplace, but were unsuccessful, did you encounter any barriers?

- Yes - please describe them \_\_\_\_\_
- No
- N/A

Q14 If you are considering making accessibility improvements in your workplace are there any anticipated barriers?

- Yes - please describe them \_\_\_\_\_
- No
- N/A

Q15 If you are considering making accessibility improvements in your workplace are there any anticipated enablers?

- Yes - please describe them \_\_\_\_\_
- No
- N/A

Q16 The 'Access for All' training is an introduction to 'Disability Awareness' for health care providers. Are there any other topics you would have liked the 'Access for All' training to provide information on?

\_\_\_\_\_

Q17 Are there any further comments on the 'Access for All' training that you would like to add?

\_\_\_\_\_



## 8.5. Interview Questions

**Your Role:**

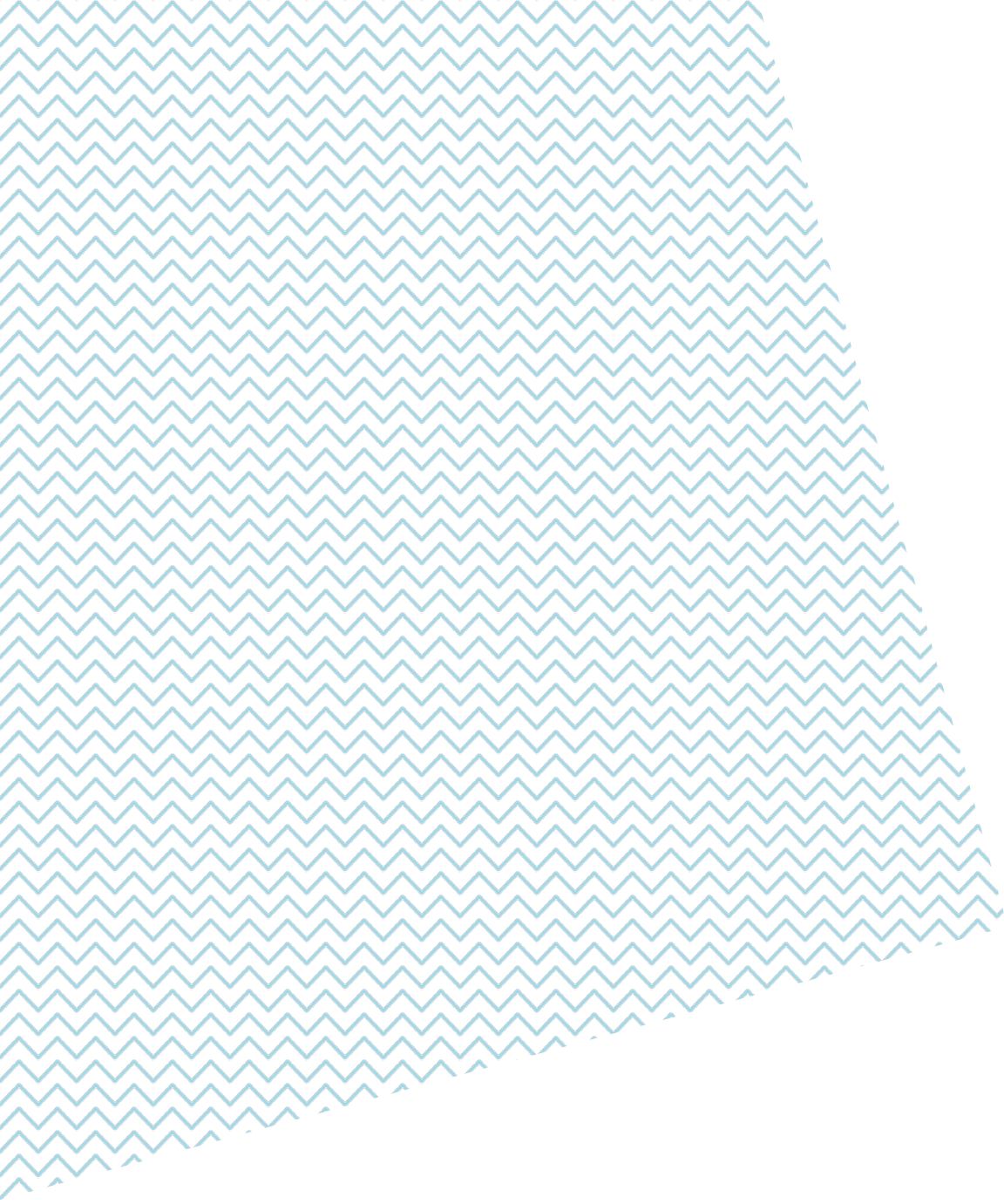
**Occupational Sector:**

Geographic Area of Work:

Have you completed all of the course modules: Yes/No (if not which ones have you completed?)

1. Tell me why you decided to undertake the Access for All training? *(if you have not completed all of the modules, could you tell me why that was?)*
2. Tell me briefly what you felt about the training? *(i.e. Relevance, gaps, comments about the resources)*
3. Were there particular activities or resources which you felt were really helpful
4. Were there particular activities which you did not find helpful?
5. Are there other topics which you would like to see included in the training?
6. What learnings from the course are you going to transfer to your workplace?
7. Are there areas of your practice which you intend to make changes as a result of the course?
8. Are you envisaging any barriers in your workplace or community when you make changes to your practice?
9. Is there anything else about the course that you would like to tell me?

Thank you for your comments



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CHECKUP



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