



Providing effective communication to patients who are deaf or hard of hearing

COMMUNICATION is the bedrock of patient care. If a patient can't comprehend the care being provided or the clinician can't understand what the patient is saying, care quality is jeopardized, which may lead to serious consequences, including death.

Using a case scenario, this article discusses the U.S. Department of Justice and the U.S. Attorney's office investigation of a healthcare system for denying "effective communication" to individuals who are deaf or hard of hearing under the Americans with Disabilities Act (ADA). In addition, the article reviews the findings, monetary damages, and settlement agreement, as well as the implications for patients, healthcare organizations, nurses, and nurse leaders.

Case scenario

Carol Cleveland*, who's deaf, arrives for surgery at a local healthcare facility. Her husband,

Nurses have a legal duty.

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who also is deaf, sister, and 15-year-old daughter accompany Mrs. Cleveland. The family communicates using American Sign Language (ASL), and the nurses ask the sister to act as interpreter.

After her sister leaves, Mrs. Cleveland requests an on-site interpreter. The nurses tell her that they'll set up the video remote interpreting (VRI) service, which uses high-speed internet to connect a qualified interpreter via videoconferencing, usually from a call center. VRI is used in many settings when interpreter services are required, eliminating the need for an on-site interpreter to be present all times. Facilities can subscribe to the service by appointment or on demand.

The staff haven't used the VRI equipment before, so several hours pass before it's connected with the remote interpreter. During that time and during surgery, the staff use written notes to communicate with Mrs. Cleveland and her husband and ask their daughter to interpret when she's there, even though the family has requested an on-site interpreter.

After surgery, the staff are able to connect the VRI service, but the images are grainy and the screen is in a fixed position that can't be moved. Mrs. Cleveland is in so much pain that she has to lie on her side and splint her abdomen, preventing her from adequately viewing the screen to see what the remote interpreter is signing. In addition, Mrs. Cleveland is experiencing dry eyes after the surgery and can't insert her contacts lenses. She again asks for an on-site interpreter, telling the nurses that VRI and the written notes aren't effective. The nurses document her statement as a refusal to use the VRI service and continue to use written notes or family members when they're onsite.

During discharge, a staff nurse who knows some sign language interprets for Mrs. Cleveland for about 30 minutes. Discharge instructions are concluded when the nurse gives Mrs. Cleveland a note stating that she should contact her physician if she has any questions.

A month after the surgery, the Clevelands make a complaint to the U.S. Attorney's office under Title III of the ADA against the hospital, alleging discrimination and failure to provide effective communication to Mr. and Mrs. Cleveland, and for requesting her family members to interpret.

Investigation and settlement agreement

The investigation determines that the facility denied the Clevelands appropriate auxiliary aids and services that are necessary for effective communication. It also found the facility in violation for requiring Mrs. Cleveland's sister, daughter, and the employee to interpret.

In a settlement agreement, the facility agrees to take several steps to comply with ADA requirements. In addition, the facility is ordered to pay a civil penalty to the United States and monetary damages to the Clevelands for the harm they experienced.

Case analysis

What were the violations committed by the facility and the staff? What are the facility's and staff's legal obligations under the ADA?

ADA and its requirements

The ADA was enacted in 1990 and amended in 2008. As the most comprehensive disabilities rights law to date, the ADA seeks to provide people with disabilities equal access, rights, and benefits as experienced by people without disabilities. The ADA has five titles; the title relevant to this discussion is Title III—public accommodations and commercial facilities. Public accommodations include, among other things, hospitals, nursing facilities, and professional healthcare providers' offices. Title III states that no one should be denied the "full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" based on their disability.

Facility's obligations

People who are deaf or hard of hearing acquire the disability in different ways, so their means of communication may vary—no "one-size-fits-all" accommodation exists. Those who are deaf from birth or early in life may communicate using sign language, while others who acquire the disability later may use lip-reading, listening devices, or written messages. Healthcare facilities can't approach all people who are deaf or hard of hearing as a homogeneous group with the same need. Facilities have an obligation to provide auxiliary aids and services to achieve effective communication individualized to the patient and context.

These aids and services must be made



Accommodations for people who are hearing impaired

The following are examples of auxiliary aids and services under the Americans with Disabilities Act.

- assistive listening devices and systems
- computer-aided transcription services
- notetakers
- open and closed captioning devices
- qualified interpreters
- telecommunication devices for people who are deaf
- telephones compatible with hearing aids
- telephone handset amplifiers
- videotext displays
- written materials
- other effective methods of making aurally delivered materials available to individuals with hearing impairments.

available to patients and their companions with disabilities to ensure effective communication. A “companion,” under the ADA, is any family member, friend, or associate who’s an appropriate person with whom the healthcare professional should communicate.

Because the nurse in the case scenario should communicate with Mr. Cleveland about his wife’s care, he’s considered a companion. Unless Mrs. Cleveland waives her rights to confidentiality and allows her sister and daughter to receive information concerning her care, they’re not companions. Also, because her sister and daughter aren’t deaf, they’re not covered under the ADA.

The actions that led to the violations and monetary damages in this case include the facility not making arrangements for the patient’s preferred means of communication before she arrived, asking the patient’s family member to interpret, and having an unqualified employee server as an interpreter.

Communication preference

Healthcare facilities have an obligation to conduct an individualized assessment to determine the patient’s and companion’s primary means of communication, taking into consideration individual communication skills and knowledge, and the nature, length, and context of the communication. If possible, the assessment should occur when the appointment is made or when the individual arrives, whichever occurs earlier. Because Mrs. Cleveland’s surgery was scheduled and her communication needs were known, an interpreter should have been available when she arrived at the facility. The responsibility for providing communication accommodation ultimately lies with the facility, but whatever means they choose must achieve effective communication with the patient and companion. Facilities should perform communication method evaluations and provide timely interventions to correct any problems. (See *Accommodations for people who are hearing impaired*.)

Communication effectiveness

Many circumstances exist under which the communication means chosen may not be effective, such as when Mrs. Cleveland was unable to view the video screen and when she was in pain. Depending on a patient’s reading level, written materials may not be effective. And although VRI can be useful in clinical environments, it’s not always effective. The nurses in Mrs. Cleveland’s case had an obligation to take steps to rectify the situation as soon as possible by initiating the facility’s protocol to obtain a qualified interpreter. Instead, they used communication methods that either violated the law or the patient deemed ineffective.

If the chosen means of communication isn’t effective, a reassessment should be performed and another method chosen in collaboration with the patient. Although the final choice of auxiliary aids and services lies with the facility, it’s still obligated to ensure that whichever device or method is chosen provides effective communication without sacrificing patient confidentiality and independence.

Interpreter qualifications

When a patient or companion uses sign language as the primary means of communication, a qualified sign language interpreter must

Complex communication

When healthcare communication is lengthy or complex, a qualified interpreter must be provided to a patient or companion who is deaf or hearing impaired. Examples of this type of communication include:

- discussing a patient's symptoms and medical condition, medications, and medical history
- explaining and describing medical conditions, tests, treatment options, medications, surgery, and other procedures
- providing a diagnosis, prognosis, and recommendation for treatment
- obtaining informed consent for treatment
- communicating during treatment, testing procedures, and provider rounds
- providing instructions for medications, post-treatment activities, and follow-up treatment
- providing mental health services, including group therapy, individual therapy, and counseling for patients and family members
- providing information about blood or organ donations
- explaining living wills and powers of attorney
- discussing complex billing or insurance matters
- making educational presentations, such as in birthing and new parent classes, nutrition and weight management counseling, and cardiopulmonary resuscitation and first aid training.

be provided. If the patient or companion communicates primarily by lip reading, a qualified oral interpreter is necessary, especially when the communication is long or complex. (See *Complex communication*.) A qualified interpreter is one who's effective, accurate, and impartial in receiving and expressing any specialized language required for the situation. In the case scenario, the staff violated the law when they asked the Cleavelands' family members to interpret and when they asked an employee to interpret because she knew "some sign language."

Requiring, requesting, or coercing an accompanying individual, family member, or employee to act as an interpreter for communication between healthcare personnel and a patient is discriminatory. In addition, confidentiality and potential emotional involvement issues make these individuals inappropriate for effective communication, except in an emergency that involves an imminent threat to a person's safety or welfare. However, even in these circumstances, the nonqualified interpreter and the patient/companion must be in agreement. A waiver must be documented in the patient's records and shouldn't be considered a permanent waiver of their right to effective communication.

A right to understand care

Nurses and nursing leaders have a stake in ensuring that the care provided to patients and discussed with companions who are deaf or hard of hearing is clearly understood, without placing any burden on the patient or their companions. The effectiveness of communication methods must be evaluated before use and quickly remedied if they're not sufficient. The deficiencies revealed in Mrs. Cleveland's case scenario also exposed a lack of training of clinical personnel in the communication requirements of people who are deaf or hard of hearing. Nursing leaders must take steps to provide training for all clinical staff. Failing to do so could be costly to all involved.

All patients have a right to understand and participate in their care, and companions have a right to know about their loved one's care. Anything less is substandard.

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*Name is fictitious.

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