Communicating effectively with deaf patients

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Summary
This article explores the communication needs of deaf patients who use British Sign Language as their first or preferred language. It would appear that these needs are not being met, particularly in acute hospital settings. Practical advice is provided for nurses to improve the quality of care that deaf patients receive.

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IN OCTOBER 2004 the final implementation of the Disability Discrimination Act 1995 came into force. The most significant effect of the new legislation was felt in the public sector which has been given, for the first time, a specific duty to promote disability equality (Morris and Russell 2004). Together with the UK Council on Deafness (UKCoD), the Royal National Institute for Deaf People (RNID) conducted a research survey entitled A Simple Cure (RNID 2004a) in collaboration with deaf and hard of hearing groups and charities throughout the UK. The objective was to establish whether evidence received regularly by the RNID and others suggesting widespread poor quality treatment was reflected in reality.

A Simple Cure (RNID 2004a) stated that 42 per cent of deaf and hard of hearing people who had visited hospital as a non-emergency had found it difficult to communicate with NHS staff. This increased to 77 per cent among British Sign Language (BSL) users. It also stated that 70 per cent of BSL users admitted to accident and emergency units were not provided with a BSL interpreter to enable them to communicate. It estimated that the cost to the NHS in terms of missed appointments alone could be as high as £20 million a year. The reasons for missed appointments were not broken down into categories, for example, non-attendance or the interpreter not turning up, but the appointments needed to be re-booked. However, one reason given was that some appointments were missed by patients because of not being able to hear staff calling their name. This may have occurred through a breakdown in communication which denied the nurse the knowledge that the patient was deaf.

Patient experiences

Information on the experiences of deaf people is often recorded in non-nursing journals. Evidence of nursing research in the UK is sparse with the majority of literature being American-based. Russell (1997) asked readers of the See Hear journal for their experiences of being a patient (Box 1).

Hines (2000) found that one of the major factors for inequality in care was inadequate training of nurses and medical staff in deaf awareness and associated communication skills. Hines (2000) acknowledges that there were many positive comments on the way staff communicated effectively but stated that such professionalism is rare. The reports of patient experiences and other research surveys carried out before the RNID survey A Simple Cure support its findings (Wright 1993, Heron and Wharrad 2000, Ubido et al 2002, Slaven 2003).

A patient-centred approach should be taken in the care of deaf patients to prevent a similar report occurring in the future. When professionals recognise the deficiencies in the care given to individuals it is possible to reflect on the issues and begin to improve services (Wright 2000).

Deaf awareness

The essential starting point for any action in health care is understanding the mechanisms that govern
linguistic behaviour, determining deaf people’s opinions, needs and knowledge, and examining public attitudes, ideas, beliefs and assumptions towards deafness and hearing (Munoz-Baell and Ruiz 2000). In the document Your Guide to the NHS (Department of Health (DH) 2001) one of the core principles was that the NHS would shape its services around the needs and preferences of individual patients, families and carers.

On March 18 2003, the UK government recognised BSL as a language in its own right (British Deaf Association (BDA) 2005). Patients from minority ethnic groups have a right to be given the same access to treatment and care as their English-speaking counterparts, and they have a right to communication that will create equality of access to healthcare provision (Ledger 2002). With the recognition of BSL as a language in its own right, BSL users have the same rights which, if denied, could be challenged in law. There are no accurate statistics about the number of deaf people whose first preferred language is BSL but estimates range from 50,000 to 70,000 (RNID 2004a), which indicates that nurses will, at some stage in their career, encounter a patient who is a BSL user.

‘Deaf with a capital D’ is a convention that was introduced to distinguish the cultural model of deafness from the medical model (BDA 2002). This demonstrates a community pride and an individual identity (BDA 2002). Harris (1995) describes how deaf people do not view their deafness as a disability. Deaf people say that they feel an affinity with disabled people, and particularly with campaigning groups, yet they have always felt separate and this distinction is important to them.

In communication deaf people use BSL as their first or preferred language. For many patients who use BSL, spoken or written English is their second or even third language (RNID 2004b). It is often assumed that all deaf people can lip read. Lip reading is a skill that most congenitally deaf people cannot acquire adequately for communication in most of their daily interactions (Lotke 1995). In English many phonemes are produced identically on the lips, for example, f and v, t and d, k and g, p, b and m make up almost half of the consonant sounds. A lip reader must also attempt to determine where one word ends and the next begins (Lotke 1995). Even a highly skilled lip reader can only understand 30 to 40 per cent of spoken sounds by watching the lips of a speaker (Wood 1999).

Interpreters

For patients who are BSL users, a BSL/English interpreter should be used when medical information is being given. Nurses who are not trained interpreters but have some knowledge in BSL should not act as interpreters. Interpreting requires the ability to extract meaning rapidly and to re-conceptualise it in another language (Elderkin-Thompson et al 2001).

Elderkin-Thompson et al (2001) state that untrained interpreters allow the speaker to finish before interpreting what they can remember, while professional interpreters use simultaneous interpreting – a challenging method that can produce mixed up words if used by untrained personnel. BSL/English interpreters have a code of ethics and are issued with an identity card by the Council for the Advancement of Communication with Deaf People, the Scottish Association of Sign Language Interpreters and/or by the Association of Sign Language Interpreters (RNID 2005). Everything communicated by a patient during a consultation is confidential and the interpreters cannot give advice or opinions (RNID 2005).

When planning patient-centred care it is the responsibility of nursing and medical staff to organise the interpreter so that two-way communication can take place. Since the interpreter will be communicating the treatment plan to the patient, he or she should be viewed as an integral part of the healthcare team (Haskins 2000). Some BSL users may be reluctant to use an interpreter, especially if the interpreter is well known in the deaf community. They may feel anxious about issues of confidentiality, but without an interpreter patients cannot make informed choices and a full assessment cannot be conducted.

Showing sensitivity to the patient’s concerns will help. Phelan and Parkman (1995) suggest that if the patient is to have a physical examination or investigation the patient should be asked if he or she has any objections to an interpreter being present. If the patient chooses not to have an interpreter present then two-way communication becomes difficult to maintain. Explaining to the patient the nurse’s need to have an interpreter present and assuring the patient that dignity will be maintained may help the BSL user.

A woman describes her experience of being in hospital following a stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked. ‘I suffered torments trying to stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked. ‘I suffered torments trying to stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked. ‘I suffered torments trying to stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked. ‘I suffered torments trying to stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked. ‘I suffered torments trying to stroke. The woman had two hearing aids but, following her stroke, could not remember how they worked.

**BOX 1**

**An account of a hospital experience**

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user to agree to the presence of the interpreter. Phelan and Parkman (1995) suggest that, if the interpreter is unable to be present, extra care needs to be taken to explain to the patient what will happen during the examination.

The RNID (2004a) acknowledges that there is a national shortage of BSL/English interpreters but this should not prevent hospital staff from trying to find one. If there is difficulty in obtaining an interpreter this should be documented and the appropriate risk assessment form completed. Even if friends and family members of patients are highly skilled in BSL, because of their emotional involvement there could be a serious conflict of interest if they are asked to interpret (Wood 1999). Relatives may try to protect the patient from bad news or decide to tell him or her later in private, and information about side effects may be withheld in the belief that it will improve concordance (Wood 1999). Some organisations have installed video interpreting devices. It is not a replacement for face-to-face interpreting, but it does give deaf and hard of hearing people greater access to interpreting services. The interpreter is not present in the room but can sign and interpret for the deaf or hard of hearing person via a videophone (RNID 2005).

**Communication**

The ability to communicate is a fundamental requirement for humans (Meecham 1999). Effective and sensitive communication is one of the most important ways of conveying respect for patient dignity. It is often the only way of assuring patients that nurses are interested in their experiences, perceptions and needs (Price 2004). It is well documented that being admitted to hospital creates a state of anxiety for patients (Mitchell 1997, Grieve 2002, Hughes 2002).

Communication is a key skill of modern nursing practice and yet nurses are often perceived as having poor communication skills (Jarman 1995, Rowe 1999, McCabe 2004). Patients are dependent on the nurse for the delivery of safe and effective care (Rowe 1999). Nurses work under severe time constraints which will, inevitably, mean that compromises have to be made. They also try to address the needs of many, which may blunt sensitivity to the needs of some patients (Price 2004).

In a survey nurses stated that they are aware that there are deficits in standards of care in areas that are particularly important to patients, with the majority of nurses feeling overworked (West *et al* 2005). Nurses in today’s NHS are under more pressure than ever before, resources are in constant demand, there are acute staffing shortages and morale is low (Rowe 1999). This raises concerns that patients who require a more complex patient-centred approach, such as BSL users, may not experience equality in care.

**Improving the hospital experience**

Published articles and reports offer guidance and information on what is required to improve the experience of deaf patients in hospital (Royal College of Nursing 1985, Hearing Concern 1997, DH 2004, RNID 2004a). The RNID (2004a) believes that it is possible to take practical steps to improve the experience of deaf and hard of hearing people in hospital. Recommendations for practice include:

- Keep a file with common phrases and closed questions written in plain English readily available to use with deaf patients on admission to hospital. Writing in plain English cannot always be done on the spur of the moment. The Plain English Campaign gives guidance on its internet site: www.plainenglish.co.uk (Last accessed: January 3 2006).
- Produce a short video of the ward and staff to orientate the patient to the ward environment. This should be shown with the interpreter present to answer any questions the patient may have. Funding to produce the video could be applied for from grants offered by charities. The video may be a tool that could also be used for orientation to the ward of non-English speaking patients.
- Deaf people often use communication support systems to maintain contact with friends and family. The availability of a minicom textphone, text television and access to a computer for email will help to reduce feelings of isolation.
- Before the patient is admitted to the ward or unit liaise with the surgeon and the anaesthetist to arrange for the patient to go to theatre when the interpreter is present.
- Avoid inserting an intravenous cannula in the deaf patient’s hands as this can impede the patient’s communication (Casey 1995).
- Refrain from discussing or teaching in front of a deaf patient without an interpreter to prevent any misinterpretations (Casey 1995).
- Misinterpretations can occur during ward rounds. It is important to organise a time when the interpreter can be present to discuss care and management with the patient. If the patient lip-reads, misinterpretation could occur if medical staff or nurses are discussing other issues near the patient.
- To provide information effectively, nurses require a range of skills and a sound knowledge
of the topics discussed, as well as resources to support this information (Caress 2003). At ward level, a named person with knowledge on how to obtain communication tools and people to contact for advice may be helpful.

- At an organisational level a communications co-ordinator who is fluent in BSL would be beneficial to address many of the issues raised. Mandatory training could be provided for all staff and the co-ordinator could liaise with different community organisations and forums and ward staff, have knowledge of the workings of the different types of hearing aid and act as a resource for staff to access when a deaf or hard of hearing patient is on the ward or unit. The need and benefit of employing a co-ordinator should be investigated. This position may attract applicants from the deaf community who wish to be involved in the planning and provision of health care to deaf people. Patient choice and involving people from diverse and minority groups are important to promote better care for patients.

**Conclusion**

An increase in demand for BSL/English interpreters in hospitals may encourage funding to be made available through government initiatives for training. There is a compelling need for nurses to become involved with the deaf community to develop trust. Deafness implies diversity, and diversity in relation to hearing loss needs to be acknowledged, understood and, most importantly, respected (Munoz-Baell and Ruiz 2000).

**References**


Royal College of Nursing (1985) Guidelines for Nurses Working with the Hearing Impaired in Hospital. Royal Nursing Practice, RCN, London.


