SAMPLE - Communication Aids for Patients with Vision, Hearing, Speech Impairments, or Limited English Proficiency Policy

Subject: Policy on Communication Aids for Patients with Vision, Hearing and/or Speech Impairments and/or Limited English Proficiency

Number:
Effective Date:
Supersedes SPP#

Approved by: (signature) Dated:

Distribution:

I. Statement of Purpose

To comply with Section 504 of the Federal Rehabilitation Act of 1973, whereby patients with vision and/or hearing impairments and/or limited speaking fluency in English obtain translation assistance or interpreter services, as is reasonably available.

II. Policy

To provide reasonable accommodations to assist sensory impaired, language impaired or patients with limited English proficiency to participate in their care and to have access to information they can understand regarding their healthcare treatment.

Note: If a patient’s family member or significant other is identified as sensory or language impaired and is in need of an interpreter to assist and/or understand the patient’s healthcare issues, contact the risk management professional for consultation.

III. Definitions

A. Special needs – for the purpose of this policy, special needs is defined as sensory disabilities, such as hearing and vision impairments, a language impairment or limited English proficiency.

IV. Procedure

A. Services - Any individual requesting information regarding services provided to sensory impaired, language impaired, or non-English speaking persons will be informed of the hospital’s policy of providing reasonable accommodation to participate in and benefit from healthcare services.

B. Section 504 Coordinator

1. The [insert name of position] will be designated as the 504 coordinator to act as the liaison for compliance with Section 504 of the Rehabilitation Act of 1973.
2. All complaints from patients alleging noncompliance with Section 504 will be forwarded to the risk management professional to investigate and attempt a prompt resolution, as applicable.
C. Identifying the Person in Need of Auxiliary Communication Aids and Obtaining Such Aids

1. Reasonable efforts will be made to identify persons needing auxiliary aids (e.g., interpreters, hearing devices) during pre-registration and pre-admission. Patients needing assistance may also be identified during patient registration for admission or at the ancillary department or nursing unit.

Note: Signs, in the languages of our patient population, will be located at registration areas, indicating that interpreter services will be provided to patients who need/request these services.

2. Staff members are responsible for identifying patients in need and, when applicable, inquiring what communication options are preferred by the patient during treatment or hospitalization.
   a. Visually Impaired Persons, Hearing Impaired Persons, or non-English Speaking Persons – A staff member will provide the person with the Communications Information Form (Attachment A), listing the available communication alternatives. A staff member will assist in the completion of the form (as appropriate) and will note the special need and preferred mode of communication on the form.
   b. For Hearing Impaired or Non-English Speaking Persons - If the person requests an interpreter, a staff member will notify [insert name of department]. A designated staff member from [insert name of department] will initiate contact for an appropriate interpreter. The communication form will remain in the medical record.
   c. For Visually Impaired Persons – A staff member will notify the person that someone will be made available to read printed patient care communications to her/him. (Some materials may also be available in large print or in an audio format.)

3. A signed Communications Information Form must be included in the patient’s record, indicating whether the patient is accepting or denying the offer of auxiliary aids or interpreter services. (This form should be initiated by a staff member when the patient initially presents.)

4. When a person needing auxiliary aids is not identified at admission/registration, but presents in an ancillary department or nursing unit, the department receptionist or unit secretary will notify [insert name of department] to assist in arranging the appropriate services, as are reasonably necessary and consistent with this procedure.

5. When interpreter services are needed, [insert name of department] will be responsible for attempting to arrange for an interpreter.
   a. A staff member will obtain the following information: the person’s impairment/need, when the interpreter is needed, type of information that will need to be interpreted, duration interpreter may be needed, and probable frequency of contact.
   b. A staff member will make reasonable attempts to contact an interpreter. The above information will be relayed to the interpreter. If it is determined that the interpreter can meet the needs of the patient, an agreement will be made with the interpreter to provide the services.
   c. Once an agreement has been reached, the interpreter will be given the patient’s name, location, the name of a contact person, and any other necessary instructions. Note: A staff member from [insert name of department] will record all attempts to obtain an interpreter/translator.
   d. When the interpreter arrives at the hospital, a staff member will obtain the interpreter’s signature on the Authorization for Interpreter Services form (Attachment B) and the Patient Confidentiality Form (Attachment C). The Communication Information Form and the Patient Confidentiality Form documents are to be placed in the patient’s medical record.
e. The unit/department contact person will complete and verify the accuracy of the Authorization for Interpreter Services form and give it to the interpreter, who will return the form to [insert name of department] upon completion of providing interpreter services.

f. After [insert name of department] verifies the information on the Authorization for Interpreter Services form, the form is submitted for reimbursement and a copy is retained.

6. When an interpreter cannot be located or obtained in a timely manner, hospital and professional staff members, in consultation with and approved by the risk management professional, shall use other available communication aids/resources (e.g., telephonic interpretive services) to reasonably inform the patient of his/her intended course of treatment and/or care.

7. Interpreters will be obtained when their presence is recommended or requested, to assist with communication for the following (but not by way of limitation): taking histories, explaining the treatment program and schedule, explaining medications and possible side effects and the effects of not taking medicine, explaining changes in the treatment program and upcoming and continued hospitalization, planning for discharge, securing informed consent for surgery or other procedures, providing psychiatric evaluation and treatment, teaching/instructing patients (such as Lamaze, infant bathing, diabetic teaching), and notifying patients of their rights when placed in restraints.

D. Resources

1. [Insert name of department] is responsible for maintaining a list of interpreters and obtaining aids as requested.
   a. For the hearing impaired, requests will be made for a qualified interpreter.
   b. For the visually impaired, a staff member will read patient care material to the patient, unless the patient prefers to have a family member do so. A staff member will remain with the patient and family member to ensure that the communication is appropriate and to address any questions that may arise.
   c. For the patients with limited English proficiency, an appropriate interpreter will be provided from the internal list of language interpreters or through contact with a community organization which provides interpreters.
      i. On an urgent basis, the AT&T language line interpreter service may be utilized.
      ii. The list will include the name, means of contact, phone number, and languages spoken.
      iii. In emergency healthcare situations, it may not always be possible to provide specific kinds of communication for the persons with special needs. However, the hospital will provide the most effective communication available, given the time constraints in an emergency.

E. Information about other Tools to Facilitate Communication with the Deaf

A TDD Hearing Impaired Machine allows messages to be received and sent by phone. The TDD phone number is____________________.

F. Payment

1. Payment for interpreter services shall be the duty of [insert name of department], which reserves the right to set the fee rate.
   a. The person requiring interpretation services shall not be responsible for payment of services rendered in accordance with this policy.

This document is a work product of Coverys’ Risk Management Department. This information is intended to provide general guidelines for risk management. It is not intended and should not be construed as legal or medical advice. Your organization should add to and modify this tool to address the compliance standards and regulations applicable in your state or organization.

Updated: December 2016
b. The interpreter shall be notified of the approved fee for reimbursement prior to services being rendered. The interpreter will complete a contract agreement that will be kept on file.

2. Payment for interpreter services will be completed by [insert name of department], following receipt of the completed Authorization of Interpreter Services form.

3. A patient may request that interpretation services be provided by their own interpreter (e.g., family member, friend). The use of “ad hoc” interpreters such as family members, friends or untrained staff members is strongly discouraged due to the risk for errors or omissions and consequent adverse clinical outcomes. A staff member will offer to provide a qualified interpreter, chosen and paid for by the hospital.

G. Participants in Health Education Programs

1. When a participant in a health education program is identified as having a special need, the instructor and/or designee will make a reasonable effort to arrange for interpreter services, as may be needed.

2. The instructor or designee will contact [insert name of department] to obtain assistance in contacting an interpreter, in accordance with this policy.

3. The Communication Information Form and Patient’s Right to Confidentiality Form documents will be kept as part of the patient’s medical record.

4. The Authorization for Interpreter Services form will be completed by the instructor/designee and the interpreter and submitted to [insert name of department] for payment.

H. If a patient’s family member or significant other is identified as having a sensory and/or special need and/or requires an interpreter to assist and/or understand the patient’s healthcare issues, contact the risk management professional for consultation.
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Attachment A

SAMPLE - Communication Information Form

I, [insert patient name] am unable to [insert see*, hear, speak English, or other communication impairment].

To assist me with communication while I am here, I understand that [insert hospital name] will make reasonable attempts to provide, at no cost to me, auxiliary communication aids. These aids may not be available to me on a 24-hour basis. When the aid is not available, staff members shall use other reasonable means of communication.

To assist in the communication process, please indicate if the patient can read English:

☐ Yes  ☐ No

Ability to lip read (if hearing impaired):

☐ Yes  ☐ No

Please check or indicate your choice(s) for auxiliary communication aids:

☐ Teletypewriter (TTD/TTY device)
☐ Writing materials/written materials
☐ Interpreter/translator services
☐ Other

☐ I choose not to accept any of the above communication auxiliary aids:

Patient Signature or Patient Representative Date

Interpreters or Communication Aids

We will provide a qualified interpreter (e.g., sign language, translation assistance) for you at no cost, or you may provide your own interpreter. We encourage the use of professional interpreters.

If you prefer to use a family member or friend instead of a professional interpreter provided by us, please write his/her name, address, and telephone number below:

______________________  ____________________  ____________________
Name  Address  Phone

Note: if you provide your own interpreter, we will not pay for that person’s service.

Interpreters will be obtained, when their presence is recommended or requested, to assist with (including but not limited to): taking histories, explaining the treatment program and schedule, explaining medications and possible side effects and the effects of not taking medicine, explaining changes in the treatment program and upcoming and continued hospitalization, planning for discharge, securing informed consent for surgery or other procedures, providing psychiatric evaluation and treatment, teaching/instructing you (such as Lamaze, infant bathing, diabetic teaching) and notifying you of your rights if/when you are placed in restraints.
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Should you choose to accept any of the above communication aids, the department will notify the appropriate individuals to arrange the appropriate coordination of interpreter services. Staff members will make reasonable attempts to arrange for an interpreter to meet your needs. By signing below, you agree to the above and also authorize [insert hospital name] to release your name and other necessary information to the interpreter to carry out the interpreter services.

____________________  
Patient or Representative Signature

____________________  
Manager/Designee

____________________  
Department

____________________  
Presenter’s signature:

*this will be read to patient who cannot see
SAMPLE - Authorization for Interpreter Services - *Retain in Medical Record*

(Hospital Name) __________________________

has agreed to pay

____________________________________

for interpretation services for (Patient)

____________________________________

to begin
(Date) __________________________

B. I, (Interpreter Name) __________________________ agree to interpret for (Hospital Name) at the agreed upon rate, as outlined in the interpreter contract agreement.

I agree to sign in and out for each contact at the hospital with the department where the patient is located.

Interpreter

Address

City, State, Zip

Telephone

Interpreter Time Report

C. Summary of Contacts

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Approved: __________________________

Department Manager/Designee

Interpreter Signature
SAMPLE - Patient’s Right to Confidentiality

Interpreter Statement

Interpreter Name: ____________________________________________

Patient Name: ______________________________________________

All information concerning this patient, including identifying data, social and medical information, is confidential and, may not be revealed to anyone without the written permission of the patient and [insert hospital name].

Therefore, all information I obtain while providing services as an interpreter shall be kept confidential and will not be shared with anyone other than authorized treatment personnel, unless otherwise authorized by the patient and hospital.

I have read this statement and understand my obligation to maintain the patient’s right to confidentiality.

____________________________________________          _________________
Interpreter’s Signature  Date