



## **Guidelines for Booking Interpreters in Healthcare Settings during the COVID-19 Pandemic**

June 2020



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N.B. This document will be amended as guidelines and regulations change.

## **Table of contents**

Introduction .....	1
General information and terminology.....	2
What is deafness? .....	2
What is BSL? .....	3
What is a registered interpreter? .....	3
Legal and ethical aspects relating to deafness and provision of interpreting.....	5
Legal instruments and policies.....	5
Interpreting should be classed as essential and interpreters as key workers. ....	6
Funding of interpreting services in healthcare settings.....	6
Assessing the language needs of a deaf patient .....	6
The role of a sign language interpreter .....	9
Risk assessment for booking an interpreter .....	10
The booking process .....	11
Considerations when booking a sign language interpreter .....	12
Remote interpreting .....	13
Personal Protective Equipment (PPE) .....	15
Advice for specific groups of deaf people .....	16
Children .....	16
Deafblind patients .....	16
Deaf patients with additional disabilities .....	17
Patients with varying degrees of deafness who do not use sign language .....	18
Deaf staff .....	18
Advice for individual healthcare settings.....	20
Emergencies and emergency services .....	20
General Practice (GPs).....	20
Audiology.....	20

Ophthalmology .....	21
Dental treatment .....	21
Mental health .....	22
Residential homes .....	23
Palliative care .....	24
Deaf relatives.....	25
Language use, jargon and use of visual aids .....	26
Aftercare/follow-up with deaf People.....	27
NHS Test and Trace .....	28
Executive summary .....	29
List of national and international resources for further information:.....	31
Appendix A – Checklist for reception/admin staff.....	33
Appendix B – Communicating with a Deaf/hard of hearing person when no interpreter is present .....	34
Appendix C – BSMHD Coronavirus impact guidance for GPs .....	35
Appendix D – BSMHD Coronavirus impact guidance for emergency teams .....	36
Appendix E – BSMHD Coronavirus impact guidance for hospitals .....	37
References: .....	38

## **Introduction**

These guidelines are issued in response to deaf and deafblind sign language users being adversely affected by the COVID-19 pandemic, due to their access to information in their first or preferred language, typically British Sign Language (BSL) in the UK, being significantly reduced in all areas of life. Deaf people are not always provided the appropriate access they need, particularly in medical settings, as some healthcare professionals do not specifically consider the range of communication requirements of patients with varying degrees of deafness. Separate guidelines have been produced for interpreters that stipulate guidance on health and safety with regard to their working practices in medical settings during the pandemic.

The aim of this guidance is to give healthcare professionals an overview of the opportunities and challenges faced when working with deaf patients and sign language interpreters during the pandemic. Much of the information contained herein applies to any medical settings and under any circumstances, regardless of the current crisis, access to information and treatment should generally be provided in much the same ways as it has always been. However, some additional precautions should be taken, more information may be necessary, and the mode and set up of any interpreted encounter should be carefully considered to minimise the risks for everyone involved, while complying with the law and public health guidance. The latter does not always explicitly stipulate guidelines for minority groups, and this guide aims to fill the gaps for deaf people and give healthcare professionals more targeted information to base their decisions on.

It should be noted that guidelines, advice, and regulations issued by the WHO, Public Health England (or respective devolved government's health organisations), the government, and individual healthcare trusts should always take priority, and must be adhered to at all times, regardless of the advice contained herein. Most interpreters are not healthcare professionals, their medical knowledge is likely to be limited as is the healthcare professional's understanding of interpreting and its practicalities. Policies are often created without considering the needs of deaf patients and the facilitation of interpreting. A professional exchange of information and discussion between patient, healthcare and communication professional, and a case-by-case

needs assessment, are likely to result in the safest and most beneficial outcome for everyone involved.

## **General information and terminology**

### **What is deafness?**

The World Health Organisation estimates that over 5% of the world's population lives with a 'disabling' hearing loss and this number is likely to rise (WHO, 2019). Hearing loss is typically measured in decibels (dB) and frequency loss, measured in Hertz (Hz). Standard hearing aids generally provide effective treatment for those individuals with mild to moderate hearing loss. Nevertheless, those affected by severe to profound hearing loss will often rely on lipreading and/or the use of sign language to communicate (Clason, 2015).

In the UK, 11 million people are deaf or hard of hearing, 151,000 of those are believed to use British Sign Language (BSL) as a form of communication (GDS, 2017). However, these numbers are approximations only as there is no mandatory registration for deaf/hard of hearing people. Additionally, sign languages and other forms of visual communication are used by other groups such as those with speech impairments, or other disabilities, deaf immigrants, and hearing relatives of deaf people.

Speech (not language) production and comprehension can be affected in a wide variety of ways, from complete inability to use spoken language to relatively standard communication with hearing interlocutors (Berke, 2019; NDCS, 2019). However, the latter usually requires significantly increased effort for those with severe to profound hearing loss and is extremely tiring for the individual (Punch, 2016). Therefore, communication in sign language, and through interpreters, is often a preferred method for deaf individuals.

Deaf sign language users regularly require the services of qualified interpreters for communication support in everyday life situations, be that in medical, or legal settings, in education, at work, or for private events. Unfortunately, provision of interpreting services is variable throughout the country, as statutory regulation campaigns have not yet been successful and demand for interpreters is often higher than supply (NUBSLI, 2019).

Deaf sign language users often see themselves as members of a cultural and linguistic minority and not disabled (BDA, 2015; Reagan, 2010). The capitalized 'D' in Deaf is commonly used to distinguish a culturally, often prelingually, deaf person using sign language and belonging to a minority culture defined by their rich cultural and linguistic heritage, rather than their disability (BDA, 2019). The lowercase deaf on the other hand refers to the audiological experience of not being able to hear.

### **What is BSL?**

British Sign Language (BSL) is one of the signed languages of the Deaf Community in the UK. A rich and complex language, BSL involves a combination of hand shapes, facial expressions, mouth and body movements; it has its own grammar and sentence structure and is not a signed equivalent of English. For the majority of deaf people in the UK, English is a second or third language (RAD, 2019).

In 2003, the British government officially recognised British Sign Language (BSL) as a "language in its own right used by a significant number of people. [...] BSL is a visual-gestural language with its own vocabulary, grammar and syntax." (Parliament, 2003). However, despite being the first or preferred language of approximately 87,000 Deaf people in the UK, BSL is yet to receive the *legal* recognition in England, Wales and Northern Ireland; Scotland, however, passed the BSL (Scotland) Act in 2015.

The lack of legal recognition means that deaf people continue to face communication barriers in their daily lives. Everyday tasks like making a medical appointment or dealing with a delay on public transport can be a real challenge. (RAD, 2019).

### **What is a registered interpreter?**

The National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) ensures that interpreters and translators meet a 'safe to practice' standard. It usually takes 7-10 years of language and interpreter education to achieve full professional status (RSLI and/or RSLT).

The NRCPD criteria for admission to each registration category are as follows:

- have undergone a police check (DBS Check)
- are covered by Professional Indemnity insurance
- agree to follow a Code of Conduct (outlining professional behaviour, neutrality and maintaining confidentiality)
- are subject to the NRCPD professional conduct Complaints Procedure

A Registered Interpreter (RSLI):

- has reached the National Occupational Standards in Interpreting
- can work in most areas depending on their experience
- some areas require additional training, i.e. courts, police, mental health



A regulated Trainee Interpreter (TSLI):

- is working towards the National Occupational Standards in Interpreting
- can work in some areas depending on their experience.
- TSLIs may not work in the criminal justice system or mental health settings
- TSLIs must exercise caution when accepting work in a social care setting.



All communication professionals registered with the NRCPD, including interpreters and translators, should wear their badge while on an assignment. Registration can also be checked on the NRCPD [website](http://www.nrccd.org.uk). Their valid badge proves that the interpreter is insured and has the appropriate qualification to work in the setting, as well as

stipulating that the interpreter is bound to confidentiality in accordance with the NRCPD Code of Conduct (Article 2.1).

## **Legal and ethical aspects relating to deafness and provision of interpreting**

### **Legal instruments and policies**

1. The Human Rights Act 1998 stipulates that public bodies, including the NHS, should provide services that are non-discriminatory, actively promote equality and respect the needs of hard-to-reach and minority communities.
2. The Equality Act 2010 states that deaf people who use BSL constitute *both* an officially recognised minority cultural group in the UK and a population with 'protected characteristics'. There is a public sector duty to ensure that service provision does not discriminate access to treatment.
3. NHS England's Accessible Information Standard (SC11605 Accessible Information) indicates that all information provided about mental health services for deaf people and communication with deaf people must conform to Standard 37. Section 11.5.1, states organisations must ensure that communication professionals (including British Sign Language interpreters and Deafblind manual interpreters) employed in health and adult social care settings have appropriate qualifications; have Disclosure and Barring Service (DBS) clearance; are subject to a regulatory body Code of Conduct and complaints process; have appropriate insurance; and engage in continuing professional development (Bevan, 2018).
4. The Equality and Human Rights Commission (EHRC) also stipulates that an organisation's duty to make reasonable adjustments is 'anticipatory'. Organisations are required to consider access needs before a disabled person wants to use them, as well as on an ongoing basis. (EHRC, 2019).
5. The World Federation of the Deaf (WFD) and the World Association of Sign Language Interpreters (WASLI) have published a statement encouraging stakeholders to ensure access in sign languages in various settings, including healthcare. Interpreters and deaf people are encouraged to work together to find solutions that minimise the risks while ensuring appropriate access and protecting interpreters working in emergency, i.e. PPE (WASLI, 2020).



6. WHO guidance on risk communications includes recommendations on accessibility of information for 'linguistic minority groups, including sign language users (WHO, 2020).

### **Interpreting should be classed as essential and interpreters as key workers.**

Considering the legislation and recommendations above, it is clear that access to information and treatment in sign languages is mandatory, particularly in public health settings. General health and safety advice and policies for healthcare workers should be applied to interpreters working in healthcare settings as well.

### **Funding of interpreting services in healthcare settings**

Healthcare trusts will have contracts with interpreting and translation service providers that cover spoken language as well as BSL interpretation.

- Check who your provider is with your Trust.
- Most providers also have remote options.

Charities such as SignHealth and RAD are currently covering gaps in the provision to ensure deaf people are able to access health services in their preferred language at all times and in all areas. However, ***the responsibility*** to provide accessible information and communication support ***always lies with the organisation***, as outlined both in the NHS accessible information standard (NHS, 2015) and guidance provided by the Equalities and Human Rights commission (EHRC, 2019).

### **Assessing the language needs of a deaf patient**

Any deaf person being seen in a medical environment should be asked for their preferred communication method and language requirements (including the provision of a deaf and hearing interpreter team - there is a precedent for the provision of this form of interpreting service where necessary). This information should be:

- put on the ALERT function of the Trust's medical IT system, so that any healthcare professional can see and find this information easily and quickly

Appropriate providers can then be contacted, who in turn will choose the right communication professional(s).

Language requirements may vary significantly depending on the deaf person's level of hearing loss, age of acquired hearing loss, use of technical aids, additional disabilities, their social context, education, geographical location, as well as personal

preference. To meet the deaf person's communication needs, communication professionals with differing skill sets may be required. This could include:

- a BSL interpreter,
- a deaf translator (who can work between written English and BSL),
- a Deafblind manual interpreter
- a lipspeaker
- an interpreter working with a sign language other than BSL

The communication professional may need experience in specific settings, such as mental health or legal interpreting, depending on the nature of the booking.


Most deaf people will have established methods and preferences for communication, as they would have been using interpreting services regularly throughout their lives (Young, Napier and Oram, 2020). **Therefore, they are the experts in assessing their own language needs. Decisions on what kind of communication professional to book should never be made without consulting the patient or, with consent, their trusted relatives or carers.**

Documenting the deaf person's needs so that it is quick and easy to locate for medical staff, is paramount to ensure deaf people have the best possible access to information. This also ensures compliance with legal requirements under the Equality Act. This information should regularly be reviewed, as it may change over time.

Be particularly mindful when cancelling and rescheduling appointments for deaf patients who are BSL users. Only cancel via:

- text message,
- email or
- letter.

Give the patient contact options for rescheduling. **Phoning** the patient or leaving a voicemail message **may cause unnecessary distress** and might even require them to ask friends and family for help with communication, which raises confidentiality issues as well as potentially impacting the autonomy and confidence of the patient.



In most cases and for various reasons, ***it is not appropriate to use written English***; many deaf sign language users, and particularly deafblind people, have limited understanding of written English.

It is also not suitable, and ***unethical, to use family members to facilitate communication***. The strain on relatives who are untrained and emotionally involved can potentially impact their mental health and may also adversely affect their relationship with the patient.

## The role of a sign language interpreter

According to the World Association of Sign Language Interpreters (WASLI, 2014)

***In order to work effectively as an interpreter, it is important that the interpreter focus on impartially performing their interpreting work. Interpreters provide interpretation including all of the content, contextual information in order to realize the communication goals of the persons involved in the interaction and improve conditions for productive communication to both sides.***

And a sign language interpreter may or may not be a deaf person.

***The role of the interpreter who is not deaf is to interpret between people who use a signed language and a spoken language and provide complete and accurate information both to Deaf and hearing people***

An interpreter who *is* deaf uses their expertise in sign language(s), along with other communication strategies, to tailor a culturally and linguistically appropriate interpretation for deaf consumers that hearing interpreters may not be able to provide. These may include:

- deafblind people
- deaf children
- deaf people with mental health issues
- deaf people who sign a different sign language
- deaf people with atypical/non-standard signing
- deaf people with cognitive difficulties
- deaf people with language deprivation or
- deaf people who specifically request a deaf interpreter.

Due to the nature of sign language interpreting and the modalities involved, it is usually possible for an interpreter to provide their service at a distance of several meters, and (if needed) through glass (if the spoken language source is audible). In some cases, such as for deafblind people, or if the patient's positioning does not

allow a good view of the interpreter and vice versa, this distance may need to be reduced (see [advice on specific groups](#)).

### **Risk assessment for booking an interpreter**

There is a risk of infection when an interpreter is present, however, deaf people have a right to access information and treatment, at any stage of the treatment, in a language they can fully understand. Qualified BSL interpreters ([RSLI](#)) are registered with the [NRCPD](#), trained to (at least) degree level, and have a Code of Conduct that includes the overarching principle of 'do no harm'. Section 1 states interpreters:

- must act in the best interest of the people and organisations using their service

This ensures that an interpreter will advise on appropriate ways of conducting the assignment (e.g. [remote interpreting](#)). They will only accept a booking in a high-risk environment if they deem it to be absolutely necessary and no other option to facilitate communication support is feasible.

In medical settings, the healthcare professional and the interpreter can use their respective expertise to come to the best solution for everyone involved. Section 3 states interpreters:

- must work within the limits of their training, skills and experience

Interpreters are trained to assess their suitability for an appointment. They weigh up the risks for themselves and others in an assignment, based on the information they receive about the booking. If all relevant information is passed on to the interpreter in advance, they are able to both conduct an appropriate risk assessment and make an informed decision about their ability to undertake the booking. Also worth noting, is Section 5.1 of the Code that states an interpreter:

- must limit their work or stop practicing if their ability to practice could be negatively affected by their mental or physical health

This infers that any interpreter with relevant symptoms of COVID-19, or any other infectious disease, would not work in high risk settings under any circumstances, this is especially relevant during the current pandemic.

**Any breach of the NRCPD Code of Conduct can lead to sanctions against interpreters, including the loss of registration.**

Best practice guidance is available for interpreters on behaviours during crises, effective use of PPE, and remote interpreting, etc., from national and international organisations. Decisions to book sign language interpreters, whether *in situ* or remotely, should be made on an individual, case-by-case basis. General guidance should always accommodate the individual's communication needs as much as possible; weighing the risks and benefits of such decisions should be made jointly by the medical and communication professionals.

### **The Booking Process**


Contact information for the language service provider holding the contract for BSL in the Trust should be made easily available for reception staff and any others responsible for booking interpreters. Under the specific circumstances of this guide, interpreters/booking agencies will require the following information:

#### **General:**

- a) Name, age and gender of the patient (this is GDPR compliant as the agency needs this information to match the client with the right interpreter and to avoid potential conflicts of interest)
- b) Department and reason for appointment (such as treatment, consultation, check-up, operation)
- c) Estimated duration of the appointment (it is common practice to calculate additional time for interpreted consultations, usually double appointments, longer for complex cases and patients with additional needs)
- d) Language requirements of the patient, e.g. BSL, SSE, lipspeaker, deafblind manual; including any other factors that may impact language needs, such as a previous stroke

#### **Additional information for infectious settings:**

- a) Is the patient infected/ are they in the hot or cold zone of the hospital?
- b) Clear directions to the location of the ward or department
- c) Any instructions linked to infection control, such as temperature screenings before entering the hospital
- d) Availability of and requirements for PPE, location of changing rooms and any other procedures linked to protective gear



Ensure the patient has given consent to share any information on the ALERT system that will be shared with the interpreting service provider. This information will only be disclosed to the attending interpreter and will be kept confidential (in accordance with the NRCPD Code of Conduct).

### **Considerations when booking a sign language interpreter**

BSL interpreting can be provided either face-to-face either *in situ* or remotely.

Research has shown that the quality of an interpretation declines after 20-30 minutes of continuous work without a break *in situ* (Moser-Mercer, Künzli, and Korac 1998) or remotely (Moser-Mercer 2005). If bookings are longer than one hour, a second interpreter, or break, will be required. In addition, the interpreting process may be affected by a number of variables, including potential additional physical and mental strain due to the setting, i.e. wearing protective equipment, background noise, or the nature of the assignment itself.

Moreover, a deaf interpreter will most likely be needed if the client is in one of the following groups:

- deafblind people
- deaf children
- deaf people with mental health issues
- deaf people who sign a different sign language
- deaf people with atypical/non-standard signing
- deaf people with cognitive difficulties (Woll, 2018; Mayberry & Kluender, 2017)
- deaf people with language deprivation or
- deaf people who specifically request a deaf interpreter.

These professionals specialise in relaying information in a way that a patient with atypical language needs can understand, which may be outside of standardised language norms and therefore outside of a regular interpreter's remit.

If two interpreters are booked, make special considerations to the location and room size, so that social distancing can be adhered to where possible and the risk of contamination is minimised.

The decision of how to facilitate interpretation should be made in agreement with all parties, i.e. the patient, the interpreter, and/or booking agency.

- The wishes of the patient regarding interpreting should always be respected, unless there are urgent and unavoidable medical/public health reasons not to do so.

If this is the case, the patient:

- should be informed of these reasons immediately
- their request should be implemented at the earliest opportunity.

### **Remote interpreting**

Remote interpreting may be appropriate in some settings and for some clients. There are particular situations and clients for whom this may not be appropriate:

- a) deafblind clients
- b) vulnerable clients with significant idiosyncratic language or additional disabilities
- c) mental health assessments, particularly if they have legal consequences (e.g. capacity assessments)
- d) counselling or psychotherapy
- e) for physical assessments that require extensive movement around the room or the use of medical equipment
- f) severely ill patients, for example if they are receiving oxygen or their movement and positioning is restricted by medical equipment
- g) pre- and post-op consultations as well as in the operation theatre
- h) patients who are under the influence of substances, medical or otherwise, that may impair their language production and comprehension
- i) end of life decisions including informed consent to continuing or withholding treatment
- j) elderly patients who may struggle with the use of technology
- k) deaf children whose parents may have limited access to BSL

It also may not be possible if technical equipment, or the strength of the Wi-Fi-signal prevents a continuously stable connection.



Remote interpreting may be the preferable option to minimise the risks of infection for all parties under the following circumstances:

- a) routine appointments that do not require any physical contact, treatment or extensive history taking
- b) repeat prescriptions
- c) requests for letters or copies of official documents
- d) referrals
- e) clients who prefer this method to other options
- f) in emergencies, where no face to face interpreter is available

In these circumstances, it is worth considering whether the deaf interpreter, where assigned, should be the only interpreter that can be seen (on screen) by the patient for clarity.

Platforms for remote interpreting may vary from one provider to another. It is worth discussing with the booking agency:

- which platform is used
- what technical requirements are stipulated
- what is available in the setting, either via the patient's or the venue's devices.

**Data protection laws apply.**

Remote interpreting is not recommended for some settings. However, situations may occur when there is no alternative, e.g. in emergencies where instant solutions must be found, or where patient, interpreting provider and healthcare professional **decide together** that the risks outweigh the benefits of *in situ* interpreting. Here, remote interpreting options should be explored, as there is no alternative for BSL access.

- Remember that written English via mobile phone app, or pen and paper communication, cannot replace direct communication in the patient's preferred language.

More in-depth guidance on remote interpreting can be found under further resources.

## Personal Protective Equipment (PPE)

1. Interpreters should be supplied with the same PPE medical staff are wearing in the setting if they are exposed to the same risk level. As they may not be trained in its use, advice should be given to interpreters on appropriate handling. A guide for interpreters in infectious settings is [available](#).
2. If masks are worn by medical staff, interpreters should also be offered this. The risks and benefits may need to be assessed, as ***the mask conceals mouth movements and distorts facial expressions***, which are part of the grammar of sign languages, ***severely impairing the interpreting process***. Some signs are produced on body parts, e.g. the face, hindered by a mask. If the interpreter can be positioned at a safe distance from the patient, they may choose to remove their mask for the duration of the assignment, for clarity. Another solution for this issue could be a mask with a clear field making lip movements visible. These would need to be made available in sufficient quantities, reserved for interaction with deaf or hard of hearing patients, and interpreters made aware of locations to retrieve them from. Clear masks will be most effective if worn by all staff who are in contact with the patient, or deaf staff members, not just the interpreter, as they may enable a limited amount of direct communication, if the patient is able to lip read.
3. Clear ***face shields*** may be an alternative measure that is more deaf-friendly but ***should provide sufficient protection*** for the interpreter and others around them, as long as a safe distance can be maintained. However, they also restrict the interpreter's ability to use signs that are usually produced on the face.
4. If gloves need to be worn, clear or white gloves are preferable to the blue gloves, as the colour may be a distraction and might make it more difficult to understand the interpreter clearly, particularly if blue scrubs are also worn, as there is not enough colour contrast between hands and upper body.
5. If interpreters are attending more than one assignment in the same venue, but in different departments/with different patients, separate single use PPE and changing facilities should be provided for each booking, as stated in infection control guidelines for health professionals.

## **Advice for specific groups of deaf people**

### **Children**

Deaf children's language may be very different to adult language. Many deaf children suffer from language deprivation (Rowley, 2018) and their exposure to sophisticated language models may be limited, if they are born into hearing families who do not sign. Their reading age may be significantly lower than that of their hearing peers.

Therefore, it is essential to let the interpreting provider know:

- the patient is a child
- what age they are
- whether they use any technical aids
- what their specific communication needs are

This should be recorded in their file and updated regularly, as methods are likely to change over time.

**In most situations, a deaf interpreter should be considered.**

It is also necessary to note whether parents are deaf or hearing and what their communication needs are. Instances of hearing children having to interpret for their parents are still being reported and ***should be avoided at all times***, as this reneges on the legal duty to provide appropriate access. This also prevents psychological stress for the children, helps to maintain an appropriate relationship between parents and children, and removes the high potential for miscommunication of complex medical and sensitive information (The Children's Society, nd). It is also stipulated in the NHS Accessible Standards that relatives should not interpret for patients.

### **Deafblind patients**

Deafblind patients may use various communication methods depending on the severity of their visual impairment. This could include a number of methods such as:

- Visual Frame Interpreting: Where peripheral vision is limited, the interpreter may sit closer than usual and sign within a smaller frame that the patient can see

- Hands-on BSL: In this method, the deafblind individual places their hands over the hands of the interpreter to recognise the handshapes, movements and locations of the interpreter's signs
- Deafblind Manual: Here, each letter of the alphabet is spelt out on the hand of the deafblind person. The alphabet is similar to BSL with some adaptations to improve recognition through touch rather than sight (Sense, 2019)
- Block Alphabet: Capital letters are spelt out on the deafblind person's palm. This takes longer than other methods, but may be particularly useful for those who have lost their sight and hearing later in life.

Most communication methods with deafblind patients will require very close proximity and/or physical touch between interpreter and patient.

- The risk of cross-contamination cannot be eliminated in this case.
- Remote interpreting is also not an option here.
- Discuss the use of PPE for both patient and interpreter.

BSL interpreters are **not** automatically trained in communication methods for deafblind persons. It should also be factored in that interpretation is likely to be more time-consuming.

- In most cases, a deaf interpreter should be considered, as only a small number of interpreters are specifically trained and have the skills to work with deafblind individuals.

Often, deaf communication professionals provide this service, and may sometimes have a hearing colleague with them, working as a team. This is commonly known as relay interpreting. Therefore, it is of utmost importance to let the interpreting provider know what the patient's preferred communication methods are.

### **Deaf patients with additional disabilities**

Deaf patients with additional disabilities, learning difficulties or mental health problems may exhibit more idiosyncratic language than other patients. Physical impairment may restrict their upper body movement and expressivity as well as facial expressions. It could also impair their ability to comprehend both written English and sign language. They may use other communication systems such as Makaton rather than BSL. This can:

- make remote interpreting less feasible
- require an interpreter who is familiar with the patient and/or who has specialist training in this area, a deaf interpreter, or possibly a different communication specialist.

Ensure the patient's needs are identified and this information is passed on to the service provider. Also expect that conversations may take more time than with other patients and check understanding of salient points regularly.

### **Patients with varying degrees of deafness who do not use sign language**

Patients who have lost their hearing later in life, those who have been brought up speaking and speechreading, rather than using BSL, or those who have other conditions such as auditory processing disorder, may have various communication strategies that may not involve a communication professional. Instead, they may rely on technical aids such as cochlear implants and hearing aids, or lipreading, written communication, or any combination of those, as well as carers or personal assistants.

As previously described, this is particularly difficult in medical settings where the use of facemasks is required and can cause great distress for patients. Be sure that

- staff are aware of the patient's needs
- use name tags for staff to identify themselves
- use whiteboards or electronic devices to support communication.

Where possible, safe and permitted, remove masks, or use masks with clear windows or face shields to enable lipreading. Speak loudly but do not shout, speak clearly, not too fast and without overly exaggerating mouth patterns. Also, make use of gestures and clear facial expressions to underline your message.

- Keep sentences short and avoid the use of complicated specialist language.

### **Deaf staff**

Staff who are deaf or hard of hearing may face a range of additional challenges under the current circumstances when it comes to communication:

- the use of face masks will prevent them from seeing facial expressions and lip reading

- their access to interpreters may be even more limited via their Access to Work scheme or they may have been reassigned to different roles, as they are no longer able to use their usual communication strategies with colleagues and patients
- their access to vital information, in environments where guidance may change at very short notice, may be limited and delayed.

This can lead to anxiety, feelings of loss of identity and purpose (Jahoda, 1997), a sense of deprivation and isolation in the workplace as well as loss of confidence in interaction with others.

**Additional support for those staff members should be put in place so that they continue to be well informed and feel included.**

All instructions should be made available in written format as soon as possible, face-covering PPE only be used where unavoidable. Ideally, face masks with clear fields to enable lip reading should be used for all staff and in any areas where deaf or hard of hearing staff are present.

For those whose first or preferred language is BSL, interpreter support should be made available as it would have been in other circumstances, either remotely or face to face, for team meetings, briefings, ward rounds and any internal and external communication. Additional interpreter support hours via the Access to Work scheme may need to be discussed with the Department for Work and Pension to compensate for communication that would not need interpretation without the use of face masks.

Ensure any staff training is accessible and interpreters are booked where requested by the staff member, factoring in room size needed for social distancing. Two interpreters will be needed for training sessions/team meetings lasting more than an hour.

## **Advice for individual healthcare settings**

### **Emergencies and emergency services**

Emergency situations are unsettling for any patient and relatives. Added barriers for communication can exacerbate anxiety and distress for deaf people, especially if staff are wearing PPE that prevents communication. Staff working in these environments should be made aware of potential issues and be prepared to adjust communication styles. Where removing face masks is not an option, consider:

- pen and paper or technical devices (phone/tablet)
- speech to text apps on phone/tablet
- gestures to aid communication
- CARDMEDIC app/flashcards

Emergency departments at hospitals should be informed of the patient's communication needs immediately so that arrangements such as booking an interpreter can be made for their arrival, and communication support must be provided at the earliest opportunity.

### **General Practice (GPs)**

GPs should provide accessible contact methods such as email and text. Some contracted interpreting providers may have remote options available to conduct appointments. Both RAD and SignHealth currently provide services to enable d/Deaf people to contact GPs (correct as of May 2020).

- This information should be available to reception and admin staff.
- Preferred contact methods should be easily visible and noted in the patient's file, particularly in case of emergencies.

### **Audiology**

Hearing aids are key technology to at least aid communication on basic levels and to help deaf people manage everyday tasks. Functioning and well-calibrated hearing aids are vital for many users, but with potentially limited access to communication support in crisis situations, this becomes absolutely critical for some deaf users, even for basic activities such as crossing the road, hearing announcements, or even being aware that someone is speaking while wearing a mask, as they cannot see the lip movements (i.e. attempts to communicate). Therefore, audiology services must

continue to be available and accessible for deaf patients, including accessible forms of contact such as email and text or remote, text relay and interpreting facilities.

## **Ophthalmology**

Eye tests, assessments and procedures pose obvious challenges for the interpretation process. In a dark room, or if their view is obstructed in any other way, the patient may struggle to see the interpreter.

- The patient may not be able to follow instructions during the procedure.

All tasks and procedures should be explained before commencing and arrangements discussed for example for reading charts.

- If the patient has to hold any equipment, they will not be able to communicate easily using their hands.
- If dye is put into the eyes of deaf patients, they will not be able to see the interpreter so instructions must be provided first.
- The interpreter may have to stand/sit closer than usual.

Many deaf people are uncomfortable using their voice, and it is not always intelligible for unaccustomed hearing people, so that this method is rarely an option. Hand signals may be a possibility, or pointing at objects/words on a card/writing down letters, if communication is needed during the procedure.

- Many deaf people will already have established strategies for such procedures, due to their life-long experience of facing barriers and working with interpreters.
- These strategies should be respected, discussed and used.

## **Dental treatment**

Maintaining a safe distance between patient and healthcare professional will not be possible during dental treatment. It is expected that staff will be wearing various forms of PPE, which will make direct communication with a deaf sign language user extremely challenging. Due to the common positioning of the patient and restrictions of eye gaze, using an interpreter during treatment is also difficult, if not impossible.

- All explanations regarding treatment should be made via the interpreter BEFORE commencing treatment.
- Hand signals should be agreed if the patient wishes to stop or communicate.



Communication in reception areas before and after treatment should also be considered. If staff are wearing masks, patients may find it impossible to understand and follow instructions.

- The timing of the interpreter booking should therefore be adjusted accordingly.

If the patient needs to take any precautions or if there are instructions for arrival at the venue, such as waiting outside until commencement of the appointment, this should be communicated to the patient:

- ideally via a remote interpreting service
- additionally in writing (plain English)
- the patient should be offered alternatives to contacting the practice by phone.

## **Mental health**

Mental health settings, particularly closed wards, present additional challenges for interpreters under the current circumstances:

- social distancing measures may be difficult to enforce
- remote access may be problematic to facilitate in terms of equipment and its handling by staff and patients

**In most situations, a deaf interpreter should be considered.**

It is of utmost importance that interpreting service providers, interpreters, patients and healthcare staff work together to find the best solution for individual tasks. This includes exchanging all necessary information on the patient's:

- language needs
- history and general diagnosis
- any potential risks of physical harm
- the purpose of the meeting, i.e. therapy, discharge, assessment etc., duration
- access restrictions of the facility or security measures
- and additional measures taken during the Coronavirus pandemic.

If a deaf sign language user is assessed under the Mental Health Act (1983), for example where the question of an individual's restriction of freedom/movement is concerned (e.g. section 5, section 136), it is of particular importance that their communication is reflected adequately.

**Assessments should ONLY be carried out with either a deaf professional or an interpreter or both present (remote or face to face, as appropriate), who are experienced in working in these environments.**

As the production of sign language includes body movements and facial expressions as part of its grammar (Sutton-Spence and Woll, 1999), these movements could easily be misinterpreted as violent or aggressive by those who do not understand their purpose. If the deaf individual cannot understand the instructions they are given verbally or were not aware of public guidance that is only available in English, ***the behaviours they exhibit could stem from lack of knowledge rather than illness*** or intentional misdemeanour. Not only could the effects of this misinterpretation have grave, immediate consequences for the individual and their families, it could also have a long-term impact on their mental health if perceived as a traumatic event.

**Potential legal consequences of an incorrect assessment without, or with inadequate, interpretation should also be considered.**

Furthermore, professionals should be aware that standardised, psychometric assessment tools such as the PHQ-9 are unlikely to provide accurate results when administered in English, even with an interpreter present. These are normed based on the testing of hearing, native English speakers and interpretation may skew the results (Rogers et al, 2012; Cromwell, 2005). Research on this topic is currently being undertaken and BSL versions are available for some tests.

**See ASLI's Best Practice Guidance for Mental Health Settings as well as SignHealth's website for more information on the wider topic.**

### **Residential homes**

Deaf sign language users in residential homes are likely to face communication barriers on a daily basis both with staff and with hearing residents, often leading to increased social isolation. Social distancing measures, PPE and relatives unable to visit exacerbate this problem.

As the increased rate of infection in residential homes has given cause for concern, ***extra care should be taken when facilitating communication support***, as well as for transfer arrangements to and from institutions. At the same time, residents in such facilities may face additional challenges using remote interpreting services, as they may lack confidence and skill in handling devices and experience in using such services.

The residents may display idiosyncratic language use due to additional disabilities or illness, requiring further scrutiny to choose the communication method that is right for them, while minimising risks for everyone involved. Staff should discuss arrangements and communication preferences with residents and next of kin regularly (with permission of the resident) in case of emergencies.

**In most situations, a deaf interpreter should be considered.**

### **Palliative care**

As in other settings, respecting the patient's wishes, particularly in terms of communication with them and their next of kin, is paramount. Where possible, it should be discussed with the patient whether they would like:

- an interpreter
- a deaf interpreter
- face-to-face *in situ* or remote interpreting, both for communication with healthcare professionals and with relatives
- what alternatives there may be.

Remote interpreting is unlikely to be suitable for end of life care communication, not only due to the severity of the situation and the patient's health, but also due to technical equipment and treatments/medication being used that may impair language production and comprehension.

It is worth noting that 95% of deaf people are born into hearing families. Not all families learn to sign, and deaf individuals may learn to communicate in BSL much later in life, through school and/or informal contact in the Deaf Community.

- Communication between family members may sometimes be limited due to language barriers, particularly remotely.

- Using an interpreter may be the patient's only way to speak with their loved ones.

If requested by the patient (and time willing), decisions of:

- continuation or withdrawal of treatment
- pain management
- legal questions such as making a will

**should only be discussed with an interpreter present**

This enables patients and their families to make informed decisions and those decisions are communicated appropriately.

The patient's preferences for privacy and dignity should be respected at all times.

The patient may request a specific interpreter whom they trust, or a particular:

- gender
- age range
- language variation (e.g. BSL, SSE or an interpreter regularly working in a particular region and using that region's linguistic variation)
- direct contact for an interpreter of their choice

If the interpreting service provider is made aware of this information, they should do their utmost to fulfil the request.

**Deaf relatives**

All the previously mentioned explanations also apply to deaf family members. Deaf spouses, parents, children, legal guardians, etc., who are involved in caring for the patient, or live in the same household, should be fully included in any communication with healthcare professionals, if the patient wishes to share information with them.

This has particular significance in areas such as:

- paediatrics
- maternity care
- palliative care and geriatrics

Deaf relatives may have to make decisions for patients at very short notice.

**Contingency plans should therefore include emergency communication methods, contact details and locations of any relevant documentation (e.g. wills, power of attorney, DNR forms etc).**

**Relatives, particularly children, should never be used as interpreters.**

(See the NHS Accessible Information Standards)

Even if a deaf sign language user agrees to a family member or friend supporting communication, a professional interpreter should still be offered (and might be seen as a legal requirement). Hearing family members should not have to feel obliged to take on the additional role of communication support. Apart from the psychological impact, the ethical and legal principles of confidentiality and impartiality could be violated.

### **Language use, jargon and use of visual aids**

BSL is a visual-spatial language which does not have a written form and has a grammar and structure distinct from English. Many deaf people do not have full mastery of written English, as with any second language user. In addition, poor access to education (in many instances) has led to significant knowledge gaps for some deaf people, exacerbated by the fact that they are exposed to much less incidental learning: TV, radio and newspapers can be completely inaccessible for deaf sign language users. What could be self-evident for hearing people because it is on the news regularly, an everyday topic for small talk, or a common experience or linguistic expression in the daily lives of hearing people, may not be something every of which a deaf person is aware. Therefore, any written communication should take this into account.

- Use plain English
- No assumptions should be made on common knowledge of idioms, expressions or terminology.

Not all deaf people, particularly in older generations, are familiar with modern technologies, devices and the use of the internet to find information. However, deaf people tend to have excellent image generation abilities (Emmorey & Kosslyn, 1996).

**Visual aids to explain medical conditions or treatments can therefore be an invaluable resource, even when an interpreter is present.**

Using models of body parts, showing examples of instruments/equipment used, or illustrations of organs, and their functions can dramatically reduce anxiety, encourage compliance and aid better understanding of procedures. This also applies to aftercare with respect to explanations regarding medication, exercises or specific behaviours recommended for rehabilitation and recuperation.

**Videos with BSL content and /or subtitles are also available for a range of medical topics on the SignHealth website as well as from some individual healthcare Trusts. Commissioning the production of more BSL resources, ideally using deaf translators, is strongly encouraged for all healthcare providers.**

#### **Aftercare/follow-up with deaf people**

If follow up contact is required, alternatives to telephone contact must be provided:

- ideally contact via BSL

This contact needs to be consistent, ideally better than typical provision to date.

Deaf people should also be reminded of ways to contact services in emergency situations. Please be aware that this information may differ in the devolved nations. In England, emergency services (999) can be contacted through Relay UK or emergency SMS. More information can be found here:

- <https://www.relayuk.bt.com/how-to-use-relay-uk/contact-999-using-relay-uk.html>
- NHS 111 BSL. This service is provided by InterpreterNow: <https://interpreternow.co.uk/nhs111>
- SignHealth also operates a crisis text services for people with mental health problems, which can be accessed by texting DEAF to 85258

All of the above information should be available and easily accessible for staff at receptions in medical facilities so that deaf sign language users can be signposted to adequate services.

## **NHS Test and Trace**

If it becomes apparent that a person in the interpreted setting may have been infected with COVID-19, government guidelines for the Test and Trace system should be followed and all potential contacts informed.

Registered interpreters are bound to confidentiality (NRCPD Code of Conduct Article 2.1). Moreover, local deaf communities are small and often tight knit, which can cause the interpreter to consider the ethics of sharing confidential details such as names of clients and locations of bookings. Thus,

- consent should be sought
- procedure should be agreed during the appointment in case of suspected infection
- if a critical incident has occurred, this should be noted in the hospital system including name of the interpreter and service provider supplying them, so that they can easily be contacted

It is currently unclear how NHS Test and Trace will communicate with deaf individuals, which poses an additional barrier to successful tracing. The patient may also feel uncomfortable sharing contact details of the interpreter. Consequently, the healthcare facility should take responsibility for this.

**The interpreter should be offered a test as soon as possible.**

As professionals carrying out essential services in a medical setting, interpreters should be treated like healthcare professionals within the system, rather than as members of the public.

## Executive summary

- **BSL interpreters** and other communication professionals (e.g. lipspeakers, speech-to-text reporters, etc.) **can and should still be booked** for face-to-face appointments as they would be under any other circumstances.
- Registered communication professionals adhere to the NRCPD Code of Conduct; **confidentiality and impartiality is maintained at all times.**
- **Deaf people have a legal right to access information** in their preferred language under the Equality Act 2010, the Human Rights Act and the NHS Accessible Information Standards.
- Ensure that any person who is deaf or has a hearing loss has their **preferred communication method recorded on file and in an ALERT** so that it is easily detectable for healthcare staff on their respective IT systems.
- Ensure **systems are in place** for deaf sign language users **to contact the facility directly, other than by telephone.** Options include **email, text message, text relay service** and **remote interpreting** services. Communicate those options to deaf patients.
- For sign language users, options in BSL are preferable to those in written English.
- **The same procedures apply to booking interpreters for face-to-face *in situ* and remote interpreting.** This also includes funding. Interpreting service contracts cover the provision, regardless of the method. Reception and administration staff should be aware of the process. Additional information may need to be supplied to the booking service to enable them to choose the right communication professional (this is GDPR compliant as the information is necessary to assess and comply with the needs of the deaf person).
- **Remote interpreting is not suitable for a number of settings**, for example mental health assessments, for patients with additional needs, or those who



are under the influence of substances (medically required or otherwise). However, in an emergency or when no *in situ* face to face interpreter is available, **remote options are better than no interpretation at all.**

- **Written communication or mobile phone apps are NOT an alternative** to an interpreter for patients whose preferred language is BSL. English may not be their first language and comprehension of written information may be very limited.
- **Using family members to interpret is also not appropriate** or ethical, even if they are a registered interpreter. Above all, they may not be impartial. In addition, the content of the dialogue may be upsetting for patient and family, risking a negative impact on mental health and relationship of interlocutors.
- Put systems in place for basic communication with patients when no interpreter is present. **Use visual aids, such as pictures, models or drawings as well as apps, i.e. CARDMEDIC.**
- **In the case of a suspected COVID-19 infection, contacts of any person present, including the interpreter, should be identified.** Procedure should be discussed and consent sought from individual patients, and ideally agreed in general terms with the sign language interpreting provider to avoid confidentiality concerns. **The healthcare facility should take responsibility for informing individuals of the potential infection.**

## **List of national and international resources for further information:**

- Joint statement of the World Federation of the Deaf (WFD) and the World Association of Sign Language Interpreters (WASLI):

**[https://wasli.org/cat\\_news/wfd-wasli-joint-statement-on-covid-19](https://wasli.org/cat_news/wfd-wasli-joint-statement-on-covid-19)**

- National Register of Communication Professionals Working with Deaf and DeafBlind people (NRCPD):

**<https://www.nrcpd.org.uk/>**

- ASLI position paper on the use of video interpreting services for public services

**<https://asli.org.uk/wp-content/uploads/2019/04/ASLI-VMI-position-paper-final.pdf>**

- The charity SignHealth, who provides resources in BSL for medical and mental health settings as well as a remote interpreting service for deaf people in medical settings They also deliver services to reach deaf people in BSL, such as crisis textlines, domestic abuse support, psychological therapy, advocacy and residential services.

**<https://signhealth.org.uk/announcement/bslhealthaccess/>**

- The Royal Association for Deaf people (RAD) provides services to deaf people in their first language, usually British Sign Language (BSL) and supports mainstream providers to be more accessible. Services include: advocacy, community engagement, communication services, deaf awareness training, support for children and young people, employment support as well as an information, advice and guidance.

**<https://royaldeaf.org.uk/about-us/what-we-do/>**

- The British Society for Mental Health and Deafness (BSMHD) is the only UK charity that focuses entirely on the promotion of positive mental health of deaf people.

**<https://bsmhd.org.uk/>**

- An American resource available on interpreting in medical settings under the current circumstances, including recommendations for PPE:

**[https://www.amphl.org/blog/2020/3/25/f2v3t9qogd4it8o1x40bwh8swr82v8?fbclid=IwAR30nAAUqIHm\\_8y1GH4k6x9U8INJ4s-ZfQSa9ReWq16FTtn7qJCUDs1Ag\\_M](https://www.amphl.org/blog/2020/3/25/f2v3t9qogd4it8o1x40bwh8swr82v8?fbclid=IwAR30nAAUqIHm_8y1GH4k6x9U8INJ4s-ZfQSa9ReWq16FTtn7qJCUDs1Ag_M)**

- WHO guidance on risk communication:

**<https://www.who.int/news-room/q-a-detail/who-emergency-risk-communication-guidance>**

- The Limping Chicken, a deaf blog featuring case studies, personal accounts and journalist articles on a variety of topics, including the impact of the pandemic of deaf people in the UK:

**<https://limpingchicken.com/2020/04/22/coronavirus-deafblind-people-facing-communication-challenges-in-a-time-of-social-distancing/>**

- A collection of resources available to sign language interpreters on best practice and various statements from relevant organisations globally:

**<https://www.mayadewit.nl/coronavirus-info-for-interpreters>**

## Appendix A – Checklist for reception/admin staff

Ensure ALERT system is updated with patient's communication needs. It is also possible for patients to request a specific interpreter via the CAPITA booking system (where applicable).

The BSL interpreting provider for \_\_\_\_\_ Trust is:  
(last updated:     )

The lipspeaking provider for \_\_\_\_\_ Trust is:

Provide the following information:

- ✓ Patient name, age, gender
- ✓ Preferred communication method: answers could include BSL, SSE, oral/lipreading, cued speech, total communication
- ✓ Any additional information about the patient's language use and prior use/preference of (deaf) interpreters
- ✓ Department to attend
- ✓ Category the patient's health problem falls under (if different from department to attend, e.g. if pre-op assessments are situated in a department other than surgery)
- ✓ Any additional information the interpreter may need to access specific areas of the hospital
- ✓ Advice on necessary PPE and pick up location
- ✓ Record the name and contact details of the communication professional, in case contact tracing becomes necessary

Next biannual update due on:

## **Appendix B – Communicating with a Deaf/hard of hearing person when no interpreter is present**

- Speak clearly and at normal conversational speed
- Face the deaf person and maintain eye contact to enable lipreading
- Check lighting and background noise do not compromise communication
- Use gestures and facial expressions to compliment your message
- When using written communication, avoid idioms or metaphors and specialist language
- Use visual aids such as objects in the room, pictures, the internet, models etc to aid communication
- Pointing to objects or people is not regarded as rude, but part of the visual nature of sign languages, and therefore encouraged
- In groups, take turns when speaking and give the deaf person time to establish who is speaking
- Some deaf patients may find speech to text apps helpful
- Check the patient has understood instructions or advice, repeat or rephrase if needed
- Book a suitable communication professional as soon as possible and inform the deaf/hard of hearing person when the communication professional will arrive

## Appendix C – BSMHD Coronavirus impact guidance for GPs

### Coronavirus Impact Guidance for GPs



Deaf people who use British Sign Language (BSL) are significantly more likely than the general population to have poorer mental and physical health. They experience higher levels of stress and more difficulties accessing health information and services.

The Covid-19 crisis has accentuated the health inequalities faced by Deaf people. The difficulties in accessing reliable information in BSL means that they may also be at greater risk of contracting Covid-19 and passing it on.

#### News Update

- A new interpreting service: **bslhealthaccess.co.uk** is now being provided by SignHealth and InterpreterNow. Easy to use and free for all medical services!

#### What you can do to support mental well-being for Deaf BSL users (you may already be doing some of these)

- Ensure that your surgery is accessible to Deaf people. For example, consider using text messaging; accepting phone calls from Relay UK, using Skype / FaceTime / WhatsApp / Zoom to make appointments; accepting phone calls from third parties e.g. BSL interpreters speaking for a Deaf BSL user to make appointments.
- Place an introductory video in BSL on your website to explain how Deaf people can contact you at this time.
- If you already have an arrangement for providing BSL interpreters please continue to use this especially for appointments on the phone. If not, then there is a new BSLHealthAccess service (see News Update).
- Remind your Deaf patients that the **NHS 111** website is accessible with a BSL facility.
- Consider how your Deaf patients can renew their prescriptions – some will walk or drive to the surgery to renew their prescription because they can't make an appointment by telephone.
- Contact your local social services or council to get in touch with community groups of Deaf BSL users. They are often likely to provide informal support.

#### If you are worried about a Deaf patient's mental health:

- Check the advice from the Joint Commissioning Panel for Mental Health: **jcpmh.info/good-services/services-deaf-people/**
- For a service in your region, check BSMHD's list of contacts: **bsmhd.org.uk/2020/05/05/new-list-of-mental-health-services/**



#### Deaf Community Action

Deaf BSL users are helping other Deaf BSL users to download apps such as **Zoom** or **WhatsApp**



#### Deaf Community Action

Deaf BSL users have set up a **Stay at Home** community on Facebook

*Our aim is to promote mental health wellbeing for Deaf BSL users and People with Hearing Loss – getting the communication right is often crucial for their wellbeing.*

The British Society for Mental Health and Deafness  
**bsmhd**  
Promoting Positive Deaf Mental Health

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# Coronavirus Impact Guidance for Emergency Teams

Deaf people, and people with some hearing loss



There are people whose hearing has a big impact on their communication. Some people are deaf from birth. Others lose their hearing to varying degrees. Around 70% of over 70's will have some form of hearing loss.

Some people may depend on hearing aids and lip-reading. Wearing a mask means that their ability to hear your speech and to lip-read will be made impossible. You may have to use written notes, but they may still be able to talk to you.

Occasionally the deaf person may rely on British Sign Language for effective communication. Use simple written English to ask them what they need – they may be used to managing their communication issues.

If the person needs a sign language interpreter either continue to use your existing arrangements or connect to **[bslhealthaccess.co.uk](https://bslhealthaccess.co.uk)** using a computer to access an online interpreting service run by SignHealth and InterpreterNow. Free for all medical services during the Covid-19 crisis.

### What can you do?

- Check you have pen and paper to hand.
- Make sure other colleagues know about the person and their preferred method of communication – this will minimise frustration and save time.
- There may be someone in your hospital/team/unit who has some experience of deafness and hearing loss – ask them to help.
- Your hospital or organisation may have some equipment to help, such as a microphone and loop system.
- Most hospitals and NHS Trusts have links with local interpreting service and support groups – ask your organisation's Equality and Diversity Officer for information.

*Our aim is to promote mental health wellbeing for Deaf BSL users and People with Hearing Loss – getting the communication right is often crucial for their wellbeing.*



## Appendix E – BSMHD Coronavirus impact guidance for hospitals

### Coronavirus Impact Guidance for Hospitals

Deaf people, and people with hearing loss



There are people whose hearing has a big impact on their communication. Some people are deaf from birth. Others lose their hearing to varying degrees.

Around 70% of over 70's will have some form of hearing loss. Occasionally your hospital will have a patient who is a British Sign Language (BSL) user

This Guidance is designed to assist you and your staff teams at a time of crisis. Here is a simple checklist to ensure that your teams are able to support patients with hearing loss or who use BSL.

#### What can you do?

- Make deaf awareness training available for all staff.
- If you already have a current and local arrangement for the provision of sign language interpreters, do maintain this. For those that do not have any, there is a new free BSL interpreting service provided by SignHealth and InterpreterNow: [bslhealthaccess.co.uk](https://bslhealthaccess.co.uk) which will need to be

advertised to all staff. This provides immediate access to a remote interpreter using a computer/laptop with a web browser and camera. This is free for all medical services during the Covid-19 crisis. However, for those that already have arrangements in place, this new service should be considered as back-up and not a replacement service as it is yet unknown whether this new service will continue after any lockdown.

- Find out and advertise if hearing enhancing equipment is available, such as a Conversation or Personal Listener, or a loop system.
- Identify staff in your organisation who may be able to use sign language.
- Provide an internal information hub (intranet) with sources of information about how to support people with disabilities including Deaf BSL users & people with hearing loss.
- Find out if your NHS Trust has made a commitment to the BSL Charter with the British Deaf Association, or Louder than Words with Action on Hearing Loss.
- Make links with your regional or national deaf mental health service, they can provide advice and guidance. See: [bsmhd.org.uk/https://bsmhd.org.uk/2020/05/05/new-list-of-mental-health-services/](https://bsmhd.org.uk/2020/05/05/new-list-of-mental-health-services/)
- Make links to local social care services to get in touch with community groups of Deaf BSL users or people with hearing loss. These are often able to provide informal support, such as visitors and volunteers, who can be vital to help maintain mental health and prevent isolation.

*Our aim is to promote mental health wellbeing for Deaf BSL users and People with Hearing Loss – getting the communication right is often crucial for their wellbeing.*



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