# SBAR FOR INCLUSIVE AND EQUITABLE PATIENT CARE

SBAR is a technique that is typically used to frame conversations between health care providers regarding a patient's condition and clinical status. SBAR in this circumstance is adapted to promote respectful and inclusive patient communication and care. It is important to recognize that each patient, couple, and family are unique. These sample SBARs are not all-inclusive.

## SBAR forDeaf/DeafBlind*/DeafDisabled/Late-Deafened/Hard of Hearing (DDBDDLDHH) Community

### Situation

A care provider enters a patient's room to meet and establish care with their patient in a maternity care setting. The patient is a 30-year-old G2 P1 in early labor; they are accompanied by their spouse and mother. The family informs the care provider that the patient is deaf and communicates with American Sign Language (ASL). Both mother and spouse are fluent in ASL. The patient has limited lip-reading ability, which is hampered by mask-wearing (e.g. operating room, personal protective equipment).

### Background

What are some of the challenges that patients who are deaf or hard of hearing encounter when receiving health care?

- Deafness is often labeled as a disability; however, many individuals who are deaf prefer to view it as a culture. Title II, III, VI, and Section 504 of the Rehabilitation Act of 1973 mandate equal access to health care, including appropriate communication (National Association of the Deaf, 2023) during health care encounters.
- Although access to health care is a right, barriers exist for the deaf population, particularly for those in their childbearing years. Health care literacy impacts women who are deaf in the education they receive around sexuality, health and wellness screenings, birth control, and pregnancy, which may cause further marginalization of this population (Kuenburg et al., 2016).
- Women who are deaf or hard of hearing are at increased risk for adverse outcomes during pregnancy and birth such as preterm birth or having newborns who are low birth weight (Ptacek, 2021). Lack of adequate communication and accommodation may contribute to poor outcomes (Ptacek 2021).
- Women who are deaf report lower satisfaction with prenatal care and with provider communication when compared to those who can hear (O'Hearn 2006).
- Some who are deaf may prefer to be called "Deaf" (capitalized) rather than "people with hearing loss" or "people who are deaf" (lowercase, [Dunn & Andrews, 2015]), while some may prefer "hard of hearing" rather than "hearing-impaired."
- Ineffective methods of communication that should be avoided include lip/speech reading, talking loudly, and writing as a form of communication (National Association of the Deaf, 2023).

### Assessment

Based on what you know, which assessments are a top priority in establishing a positive relationship with this patient and their family?

Self-Assessment:

- I will first engage in self-assessment to identify and recognize any personal bias.
- I will acknowledge how communication barriers can lead to marginalization and worsen health care outcomes.
- I will acknowledge the relationship between communication, hearing, and culture. I will attempt to educate myself regarding (DDBDDLDHH) community and culture.
- I will familiarize myself with all available resources that will enhance communication, such as ASL and assistive listening devices.
- I will understand personal and institutional barriers to delivering care and how to eliminate discrimination against people who are deaf or hard of hearing.
- I am aware that there are regional differences in sign languages (i.e., American Sign Language, Spanish Sign Language, Auslan). I will obtain a medical interpreter with the correct skill set.

Patient Assessment:

- I will work to build trust and rapport with this patient and their family by always using visual medical aids, as well as interpreters or video remote interpreting services.
- When using an interpreter, I will look at the patient who is deaf and speak directly to them, even if the patient is looking at the interpreter.
- I will honor the patient's preferences for their choice of language or terminology when referring to their disability or culture.
- I will ask about their previous birth experiences, listen, and validate their concerns with compassion and respect using a trauma-informed approach.
- I will encourage questions and elicit preferences for this birth experience.
- If a support person or significant other is deaf or hard of hearing, I will include them and help them understand what is going on by using interpreters.

### Recommendations

What actions can be taken to help this patient and their family feel heard and understood?

- I will include this patient and their family in all care decisions from admission to discharge.
- I will validate their care needs and concerns, ensuring the interprofessional team understands their communication needs and preferences to deliver individualized care and support.
- I will act promptly on the signs and symptoms they express to prevent, minimize, or eliminate harm.
- If using video remote interpreting is the best option available, I will maintain awareness that this option may not be preferred as it may be unreliable and difficult to use.

** Components of this SBAR may not be applicable to those that are blind or visually impaired.*

## ACTIONS

- After hearing and documenting this patient's previous birth experience, I will reflect on what I can do to decrease discrimination and bias to ensure they receive respectful, compassionate, individualized care.
- I will strive to identify and address unit, hospital, and systems issues that impact the overall care provided for patients in the (DDBDDLDHH) community.


**References:**

Dunn, D. S., & Andrews, E. E. (2015). Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *The American Psychologist*, *70*(3), 255–264. https://doi.org/10.1037/a0038636

Kuenburg, A., Fellinger, P., & Fellinger, J. (2016). Health care access among deaf people. *Journal of Deaf Studies and Deaf Education*, *21*(1), 1–10. https://doi.org/10.1093/deafed/env042

Mitra, M., McKee, M., Akobirshoev, I., Valentine, A., Ritter, G., Zhang, J., McKee, K., & Iezzoni, L. (2020). Pregnancy, birth, and infant outcomes among women who are deaf or hard of hearing. *American Journal of Preventive Medicine*, *58*(3), 418. https://doi.org/10.1016/j.amepre.2019.10.012 National Association of the Deaf. (2023). Position Statement on Health Care Access for Deaf Patients. https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/#:~:text=Position%20Statement%20On%20Health%20Care%20Access%20For%20Deaf,Communication%20Approaches%3A%20Resources%20...%208%208.%20Relevant%20laws

National Association of the Deaf. (2023). Position statement on health care access for deaf patients. https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/

O'Hearn A. (2006). Deaf women's experiences and satisfaction with prenatal care: A comparative study. *Family Medicine*, *38*(10), 712–716.

Ptacek, M. (2021). Pregnancy outcomes and disparities or deaf and hard-of-hearing mothers. *Lurie Institute for Disability Policy*. https://heller.brandeis.edu/parents-with-disabilities/pdfs/dhh-mothers-1.pdf




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