

Phase II

VISUAL REPORT SUMMARY



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Provincial Language Service, a program of the Provincial Health Services Authority (PHSA), engaged in a process to review the current service delivery model for provincial medical Sign language interpreting services, known as MIS. This service is provided for the Deaf, Deaf-Blind and hard of hearing community under a contract administered by Provincial Language Service.

The engagement had four phases:

- » **Phase I** – communicate the project and generate interest with Deaf, Deaf-Blind and hard of hearing communities in becoming engaged;
- » **Phase II** – five engagement workshops across the province with community stakeholders;
- » **Phase III** – a follow-up workshop to report on the input received in Phase II and to propose an interpreting service model and seek input;
- » **Phase IV** – communicate the input received on the proposed model and outline the next steps for the provincial medical Sign language interpreting services.



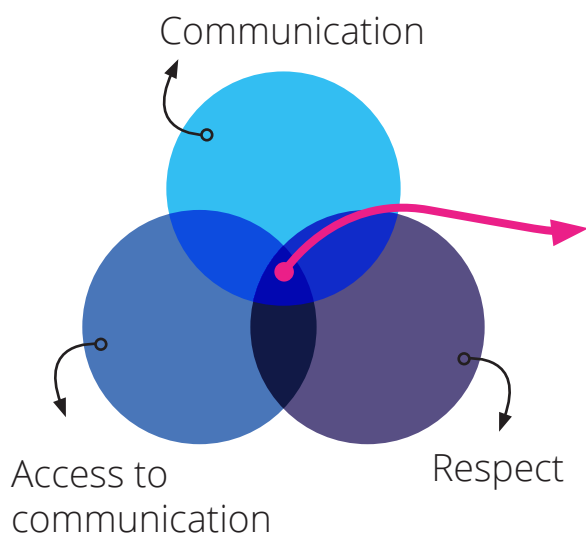
This report **visually** summarizes the input received during Phase II of the engagement project.

The purpose of Phase II was to gather input from service users to help improve service delivery to better meet community needs. Feedback was gathered through five community meetings held across the province.

A video log of a summary of the full Phase II report can be found online at <https://www.youtube.com/watch?v=xiFxC8mLPgc&feature=youtu.be>



1. SERVICE PRINCIPLES



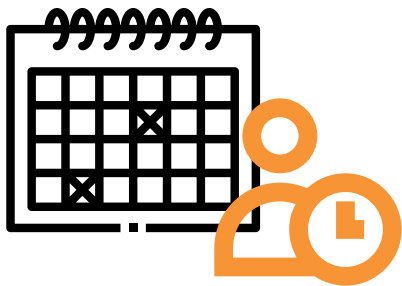
The three key values that should lead the future design of the medical Sign language interpreting services.

Understanding *what services are covered, to what extent, and why or why not* - needs to be clearly and continuously communicated to deaf, deaf-blind and hard of hearing patients.



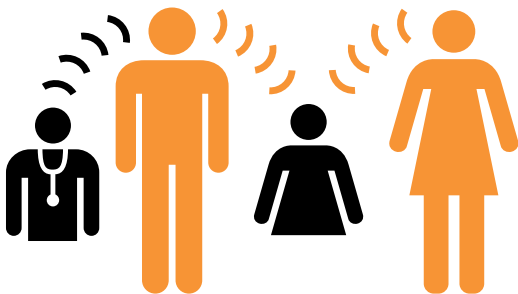
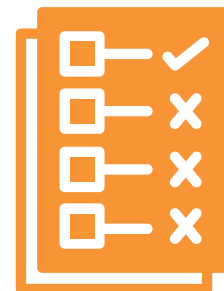


2. INTAKE/ DISPATCH EXPECTATIONS



When organizing schedules, interpreters should not be double-booked or booked for appointments that are tightly scheduled. *An interpreter needs to stay with the patient for the entire appointment.*

Deaf, deaf-blind and hard of hearing persons should have *a greater say in the selection of interpreters* for their appointments.



Deaf Interpreters should have a clearly defined role in interpreting and *deaf, deaf-blind and hard of hearing patients should have the option of choosing the services of a Deaf Interpreter in addition to a hearing interpreter* (in such cases, the interpreting team would include a Deaf Interpreter and a hearing interpreter).



3. INTERPRETER RESOURCES



Rural, remote and isolated communities struggle with the lack of interpreter resources. This needs to be addressed in creative ways – training local people who are fluent in ASL, setting up technology (such as Video Remote Interpreting¹), and providing incentives for interpreters to move to the North.

More interpreters, including Deaf interpreters, need to be trained and certified to work as medical Sign language interpreters. Deaf interpreters are not always available and they should be a common option for interpreting.

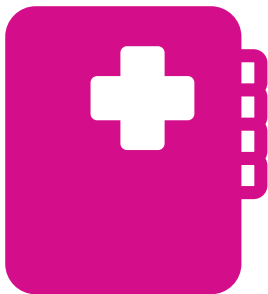


There are some basic requirements that clients expect from interpreters: Medical Sign language interpreters have to be qualified and well-versed in medical terminology; have their background checks and screening done prior to getting employed; be respectful; have an understanding of the Deaf culture and Indigenous culture; have an understanding of their role; and, *be timely, professional and follow the Code of Ethics.*

¹ Video remote interpreting (VRI) is a video-telecommunication service that uses devices such as web cameras or video-phones to provide sign language or spoken language interpreting services.



4. HEALTH CARE SYSTEM/ PROVIDER



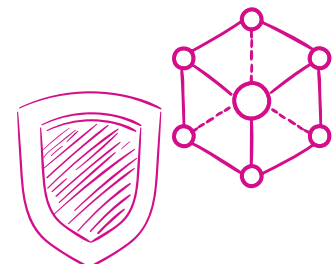
Information about a patient being deaf, deaf-blind or hard of hearing should be **part of a patient's medical record** and should be accessible by health professionals ahead of time.

Medical professionals need to understand the role of the interpreter, and its importance for effective communication, as well as have an awareness of Deaf culture, and the basics of communicating with the deaf, deaf-blind and hard of hearing persons.



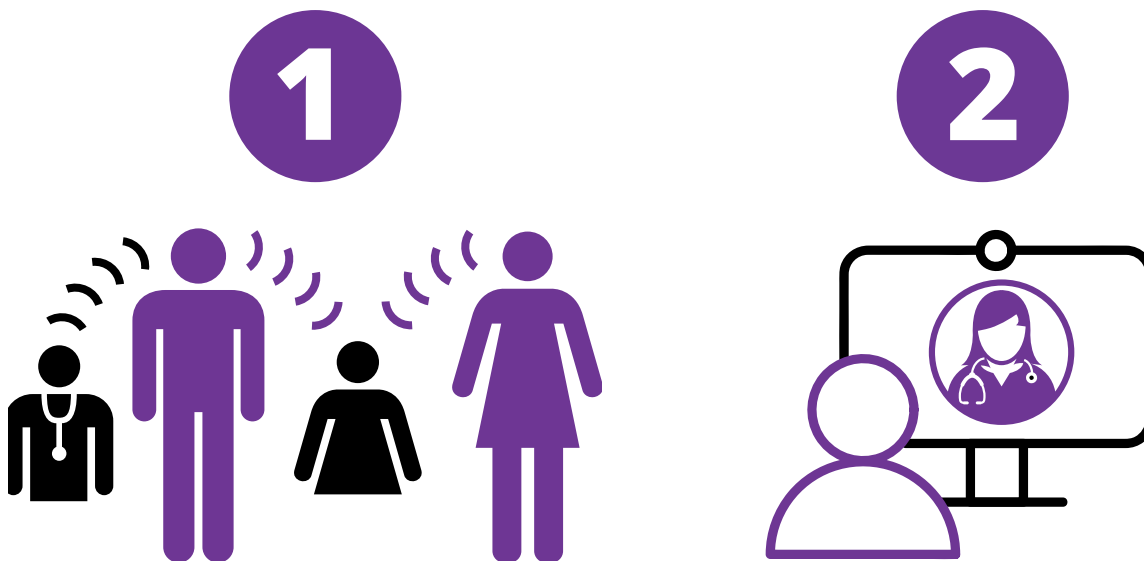
Emergency Room staff need to be trained on how to book interpreters and provided communication tools for establishing contact with patients until an interpreter arrives.

Aboriginal Provincial Liaison workers should work closely with American Sign Language (ASL) Interpreters (both deaf and hearing) to **ensure deaf people from Indigenous communities receive culturally-appropriate service.**





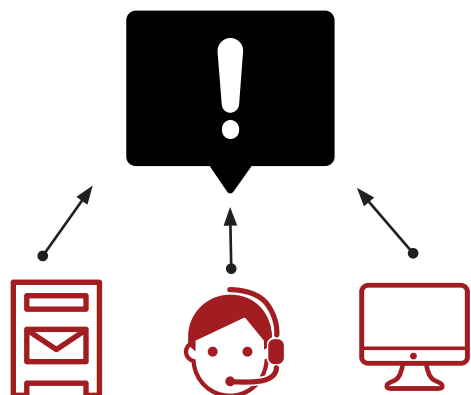
5. TECHNOLOGY



In-person interpreting should be the priority, but technology can be beneficial in emergency situations, for interpreting in rural and remote areas, and for times when an interpreter is not present or is unavailable.

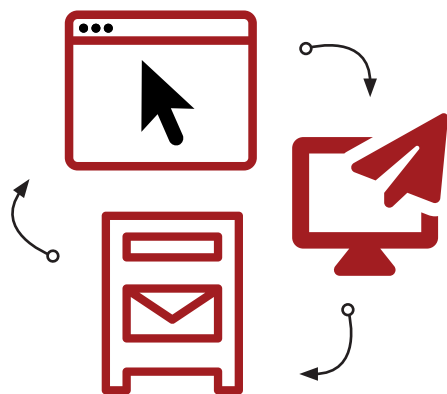


6. COMMUNITY ENGAGEMENT/ OUTREACH



The service should have *a clear and transparent complaints process* with a variety of ways to submit input.

The work of the provincial medical Sign language interpreting services should be *overseen by a Deaf Committee, Commissioner or another body* that understands the needs of the deaf, deaf-blind and hard of hearing British Columbians.



Communication with community members can be directed through representative organizations; however, because many deaf, deaf-blind and hard of hearing people do not affiliate with these organizations, *the communication should also be shared in other ways (via a website, email blasts, or snail mail).*