



# P#45

<b>Abstract Title:</b>	<b>It Takes A Village: A Multidisciplinary Approach To Coordination Of Care To Meet Communication Equity For A Deaf Patient</b>
<b>Author and Co-authors:</b>	Dana Y. Nakamura, OTR/L, Yuri Shiozawa, RN, Anju Saraswat, MD, Joseph Molnar, MD, PhD, James Holmes, IV, MD Wake Forest Baptist Medical Center, Burn Center, Winston Salem, NC
<b>Objective:</b>	1) Describe a multidisciplinary team approach to meeting communication equity for a deaf patient.
<b>Abstract:</b>	<p><b>Introduction:</b> Appropriate, effective and quality communication is critical for equity in healthcare access for deaf individuals. In order to provide excellent patient-centered care and equity in communication, representatives from the Deaf Community, Service Excellence and Interpreter Services departments, as well as Community Social Services, were included as part of the Burn Care Team for management of a deaf patient.</p> <p><b>Methods:</b> The patient was admitted to our Burn Intensive Care Unit following a house fire, in a distant community from the Burn Center. The patient sustained flame burns to his face and both hands/forearms, and severe smoke inhalation injury. He was intubated for an extended time, and restrained for medical safety, unable to communicate by signing, writing or mouthing words. The patient was highly agitated, and we learned that he was a single Dad and only caregiver for two young daughters, ages 4 and 10 years old, and was concerned about their status. Social services located his daughters and brought them to the Burn Center for an initial visit, after which time the patient was calm and cooperative with all care.</p> <p>American Sign Language (ASL) interpreters were present for change of shift report and for other times during the day (MD assessments, wound care, therapy interventions with Speech and Language Pathology, Respiratory, Recreation, Physical and Occupational Therapy). We also had access to remote interpreters but faced challenges with the patient being able to view the screen.</p> <p>Our patient required excision and grafting of his face and hands/forearms. The Plastic Surgeon used fibrin glue to secure the grafts, and no staples. The typical post-operative plan following grafting of the hands is for plaster slab positioners applied with bulky burn dressings and outer ace wrap, in place for 5 to 7 days. Occupational Therapy advocated for self-adhesive cohesive bandage, applied directly</p>

over greasy gauze for graft protection and gentle compression. A thermoplastic hand orthosis was fabricated for the hand with deeper burns, and concerns for protection of underlying structures and graft shearing. Bulky dressings to the patient's face following application of autologous skin cell suspension were removed on post-operative day (POD) 2, instead of left in place until POD 6. These modifications allowed the patient to sign or write his needs and communicate more efficiently and effectively with staff. A new mobile phone also enhanced communication for our patient as he was able to text friends and participate in social media platforms, as well as facetime with his daughters.

**Results/Conclusions:** As the patient was able to continue with functional use of his hands, he demonstrated active range of motion and exceptional functional independence in self-care and mobility at discharge. The patient's communication and reintegration needs were met by the coordination of care by multiple disciplines and use of current technology. Coordination with interpreter services and Deaf Community representatives was imperative to successful treatment of this patient.