

Accommodation as Institutional Infrastructure: A Scoping Review of Inpatient Disability Policy and Implementation

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Abstract

Adults with disabilities frequently encounter barriers in inpatient care, including environmental, communication, cognitive, and sensory challenges, despite legal obligations to provide reasonable accommodations. This study maps how inpatient accommodation policies are specified and operationalized. A PRISMA-ScR-guided scoping review was conducted across MEDLINE, Embase, CINAHL, PsycINFO, and Scopus (inception–July 2025), supplemented with grey literature. Twenty-three sources met the inclusion criteria. Policies were most developed for communication access, while accommodations addressing cognitive, psychosocial, sensory, and multi-component needs were less consistently operationalized. Implementation depended on reliable systems for identifying and documenting needs, clear role allocation, access to resources (e.g., interpreters, accessible formats, support persons), and limited mechanisms for measurement and accountability. These findings position accommodation as anticipatory, system-level infrastructure for inpatient safety and equity, while highlighting design gaps that hinder consistent delivery.

Abstrak

Penyandang disabilitas dewasa sering menghadapi berbagai hambatan dalam layanan rawat inap, termasuk hambatan lingkungan, komunikasi, kognitif, dan sensorik, meskipun terdapat kewajiban hukum untuk menyediakan akomodasi yang layak. Studi ini bertujuan memetakan bagaimana kebijakan akomodasi rawat inap dirumuskan dan dioperasionalkan. Scoping review berbasis PRISMA-ScR dilakukan melalui basis data MEDLINE, Embase, CINAHL, PsycINFO, dan Scopus (awal hingga Juli 2025), serta dilengkapi dengan literatur abu-abu. Sebanyak 23 sumber memenuhi kriteria inklusi. Kebijakan paling berkembang pada aspek akses komunikasi, sementara akomodasi untuk kebutuhan kognitif, psikososial, sensorik, dan multi-komponen masih kurang konsisten dioperasionalkan. Implementasi bergantung pada sistem identifikasi dan dokumentasi yang andal, kejelasan peran, akses terhadap sumber daya (misalnya interpreter dan format aksesibel), serta keterbatasan mekanisme pengukuran dan akuntabilitas. Temuan ini menempatkan akomodasi sebagai infrastruktur sistemik yang bersifat antisipatif bagi keselamatan dan keadilan layanan, sekaligus mengungkap kesenjangan desain kebijakan yang menghambat implementasi yang konsisten.

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A. Introduction

Adults with disabilities are frequently admitted to inpatient hospital units and often encounter barriers that non-disabled patients do not, including inaccessible physical environments, delays or absence of communication supports, difficulties providing informed consent due to inaccessible information, and inadequate recognition of sensory, cognitive, or psychosocial needs (Morris et al., 2021; Read et al., 2018). These barriers can compromise autonomy, safety, and quality of care, particularly in fast-paced acute settings where patients rely heavily on standardized processes and staff responsiveness (Morris et al., 2021). To address these inequities, jurisdictions have established legal and ethical mechanisms, termed “reasonable adjustments” in the United Kingdom and disability accommodations in the United States, Canada, and Australia, intended to remove disability-related barriers and ensure equitable access to hospital services (King & Duffy, 2022; Read et al., 2018). Despite longstanding legal protection, these barriers persist systematically within inpatient systems.

In this review, “adults with disabilities” is used as an umbrella term inclusive of individuals with physical, sensory (hearing/vision), communication, intellectual, neurodevelopmental, cognitive, psychosocial, and chronic health-related disabilities, recognizing that disability status is shaped by the interaction between impairment and environment. In inpatient care, that environment includes clinical pace, standardized routines, staff turnover, spatial constraints, and information systems, which can transform otherwise manageable impairments into high-impact barriers. Accordingly, accommodations in inpatient care function as upstream safety and equity infrastructure: they shape whether routine workflows can be accessed safely and with dignity.

Across healthcare systems, the literature identifies several core strategies required to support equitable inpatient care for adults with disabilities, including reliable identification and documentation of disability-related needs, environmental adaptations such as accessible rooms and equipment, administrative assistance with forms and processes, and tailored communication approaches using plain-language materials, augmentative or alternative communication devices, and interpreter services (Morris et al., 2021; Panocchia et al., 2025; Read et al., 2018). Clinical guidance further emphasizes that informed consent processes must be adapted through modified language, accessible formats, and the involvement of communication aids, support persons, or legal guardians when appropriate to ensure valid participation in decision-making (Forber-Pratt et al., 2022). Together, these strategies underscore that accommodation is not a single intervention but a coordinated set of practices spanning documentation, communication, environment, and care delivery (Morris et al., 2021; Panocchia et al., 2025). However, the presence of these strategies in policy documents does not guarantee their consistent implementation at the unit level, and practices may be informal, variable across jurisdictions, and dependent on local resources and accountability structures.

Legal and regulatory frameworks place explicit duties on hospitals to address these challenges, yet persistent gaps remain between statutory requirements and lived experience. In England, the Equality Act 2010 requires healthcare organizations to make anticipatory reasonable adjustments that remove disability-related barriers across physical environments, communication, and service delivery, rather than relying on reactive responses to individual requests (King & Duffy, 2022; Read et al., 2018). In the United States, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act mandate effective communication and equitable access through timely provision of auxiliary aids and services, obligations that apply to both public and private hospitals (Betancourt et al., 2017; Forber-Pratt et al., 2022; Iezzoni et al., 2022). Accreditation standards, including those from The Joint Commission, further require hospitals to identify and document patients’ communication needs, provide appropriate disability accommodations, and train staff accordingly, yet compliance does not

consistently translate into reliable bedside practice (Ibrahim et al., 2022). Critically, these legal and accreditation frameworks are not designed as case-by-case “exceptions”, they require anticipatory, system level processes that embed accommodation into routine operations (e.g., workflows, documentation, escalation, and resourcing).

Importantly, existing policies and standards tend to prioritize communication disabilities, particularly hearing, vision, and speech impairments, reflecting longstanding legal emphasis on “effective communication,” while accommodations for cognitive, psychosocial, sensory processing, and executive function needs are less consistently specified and operationalized (Forber-Pratt et al., 2022; Kearns et al., 2025; Oshita et al., 2024, 2025). Empirical work in intellectual disability contexts repeatedly documents low and unreliable recognition of disability during admissions, undermining the ability to trigger adjustments and sustain them across shifts and departments (Moloney et al., 2025; Walker et al., 2022).

Prior work has examined (i) disability barriers in hospital care, (ii) communication accommodations and effective communication mandates, and (iii) selected tools such as passports or flags – often within single disability domains (especially intellectual disability) or single source types (either empirical studies or policy guidance). What remains underaddressed is a cross-source, inpatient-focused synthesis that simultaneously: (1) maps the content domains of inpatient accommodation policies beyond communication alone; (2) identifies unit-level operational mechanisms (identification, documentation, workflow triggers, escalation, role ownership); and (3) examines how accountability and measurement are designed (or absent) across health systems.

Against this backdrop, a comprehensive synthesis of inpatient accommodation policies for adults with disabilities is needed to understand what policies cover, how they are implemented in practice, where breakdowns occur, and what outcomes have been evaluated. This scoping review maps existing inpatient policies for accommodating adults with disabilities, examining policy domains, implementation mechanisms such as identification flags and workflows, documented barriers and enablers, and reported impacts on care delivery. By situating policy content alongside empirical evidence on implementation, this review aims to clarify how hospitals operationalize legal and ethical duties and to identify gaps that must be addressed to achieve consistent, equitable inpatient care for adults with disabilities.

B. Research Methods

1. Protocol and Reporting

This scoping review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) principles to support transparent identification, selection, and synthesis of evidence (Tricco et al., 2018). The PRISMA-ScR checklist was formally applied. An a priori plan was developed to chart both peer-reviewed empirical studies and relevant grey policy sources addressing inpatient disability accommodations. Consistent with scoping review methodology, the review aimed to map the range, content, and implementation features of accommodation policies rather than to assess policy effectiveness or compare institutional performance.

Scoping review methodology was selected because the literature spans heterogeneous source types, including statutory policy documents, accreditation standards, hospital-level guidance, qualitative studies, mixed-methods evaluations, and descriptive audits, that are not amenable to traditional systematic review synthesis or risk-of-bias assessment. The objective was therefore to characterize the landscape of inpatient accommodation policy and practice, identify conceptual and

operational patterns, and highlight evidence gaps rather than to quantify effect sizes or determine policy superiority.

The review protocol was developed internally by the research team and informed by established methodological guidance for scoping reviews. No protocol registration was undertaken because the review focused on mapping policy content and implementation mechanism rather than evaluating intervention effects, which limits fit with common registries.

To enhance methodological transparency, the team specified upfront (i) the operational definition of “inpatient accommodation policy,” (ii) the domains of accommodation to be charted (communication, mobility/physical access, sensory environment, cognition/executive function, psychosocial/behavioral support, administrative/process supports), and (iii) the implementation mechanisms of interest (identification/flagging, workflow integration, accountability/roles, training, audit/metrics).

2. Search Strategy

We searched MEDLINE, Embase, CINAHL, PsycINFO, and Scopus from database inception to July 2025 using controlled vocabulary and free-text terms related to disability, accommodation, accessibility, inpatient or hospital care, reasonable adjustments, policy, effective communication, and accessible information. Search strategies were adapted for each database to capture literature spanning health services research, rehabilitation, nursing, policy, and disability studies. Grey literature searches targeted national guidance, regulatory documents, and hospital-level policy materials addressing disability accommodations in inpatient settings, including documentation systems and record-based identification tools used to signal accommodation needs. Reference lists or included sources were also screened to identify additional relevant materials.

Grey literature searches were restricted to publicly accessible documents from (i) government health departments, (ii) national health services guidance repositories, (iii) accreditation bodies, and (iv) disability advocacy organizations. Hospital-level policies were included only when publicly available online; internal or non-public policies were excluded. Searches were limited to documents explicitly applicable to inpatient (acute/ward) settings or clearly generalizable to inpatient workflows (e.g., HER flags, admission screening, interpreter escalation policies).

3. Eligibility Criteria

Sources were eligible for inclusion if they: (1) addressed inpatient hospital policies, guidance, or formal practices related to accommodations for adults with disabilities; and/or (2) reported empirical data describing, evaluating, or examining the implementation of such policies, including staff practices, documentation systems, accommodation delivery, or patient experiences. Both policy documents and empirical studies using qualitative, quantitative, mixed-methods, or evaluative designs were eligible. Sources were excluded if they focused exclusively on outpatient care, addressed pediatric populations only (unless policies were clearly transferable to adult inpatient contexts), or lacked substantive policy or implementation content. No restrictions were placed on country of origin, recognizing that legal terminology and policy frameworks vary internationally but share common principles related to non-discrimination, access, and reasonable accommodation. Only English-language sources were included due to feasibility constraints.

Screening was conducted using Covidence. During title/abstract screening, the initial reviewer disagreement rate was 12%, and disagreements were resolved through consensus discussion. Unresolved cases were adjudicated by a third team member or by team consensus.

For the purposes of this review, “policy” was defined broadly to include formal organizational protocols, national guidance documents, accreditation standards with operational requirements, and toolkits explicitly intended to shape inpatient practice. Commentary articles were excluded unless they contained concrete inpatient policy content, implementation mechanisms, or evaluative findings.

4. Selection Process

Two reviewers independently screened titles and abstracts, followed by full-text review of potentially eligible sources. Screening was guided by predefined inclusion and exclusion criteria to promote consistency and reduce selection bias. Disagreements were resolved through discussion and consensus. A calibration exercise was conducted during initial screening to ensure alignment in interpretation of eligibility criteria, particularly with respect to distinguishing policy-relevant sources from general accessibility commentary. Full-text screening decisions were documented with reasons for exclusion to support transparency. The PRISMA-ScR flow diagram (Figure 1) summarizes identification, screening, eligibility, and inclusion counts.

During calibration, reviewers jointly screened a subset of records to align on borderline cases, such as papers addressing disability in hospital settings without describing accommodation policies or workflows. This step was intended to reduce drift in interpretation over time and improve consistency in distinguishing implementation-focused sources from general descriptive reports. Where full texts were not readily accessible, attempts were made to retrieve via institutional access or publicly available repositories; sources that could not be obtained were excluded at the full-text stage.

5. Data Charting

Data were extracted using a standardized charting framework capturing jurisdiction, care setting, disability populations addressed, policy domains (including communication, mobility, sensory, cognitive, and psychosocial accommodations), implementation mechanisms (such as adjustment flags, checklists, or admission pathways), staff roles and training requirements, and reported outcomes or barriers to implementation. Charting was conducted iteratively to allow refinement of categories as new accommodation models and implementation strategies emerged. Extracted data were synthesized descriptively to identify patterns across policy approaches and implementation practices rather than to rank or evaluate individual policies.

Charted variables were grouped into four analytic buckets: (1) scope (what disabilities and accommodation domains were covered), (2) operationalization (how policies translated accommodations into steps, tools, and workflows), (3) implementation supports (roles, training, resources, escalation), and (4) accountability/evaluation (metrics, audits, reporting, enforcement). This structure was used to facilitate cross-source comparison and thematic synthesis across diverse document types.

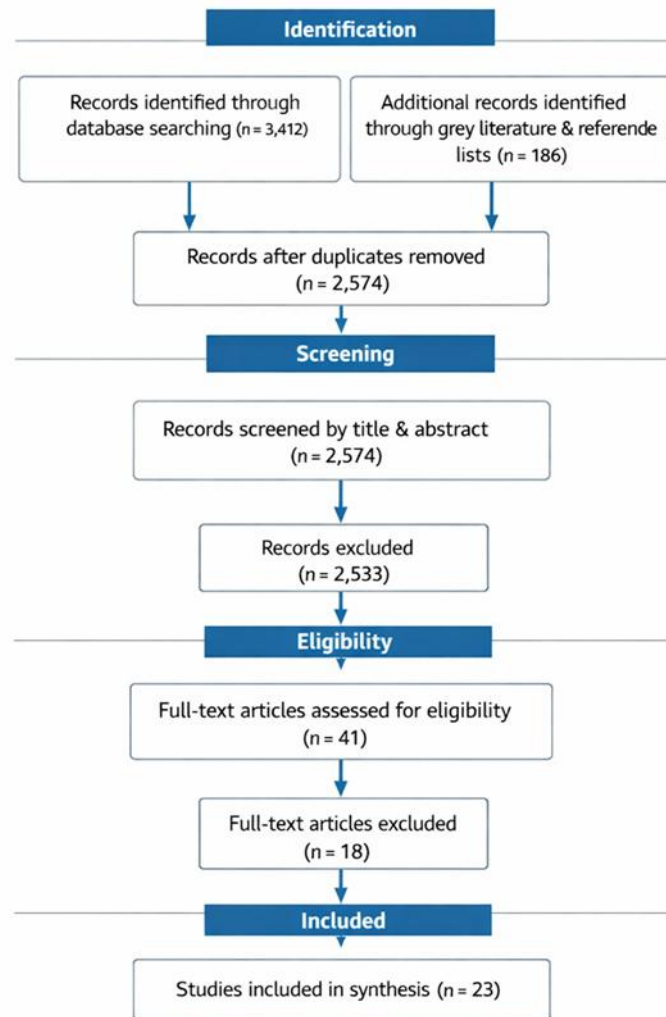


Figure 1. PRISMA Flow Diagram

6. Data Synthesis

Consistent with scoping review methodology, findings were synthesized narratively and thematically rather than quantitatively. Policy documents and empirical studies were analyzed together to identify convergence and divergence between formal policy provisions and reported practice. Themes were developed through inductive comparison across sources, with attention to how policies conceptualized disability, what accommodations were specified, how implementation was operationalized, and what outcomes or challenges were reported.

No formal quality appraisal was undertaken, as the aim was to map the evidence base rather than assess methodological rigor or effectiveness. However, study limitations and evidence gaps were noted to inform interpretation and future research directions.

Thematic synthesis proceeded in three steps. First, descriptive codes were assigned to extracted charting content (e.g., “EHR flag,” “passport tool,” “interpreter escalation,” “sensory environment not specified,” “audit absent”). Second, codes were clustered into higher-level categories

aligned with the four analytic buckets (scope, operationalization, implementation supports, accountability). Third, categories were refined into cross-cutting themes that best explained the recurring patterns across sources. Throughout, attention was paid to discrepancies between policy intent (what documents required) and observed practice (what empirical studies reported).

Given the policy focus, synthesis emphasized implementation mechanisms and system design features rather than individual clinician behavior. Where studies attributed gaps to “awareness” or “attitude,” these were interpreted within the context of training, workflow design, staffing constraints, and documentation infrastructure.

Policy documents were synthesized descriptively to characterize normative design (what is required, specified, and mandated), whereas empirical studies were synthesized to characterize operational delivery (what occurs in practice, what breaks down, and what barriers/enablers are reported). Integrating both source types enabled comparison between formal expectations and unit-level implementation.

C. Results and Discussion

Study Selection and Characteristics

A total of 3,412 records were identified through database searching and 186 additional records through grey literature and reference list screening. After removal of 1,024 duplicates, 2,574 unique records were screened by title and abstract, of which 41 sources were retrieved for full-text review. Following full-text assessment, 23 sources met inclusion criteria and were included in the final synthesis (Table 1). Included sources comprised a mix of national-level policy guidance, accreditation standards, hospital-specific protocols, qualitative interview studies, observational audits, and mixed-methods evaluations. Most empirical studies originated from high-income countries with established disability rights legislation, particularly the United Kingdom, United States, Canada, and Australia.

Table 1
Summary of included studies

Source (Year)	Country/region	Source type/design	Setting	Disability/population focus	Main policy/implementation focus
Read et al. (2018)	England (UK)	Empirical – qualitative interviews	Hospitals	Disables adults (varied)	Experiences of accessing reasonable adjustments; delivery gaps
Morris et al. (2021)	USA	Empirical – qualitative study	Healthcare settings (incl. hospital experiences)	Adults with diverse disabilities	Accommodation needs; barriers/ facilitators
McCormick et al. (2021)	International	Evidence synthesis – systematic review	Acute hospital services	Adults with intellectual disability	Acute hospital access; barriers/ enablers
Moloney et al. (2021)	International	Evidence synthesis – systematic review	Acute care	People with intellectual disability	Reasonable adjustments in acute care literature
Moloney et al. (2023)	Ireland	Empirical – qualitative descriptive	Acute healthcare/ hospitals	People with intellectual disability	Needed adjustments; successes/failures in practice

Source (Year)	Country/region	Source type/design	Setting	Disability/population focus	Main policy/implementation focus
				(parents' perspectives)	
Moloney et al. (2023)	Ireland	Empirical – realist – informed qualitative	Acute hospitals	People with intellectual disability	Implementation mechanisms/contexts shaping delivery
Tuffrey-Wijne et al. (2014a)	England (UK)	Empirical – mixed-methods	NHS acute hospitals	People with intellectual disability	Barriers/enablers; liaison roles; workflow/accountability gaps
Tuffrey-Wijne et al. (2014b)	England (UK)	Empirical – mixed-methods (same study as 2014a)	NHS acute hospitals	People with intellectual disability	Same focus (duplicate citation in your list)
Tuffrey-Wijne et al. (2014)	England (UK)	Empirical – mixed-methods	NHS acute hospitals	People with intellectual disability	Patient safety incidents; monitoring/prevention systems issues
Sheehan et al. (2023)	England (UK)	Empirical – retrospective linked-dataset cohort	General hospitals	Adults with intellectual disability	Under-recording/identification; implications for triggering adjustments
Walker et al. (2022)	New South Wales, Australia	Empirical – retrospective data linkage	Hospital admissions	Adults with intellectual disability	Predictors/outcomes of recognition during admission
Kenten et al. (2019)	England (UK)	Empirical – qualitative (service-level practices)	English hospitals	Children/young people with learning disability	Flagging/identification practices (implementation mechanism)
Mudrick et al. (2020)	USA	Empirical – qualitative study	EHR/clinical documentation use	Patients with disabilities	Accommodation needs in EHR; use for preparation/continuity
Oshita et al. (2024)	USA	Empirical – qualitative interviews	Healthcare organizations	Communication-related disability needs	How organizations operationalize “effective communication” acco
Oshita et al. (2025)	International	Evidence synthesis – scoping review	Healthcare settings	Disability communication access	Evidence on accommodations for equitable communication access
Kearns et al. (2025)	Multi-country	Evidence synthesis – integrative review	UNCRPD-ratified contexts	Communication disabilities/differences	Communication access supports and system strategies
Wallace (2024)	Australia	Policy/implementation paper	Hospital standards application	Adults with intellectual disability	System to develop reasonable adjustments aligned with NSQHS standards
Ibrahim et al. (2022)	USA	Policy evaluation –	Accreditation standards	Hospital accreditation standards	Evidence base underlying Joint

Source (Year)	Country/region	Source type/design	Setting	Disability/population focus	Main policy/implementation focus
		cross-sectional study			Commission standards (mandate context)
lezzoni et al. (2022)	USA	Policy/health services overview	Health system	People with disabilities	Disability civil rights laws vs persistent inequities (mandate context)
Taira et al. (2019)	International	Evidence synthesis – systematic review	Hospitals/health systems	Limited English proficiency patients	Health-system interventions for language access (communication infrastructure)
Wu & Rawal (2017)	USA	Empirical – qualitative interviews	Hospital care	Limited English proficiency patients (interpreter perspectives)	Interpreters' role in safe care; escalation/role dynamics
Hut-Mossel et al. (2021)	Multinational	Evidence synthesis – systematic realist review	Hospital care	Not disability-specific	How/why audits improve quality; mechanisms/contexts (accountability relevance)
Sarkies et al. (2023)	Multinational/health systems	Empirical – realist study	Audit & feedback scale	Not disability-specific	Implementation mechanisms for audit/feedback (accountability relevance)

Policy sources consistently referenced legal duties to provide reasonable adjustments or disability accommodations and frequently emphasized communication access and documentation as core obligations. Empirical studies were largely conducted in acute hospital settings and focused predominantly on adults with intellectual disability or communication-related impairments, with fewer studies addressing broader disability categories or intersectional needs. Across sources, four interrelated themes were identified.

Policy scope is communication-forward but disability-type narrow

Across healthcare systems, inpatient accommodation policies most consistently specified adjustments for communication disabilities, particularly hearing, vision, and speech impairments, reflecting longstanding legal and regulatory emphasis on “effective communication” and the provision of auxiliary aids. Policy and guidance documents frequently detailed interpreter access, accessible formats, and communication aids, whereas accommodations for cognitive disabilities, psychosocial disabilities, sensory processing needs, fatigue or pain pacing, and executive functioning were less consistently defined or operationalized. Empirical work in acute hospital settings, especially within intellectual disability contexts, demonstrated a persistent gap between the legal concept of reasonable adjustments and their practical delivery at the bedside, with policies alone insufficient to ensure consistent accommodation across shifts and departments (King & Duffy, 2022; McCormick et al., 2021; Tuffrey-Wijne, Goulding, Giatras, et al., 2014; Tuffrey-Wijne, Goulding, Gordon, et al., 2014).

Multiple studies characterized this gap as a systems failure rather than an individual clinician failure. Commonly reported barriers included weak or absent mechanisms for identifying intellectual disability at admission, inconsistent documentation of required supports, variable staff understanding of what constitutes an appropriate adjustment, unclear accountability for initiating and coordinating accommodations, and limited time and resources within acute care environments (Moloney et al., 2025; Tuffrey-Wijne, Goulding, Giatras, et al., 2014; Tuffrey-Wijne, Goulding, Gordon, et al., 2014). As a result, accommodation delivery frequently depended on individual staff knowledge, attitudes, or confidence, producing fragmented and inequitable care rather than standardized, organization-wide practice (Moloney et al., 2025; Tuffrey-Wijne, Goulding, Giatras, et al., 2014).

Documentation deficits further reinforced this implementation gap. A large linked-dataset cohort study in England (2006–2019) found that intellectual disability was recorded in only 2.9% of hospital admissions, substantially limiting hospitals' ability to trigger, track, and audit the delivery of reasonable adjustments (Sheehan et al., 2023). Without reliable identification and recording, accommodations were reported to be ad hoc, poorly sustained during handovers, and vulnerable to breakdown across departments (Sheehan et al., 2023; Tuffrey-Wijne, Goulding, Gordon, et al., 2014). Patient and caregiver accounts linked these failures to compromised dignity, heightened distress, poorer communication, and increased safety risks, reinforcing concerns that existing systems are not designed to capture or respond to disability-specific risk pathways (McCormick et al., 2021; Moloney et al., 2023; Tuffrey-Wijne, Goulding, Gordon, et al., 2014).

Reasonable adjustments depend on identification systems and documentation

Across empirical and policy sources, a central determinant of whether accommodations occurred in inpatient units was how disability-related needs were identified and documented. Studies consistently demonstrated that the absence of reliable identification and flagging processes was associated with missed needs, inconsistent accommodation delivery, and reliance on informal staff knowledge rather than standardized care pathways (Morris et al., 2021; Read et al., 2018; Tuffrey-Wijne, Goulding, Giatras, et al., 2014). In response, policies frequently described mechanisms such as admission screening questions, electronic chart flags, bedside prompts, and standardized reasonable-adjustment forms intended to make needs visible and support continuity across shifts and departments (Kenten et al., 2019; Moloney et al., 2025; Mudrick et al., 2020).

Evidence suggests, however, that identification infrastructure alone is insufficient. Studies examining flagging and recording mechanisms found that their effectiveness depended on consistent use, staff training, and integration into routine clinical workflows, with flags sometimes applied inconsistently, contested, or ignored in practice (Kenten et al., 2019; Mudrick et al., 2020; Tuffrey-Wijne, Goulding, Giatras, et al., 2014). Related evidence from Australia similarly showed that variable recognition and documentation of intellectual disability during admissions were associated with downstream care processes and outcomes, reinforcing that identification is a prerequisite for accommodations to be reliably triggered (Walker et al., 2022). Qualitative findings further highlighted the importance of named responsibility and liaison roles in supporting follow-through and clarifying accountability for accommodation delivery (Moloney et al., 2025; Tuffrey-Wijne, Goulding, Giatras, et al., 2014).

Across sources, effective identification systems shared several design features: (i) clear criteria for what should be flagged (diagnosis-based and/or needs-based), (ii) a standardized place in the EHR for documenting accommodations, (iii) visibility across services and transitions (ED to ward, ward to imaging, ward to OR), and (iv) linkages between identification and action (e.g., auto-populated care plans or prompts). Where these linkages were absent, flags risked becoming symbolic markers rather than drivers of care delivery. Taken together, documentation functions as a central enabling condition

for continuity and accountability, because unrecorded needs cannot reliably trigger action, be handed over, or be audited.

Implementation relies on role clarity and access to resources

Even where accommodation policies existed, implementation depended on staff understanding their responsibilities and having practical access to resources such as interpreter booking systems, captioning or communication supports, augmentative and alternative communication tools, accessible print and digital formats, quiet or sensory-adapted spaces, and mechanisms for involving support persons. Guidance from the Agency for Healthcare Research and Quality emphasized that staff training must extend beyond policy awareness to include how to operationalize communication access, such as booking interpreters, accessing on-demand services, documenting use, and applying health-literacy strategies in real-time care (Gutman et al., 2025). For patients who are deaf or hard of hearing, access to real-time communication aids and assistive technologies was identified as essential for effective participation in care (Giansanti & Pirrera, 2025).

Accreditation standards reinforced these expectations by requiring hospitals to identify and document communication needs and provide qualified interpreting and translation services, yet empirical evidence suggested that standards often lacked operational specificity, such as escalation pathways or after-hours contingencies, contributing to variability in bedside practice (Taira et al., 2019). The literature further cautioned that simply offering interpreter services was insufficient if staff were not trained to use them effectively or if systems did not support interpreters in raising safety concerns when miscommunication occurred (Wu & Rawal, 2017). Organizational studies highlighted executive leadership support, resourcing, and unit-level preparation as key enablers of consistent implementation, noting that while sign-language interpreter access was often prioritized, accommodations for speech, language, and cognitive disabilities were less consistently addressed due to their need for coordinated, multi-component supports (Oshita et al., 2024).

Effective implementation was more likely when policies specified: who initiates identification (e.g., admitting nurse/ED clinician), who confirms/documents it (charge nurse/attending/allied health), who provides specialized supports (liaison/SLP/interpreters), and what escalation occurs if resources are unavailable. When such pathways were absent, accommodation delivery could stall at predictable friction points, including after-hours periods, transfers between units, and interdepartmental care (e.g., imaging, procedures).

Measurement and accountability are limited

Few included sources reported standardized metrics for evaluating the effectiveness of inpatient accommodation policies. Empirical studies indicated that accommodation needs are common in hospital settings, yet systematic measurement of outcomes, such as accommodation delivery rates, time to interpreter or auxiliary aid, patient-reported accessibility, and downstream safety outcomes, was inconsistently captured and infrequently reported in the peer-reviewed literature (Buning et al., 2024; Kang et al., 2024; Mudrick et al., 2020). Reviews of patient-reported experience measures in adult inpatient care further demonstrated incomplete psychometric evaluation of available tools, limiting their utility for routine quality improvement and longitudinal monitoring (Kang et al., 2024).

Although audit processes were frequently referenced in policy discourse, published descriptions often lacked detail regarding audit frequency, enforcement mechanisms, and feedback loops to staff or patients (Sykes et al., 2021). Qualitative and realist studies suggested that audits were more effective when they were context-sensitive, improvement-oriented, and accompanied by actionable feedback, whereas perceptions of punitive intent or low transparency reduced engagement and encouraged performative compliance (Hut-Mossel et al., 2021; Sarkies et al., 2023;

Sykes et al., 2021). Overall, the literature indicates a need for more systematic measurement, transparent reporting, and integrated accountability mechanisms to assess whether inpatient accommodation policies translate into equitable care in practice (Buning et al., 2024; Hut-Mossel et al., 2021; Kang et al., 2024; Sarkies et al., 2023).

Across sources, a feasible inpatient accountability framework would include at minimum: (1) delivery metrics (proportion of identified needs that receive documented accommodations), (2) timeliness indicators (time-to-interpreter/AAC/accessible format; after-hours response), (3) continuity indicators (handover persistence of accommodation plans across transfers and shifts), (4) patient-reported accessibility outcomes (ability to understand care, participate in decisions, sensory safety, dignity), and (5) safety-linked indicators where supported (e.g., adverse events plausibly linked to communication or discharge failures). Importantly, measurement should distinguish between “documentation present” and “accommodation delivered and effective.” Here, “evaluative maturity” refers to the limited number of outcome-focused studies, variability in methodological rigor, and the absence of standardized delivery and timeliness metrics that would allow hospitals to benchmark and improve accommodation performance over time.

Discussion

This scoping review demonstrates that inpatient accommodation policies are most developed and operationalized in relation to communication access, reflecting the clarity and enforceability of legal and accreditation requirements in this domain. Across jurisdictions, hospitals most consistently specify and implement accommodations such as sign language interpreters, accessible information formats, and communication supports for patients with sensory disabilities, aligning with longstanding regulatory emphasis on “effective communication” and auxiliary aids. Prior research similarly shows that when obligations are explicit and auditable, organizations are more likely to translate policy into practice, particularly when supported by leadership engagement and advance planning at the system or clinic level (Kearns et al., 2025; Oshita et al., 2024, 2025).

In contrast, accommodation policies for cognitive disability, intellectual disability, and other “invisible” disabilities remain less consistently specified and enacted. Across acute care studies, supports such as individualized care plans, hospital passports, and liaison roles were frequently described as locally driven initiatives rather than standardized, system-integrated pathways (McCormick et al., 2021; Moloney et al., 2021, 2025). This mirrors earlier work documenting a persistent gap between the principle of “reasonable adjustments” and routine bedside practice, with accommodations often occurring at the discretion of individual clinicians rather than being embedded within organizational workflows and accountability structures (Moloney et al., 2021, 2025). The uneven policy coverage across disability types suggests that legal recognition alone is insufficient without corresponding operational detail and institutional ownership.

A central conceptual contribution of this review is the framing of inpatient accommodation as institutional infrastructure rather than discretionary individualized assistance. Within disability studies, this aligns with anticipatory accommodation and institutional design: barriers persist not simply because staff “fail” to accommodate, but because inpatient systems are built around default assumptions of communication, executive function, sensory tolerance, and self-advocacy. When accommodations are not embedded into infrastructure (EHR, workflow triggers, staffing, procurement, escalation), they remain fragile and uneven.

The review further highlights that implementation failures are best understood as system-level rather than individual-level problems. Commonly cited barriers, including insufficient staff training, limited dedicated resources, and the absence of integrated care pathways, undermine the ability to

identify needs, document required supports, and sustain accommodations across shifts and departments (McCormick et al., 2021; Moloney et al., 2021, 2025). These findings align with organizational research showing that reliance on informal workarounds increases variability and inequity, particularly in high-acuity inpatient environments where continuity of care depends on standardized processes. Accordingly, multiple authors argue for intellectual disability-specific policies, structured education initiatives, and leadership-driven strategies to ensure equitable access and outcomes across disability groups (Clemente et al., 2022; Moloney et al., 2021, 2025; Panocchia et al., 2025).

Across sources, reliable identification and documentation emerged as the most implementation-critical element of inpatient accommodation policy. The literature consistently demonstrates that when accommodation needs are not systematically captured and communicated, particularly across units and handovers, policies fail to translate into consistent bedside practice. Realist-informed analyses describe how reasonable adjustments remain ad hoc and clinician-dependent when identification and documentation processes are weak or fragmented (Moloney et al., 2025). Tools such as adjustment flags offer a scalable solution, but their effectiveness depends on uptake, staff training, and integration into workflows that ensure flagged needs lead to delivered supports, rather than symbolic compliance (Moloney et al., 2025; Xiong et al., 2024). These findings reinforce prior evidence that documentation infrastructure is a prerequisite for accountability and continuity in complex care settings.

Finally, this review underscores the limited evaluative maturity of the current evidence base. While some studies describe how hospitals implement communication accommodations, few assess patient-centered outcomes in inpatient settings, particularly for adults with disabilities with intersecting barriers. The absence of standardized metrics, such as accommodation delivery rates, response times, patient-reported accessibility, or safety outcomes, constrains learning and improvement. Consistent with broader quality and safety scholarship, treating accommodation policy as a safety and equity intervention would require defining core domains, specifying minimum service standards, and evaluating outcomes that matter to patients, including autonomy, dignity, distress reduction, and trust (Clemente et al., 2022; Panocchia et al., 2025). At the system level, this suggests that accommodation performance should be governed similarly to other safety-critical processes (e.g., medication reconciliation): defined triggers, assigned roles, measurable standards, audit-and-feedback loops, and resourcing that is not contingent on individual advocacy capacity.

This review's strengths include its integration of empirical studies with policy and grey literature, allowing examination of both formal policy intent and real-world implementation in inpatient settings. However, the evidence base remains uneven, with a heavy concentration on intellectual disability and communication access, limited data on other disability groups, and sparse outcome evaluation. Most included studies were qualitative or descriptive, limiting causal inference; this reflects the nature of the existing evidence base rather than a limitation of the review design. Future research should prioritize comparative evaluation of policy models, development of validated inpatient accessibility measures, and longitudinal assessment of how identification systems, documentation tools, and accountability mechanisms influence patient experience, safety, and equity across disability types.

D. Conclusion

Inpatient accommodation policies for adults with disabilities are increasingly visible and well developed in areas of effective communication and accessible information, reflecting strong legal and regulatory foundations. However, substantial variability persists in policy scope, disability inclusivity, operational detail, and accountability, particularly for cognitive, intellectual, and invisible disabilities.

The literature suggests that meaningful improvement depends on robust identification systems, clear role ownership and resourcing, and measurable standards tied to patient-important outcomes. From a rights-based perspective, persistent implementation gaps represent not only operational shortcomings but incomplete realization of legally protected disability rights within inpatient systems. Without these elements, accommodation policies risk remaining aspirational rather than transformative, limiting their ability to deliver consistent, equitable inpatient care.

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