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Registered Nurse and Nursing Assistant Perceptions of Limited English Proficient Patient-Clinician Communication

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Abstract

In this article, the authors discuss implications for nurse administrators from a recent qualitative study regarding nursing personnel perceptions of LEP patient-clinician communication. Few studies have examined nursing personnel's use and perceptions of communication resources when caring for LEP patients.

Nursing personnel are critical to the delivery of quality patient care in hospitals and spend substantial time at the bedside. As such, registered nurses (RN) and nursing assistants (NA) are at the forefront of patient-clinician communication. Their unique perceptions are important for understanding strengths and weaknesses of hospital systems, how they fail, and how to fix them (1). Therefore, nursing administrators should rely on the feedback and perspectives of RNs and NAs when making decisions regarding communication resources that enhance patient-clinician communication.

Additionally, nurse administrators have leadership accountability and regulatory obligations for supporting communication resources that address the communication needs and preferences of patients (2, 3). In the U.S., over 25 million people are limited English proficient (LEP) (4). Language barriers, which can occur with LEP patients, may result in miscommunication posing risks to patient safety (e.g. misdiagnosis, unnecessary testing) (5). With high rates of immigration, geographic dispersion, and linguistic diversity, nurse

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administrators must ensure that resources are available to RNs and NAs that enable LEP patient-clinician communication.

Common LEP patient-clinician communication resources available include interpreters, communication boards, software programs on computer tablets, call lights, and audio or visual aids (6, 7). Patient-clinician communication in hospitals often begins with call light devices and patients report a reliance on call lights to initiate care (7-9). For LEP patients, current call light systems pose significant communication barriers, affecting communication with healthcare personnel and care delivery (7, 8). Despite advancements in health communication resources (e.g., telehealth; webcams; texting; smart devices), the bedside call lights has remained relatively unchanged. Understanding the perceptions of RNs and NAs regarding communication encounters and use of communication resources when caring for LEP patients can: 1) assist nurse administrators in identifying resources that best support LEP patient-clinician communication; and 2) inform health technology innovation. However, very few studies have examined RN and NAs' use and perceptions of communication resources when caring for LEP patients.

Current Study

We conducted a qualitative study to describe RNs' and NAs' perceptions of LEP patients' call light use and their current communication practices with LEP patients. We interviewed 3 RNs and 3 NAs from 3 adult medical-surgical units with the highest rates of LEP patients over a period of 6 months. Inclusion criteria for informants were: ≥21 years old; employed ≥12 months; work ≥ 0.5 full time equivalents as regular staff providing direct patient care; licensed as RN or certified as NA; and have taken care of LEP patients while in their current position. Participant demographic information is in SDC #1. Using a semi-structured interview guide we asked informants 7 open-ended questions, followed by probes, about their perceptions of LEP call light use and their experiences with LEP patient-clinician communication. Interviews were audio-recorded and lasted 45-60 minutes. Ethical approval was obtained by the study site's institutional review board. Following the interviews, informants received a $50 gift card to compensate for their effort and time. Audio files were transcribed verbatim. Three researchers independently analyzed the data using the constant comparative methods of Glaser and Strauss (10) and qualitative content analysis (11). We discussed minor and major themes until reaching consensus.

Results

Six major themes resulted from our study, and provide insight into how RNs and NAs perceive LEP patient call light use, as well as their communication practices with LEP patients (major and minor themes with supporting quotes in SDC #2).

Call Light Use by LEP Patients

Informants reported that LEP patients use call lights infrequently, are uncertain on how to use it: *"They might not know what some of the buttons are*," and have difficulty communicating with clinicians after using their call light device.

Reliance on Family

Informants reported LEP patients strongly relied on family members to assist communication with clinicians. Family members utilized the call light themselves and communicated with the clinician on behalf of the patient: "*A lot of times if there is a family member present, they'll help them answer the questions*." The informants also stated their own reliance on family members to communicate with LEP patients: *"We're asking them if they're hungry, are they in pain, do they need water…the family member can ask them for us*."

Reliance on Interpreter Services

Informants reported interpreter services as a resource for communicating with LEP patients: *"You can't always trust translations from families. That's why I always at least request for a translator to come for each patient."* However, they identified several factors limiting their use of interpreter services, including: time availability and personnel availability. One informant stated, *"To have someone physically present, it could take over a day."* Informants also identified problems with coordinating the care team around interpreter services' availability: *"What happens sometimes is the interpreter will arrive, the doctor may not be there*."

Reliance on Ad Hoc Communication Aids

Due to the limitations of interpreter services, informants described use of numerous ad hoc communication aids, including: charades; pictures; broken English; staff who speak the patient's language; and other technology (e.g., Google translate).

Impact of Inefficient LEP Patient-Clinician Communication

Informants perceived that inefficient LEP patient-clinician communication negatively affects provision of care: *"If they're not able to communicate that they're in pain, then I'm not necessarily going to treat their pain as well."* In addition, they reported that the extra time to engage interpreter services or utilize ad hoc communication aids negatively affected nursing work flow: "*It just takes more time. You just have to like use all different avenues to try and get the question answered or figure out what they're trying to communicate*."

Discussion

Since language barriers between LEP patients and clinicians affect provision of quality care and work flow, it is imperative that nursing administrators understand causes for underutilization of interpreter services and identify strategies to support communication. Similar to Galinato and colleagues' findings (7), informants reported use of ad hoc communication aids in lieu of interpreter services. Ad hoc resources are not supported by hospital policies and generate concern since reliance on nonprofessional and ineffective communication methods are associated with higher communication error rates, resulting in patient harm (5).

Reasons for reliance on ad hoc communication aids, rather than interpreter services, parallels the work of Mayo and colleagues (12), who found that clinicians use family

members because of limited professional interpreter availability and substantial wait times for interpreters. Despite recommendations for using interpreter services (13), limitations of interpreter services resulted in nursing personnel relying more heavily on other communication aids. Informants' perceptions suggest that improved interpreter services' availability and accessibility would save time and improve care, especially on weekends when interpreter services' availability is limited. Failure to address the limitations of interpreter services can inadvertently promote use of ad hoc resources by nursing personnel.

Limitations

This study was conducted in a single hospital using 6 informants. Future work should replicate this study at multiple sites with a larger sample. Additionally, we did not collect data regarding diversity of LEP patients cared for by the informants. Communication behaviors and needs of LEP patients may vary across cultural and linguistic groups. Finally, we did not collect information regarding current hospital-provided LEP communication resources. Comparing clinician perceptions of resources available to resources actually provided by the hospital would help to further knowledge regarding health communication technology awareness and use.

Conclusion

Nurse administrators are challenged to provide clinicians and LEP patients with immediately accessible and non-disruptive communication resources. RN and NA perceptions of LEP patient-clinician communication can assist nurse administrators in making decisions regarding communication resources. Improvements in communication technology and interpreter services may additionally improve nursing workflow and ease of managing encounters with LEP patients which may improve quality of care and outcomes for this vulnerable patient population.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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