Speaking my patient’s Language: Providing language concordant care to patients with limited English proficiency

Parveen Ali, PhD, MScN, RN, FHEA

October 2015
Speaking my patient’s Language: Providing language concordant care to patients with limited English proficiency

A report submitted Mary Seacole Steering Committee following completion of a projected supported by Mary Seacole Leadership Award

Dr Parveen Ali,
School of Nursing and Midwifery
University of Sheffield
Barber House Annex
3a Clarkhouse Road
Sheffield
S10 2LA
Tel: 01142222406
Email: parveen.ali@sheffield.ac.uk
ACKNOWLEDGEMENT

Receiving a Mary Seacole Leadership Award was an honour. The award gave me the opportunity to explore a topic that I have always been passionate about and it has provided me with several personal and professional development opportunities. First, I would like to thank Almighty God who helped me achieve this milestone in my life. I would like to thank the funders and organisers of Mary Seacole Awards that focus on the health of people from Black and Minority Ethnic (BME) Communities in the United Kingdom (UK) and also contribute to the personal and professional development of nurses.

Completion of this project and the overall programme was not possible without the support of many people. I am grateful to my mentors, Dr Stacy Johnson and Mr Tom Sandford for their guidance, continued support and encouragement throughout. I am thankful to School of Nursing and Midwifery, University of Sheffield, for providing me the time to finish the task. In particular, I am grateful to Dr Tracey Moore, Head of Department School of Nursing and Midwifery. Other people I wish to thank for their contribution, support and encouragement during the project include Professor Roger Watson (University of Hull), Jesrine Clarke-Darrington (University of Sheffield), Ash Talpur, Alam Shah, Siobhan Smyth (RCN Governance Advisor), Amy Cole (RCN Governance Advisor), Catherine Langley (RCN Governance Advisor), Elizabeth Johnson (Sheffield Teaching Hospitals). I am grateful to all nurses who gave their time and shared their valuable thoughts and experiences with me. Special thanks to all my friends, and family members for their support. Finally, I am thankful to all Mary Seacole fellows for being part of this journey.
EXECUTIVE SUMMARY

- The present study was conducted to explore current communication practices of bilingual nurses when caring for patients from a shared linguistic background and to identify barriers and facilitators to the provision of language concordant care.

Background:

- With an increase in the internal and external migration and mobility of people from/to different parts of the world, the likelihood of experiencing language barriers while providing and receiving care has augmented.

- Nurses are responsible for providing care to patients regardless of their culture, religion, ethnic background or language. Language barriers, however, are hurdles that hamper development of effective communication between nurses and patients.

- Language barriers have an adverse impact on adherence to treatment regimens, follow-up for chronic illnesses, reduce comprehension of diagnosis and treatment, affect ability to seek information, and increase medical complications. Eliminating language barriers is a crucial step to providing culturally competent and patient-centred care.

Methods:

- Fifty nine nurses, working in various acute NHS trust hospitals contributed to the study through 26 individual in-depth interviews and three focus group discussions.

- The data were analysed using thematic analysis.

- A documentary review of interpretation and translation policies of 30, randomly selected, acute NHS Trusts was undertaken. Each policy was specifically reviewed to understand the guidance in relation to use of staff as interpreters.

Findings:

- Document Review: The majority of the organisations prohibited use of family, friends and children as interpreters. Use of staff as interpreters varied among organisations with
most expecting bilingual staff to communicate with patients in their language to ascertain simple information such as personal details, menu choices or to communicate with the patient in emergency situations only.

- Only two organisations specifically allowed registered medical, nursing or allied health professionals to use their language skills. The majority of organisations required practitioners to use interpreters when assessing a patient, even when they themselves could communicate in that language.

- **Qualitative Data:** Three themes: ‘current situation and my perspective’; ‘when we speak the same language’; and ‘what helps of hinders’ were identified. These themes describe the participants’ views about language concordant communication in clinical practice, its usefulness and impact on patients and nurses themselves.

- Findings suggest that patient population is diverse in terms of age, gender, ethnicity and language. The majority of the participants identified South Asian (Pakistani, Indians and Sri-Lankans) as the second largest group patient group they provide care.

- Communication was identified as the most important aspect of care provision and an essential component of a nurse’s professional role regardless of the clinical area or speciality. The language barriers were identified as the biggest obstacles in providing adequate, appropriate, effective and timely care to patients with LEP.

- Use of interpreters is very useful. However, there are limitations associated with use of interpretation service. These include arrangement difficulties, availability and accessibility of interpreter services, convenience, confidentiality and privacy related issues and impact on the patient’s comfort.

- Provision of language concordant care improves patients experience, increases their comfort, makes them feel listened to and enhances their satisfaction with the health care service.
• Generally, bilingual nurses feel comfortable in using their language abilities when providing care to their patients, however, nurses recognise that this ability can be a source of extra work that may not be very useful for their career progression.

• Factors that have an impact on the nurses’ ability to provide language concordant care include individual nurse characteristics such as confidence, years of experience as a nurse, years of experience in the work setting, and relationship with colleagues. Other factors affecting nurses’ ability to provide language concordant care included the expectation of patients with LEP, attitudes of other patients; attitudes of nurse colleagues; attitudes of managers; organisational culture and policies.

**Recommendations**

• Bilingual nurses need to be competent and confident about their language skills. Strategies such as exploring the importance of effective communication and language concordant care, and nurses’ responsibilities in relation to the provision of care to already marginalised or vulnerable patients such as those with LEP during organisational induction may be useful.

• Nurses need should be encouraged to provide feedback about the usefulness or lack of usefulness of prevalent language and interpretation services in their trust.

• Language and interpretation policies should be revisited to assess their relevance to all staff members. All stakeholders, including nurses and other HCPs should be consulted when developing or reviewing policies.

• While revisiting policies, it is necessary to consider that language and interpretation needs of patients may vary depending on the health problem. While organisational policy should provide guidance, each clinical setting (unit/ward) should have its policy/guideline to meet the needs of their patients.
- Bilingual nurses and other HCPs with a remit for clinical assessment should be allowed to use their language skills to provide care to patients they are directly responsible for.

- A register of bilingual nurses and other staff who are competent, confident and willing to use their language skills should be developed and kept in the clinical area.

- Nurses should not be penalised for using their own language skills. Neither they should not be pressurised to act as interpreters for patients for whom they are not responsible for against their will.

- When possible, bilingual nurses should be assigned to provide care to those patients who cannot speak English but share same language.

- Nurses language skills should be valued, recognised and remunerated.

- Further research is needed to explore perspectives of patients about their experiences of receiving language concordant care.

- Further research is recommended to explore the perspective of White British nurses about providing care to patients with LEP and provision of language concordant care.
Contents

ACKNOWLEDGEMENT ........................................................................................................ i
EXECUTIVE SUMMARY ..................................................................................................... ii
Table of Tables .................................................................................................................... viii
Table of Figures ...................................................................................................................... ix
ABBREVIATIONS ................................................................................................................. x
INTRODUCTION ................................................................................................................... 1
  1.1 Addressing language barriers to health care ............................................................. 3
    1.1.1 Provision of interpretation services ................................................................. 3
    1.1.2 Encouraging language concordant communication encounters ..................... 4
  1.2 Current situation and the need for the study ............................................................ 5
  1.3 Aim and objectives of the study .............................................................................. 11
METHODS ............................................................................................................................ 12
  2.1 Document review .................................................................................................... 12
  2.2 Research design ....................................................................................................... 13
  2.3 Ethical issues ........................................................................................................... 13
  2.4 Setting ...................................................................................................................... 13
  2.5 Sampling and recruitment ....................................................................................... 14
    2.5.1 Inclusion and exclusion criteria ....................................................................... 14
    2.5.2 Sampling .......................................................................................................... 14
    2.5.3 Participant characteristics ................................................................................ 14
  2.6 Data collection ......................................................................................................... 16
    2.6.1 Interview guide and pilot interviews ................................................................. 16
    2.6.2 Conducting individual interviews .................................................................... 17
    2.6.3 Focus group discussion .................................................................................... 17
  2.7 Data analysis ........................................................................................................... 19
    1.7.1 Findings consolidation workshop ...................................................................... 19
  1.8 Rigour ...................................................................................................................... 20
FINDINGS ............................................................................................................................. 21
  3.1 Findings from document review ............................................................................. 21
    3.1.1 Scope and general characteristics ..................................................................... 21
    3.1.2 Process of meeting language needs of patients ............................................... 21
Table of Tables

Table 1.1: Admissions to NMC Register by Overseas Country 1998-2008

Table 2.1: Characteristics of the Individual Interview Participants

Table 2.2: Details of Focus Group Discussions

Table 3.1: Characteristics of Face-to-Face and Telephone Interpretation

Table 3.2: Reasons for Not Allowing Family/Friends and Staff Members as Interpreters
Table of Figures

FIGURE 1.1: LANGUAGE PROFICIENCY IN ENGLISH BY REGION IN ENGLAND AND WALES, 2011.............2

FIGURE 1.2: TWENTY LARGEST NON-ENGLISH MAIN LANGUAGES BY NUMBER OF SPEAKERS IN ENGLAND AND WALES, 2011 .......................................................................................................6

FIGURE 3.1: FLOWCHART OF PROCESS OF PROVISION OF LANGUAGE AND INTERPRETATION SERVICES .........................................................................................................................22

FIGURE 3.2: THEMES AND SUB-THEMES ..............................................................................................26

FIGURE 3.3: THEME TWO: WHEN WE SPEAK THE SAME LANGUAGE ............................................32

FIGURE 3.4: FACTORS AFFECTING LANGUAGE CONCORDANT COMMUNICATION .........................35
ABBREVIATIONS

AHP: Allied Health Professional
BSc: Bachelors of Science
BME: Black and Minority Ethnic
BSL: British Sign Language
E & D: Equality and Diversity
EU: European Union
FGD: Focus Group Discussion
HCP: Health Care Professional
HR: Human Resource
LEP: Limited English Proficiency
LHV: Lady Health Visitor
NMC: Nursing and Midwifery Council
NHS: National Health Services
R & D: Research and Development
RCN: Royal College of Nursing
RGN: Registered General Nurse
RMN: Registered Mental Nurse
UK: United Kingdom
US: United States
INTRODUCTION

With an increase in the internal and external migration and mobility of people from/to different parts of the world, the likelihood of experiencing language barriers while providing and receiving care has augmented. Language barriers can contribute to health inequalities that people from minority ethnic groups experience in their country of stay. These groups may already be subjected to health inequalities due to reasons such as gender, socioeconomic status, education, sexual orientation or disability. Language barriers may worsen the situation for these already marginalised groups by adversely affecting their ability to communicate effectively. Nurses are responsible to provide care to patients regardless of their culture, religion, ethnic background and language. Language barriers, however, are hurdles that affect the provision of culturally competent and patient centred care (Bischoff & Denhaerynck, 2010; Hull, 2015). Language barriers are known, adversely, to affect adherence to treatment regimens and follow-up for chronic illnesses, reduce comprehension of diagnosis and treatment (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005), affect ability to seek information (Pippins, Alegría, & Haas, 2007) and increase medical complications (Jacobs, Sadowski, & Rathouz, 2007; Karliner, Jacobs, Chen, & Mutha, 2007).

The NHS aims to offer high quality, patient centred care to the diverse population, it serves in the UK (Department of Health, 2012). The diversity of the population the NHS serves is evident from the results of the 2011 census, which show that 16% of the population in England and Wales belong to Black and Minority Ethnic (BME) communities (Office of National Statistics, 2013). Among these, approximately eight percent (4,153,266) people (aged > 3 years) in England and Wales identified themselves as non-English/non-Welsh
speakers. As shown in Figure 1.1, among these, approximately 59% find it difficult to or cannot communicate in English (Office of National Statistics, 2013). In addition, the number of residents aged 16 and over who report to speak English less than ‘very well’ was 785,000. These individuals are known to have Limited English Proficiency (LEP) and “… are not able to speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers” (Karliner et al., 2007, p. 728). This can lead to a plethora of problems for the patients as well the health care providers (HCP) who may find it difficult to understand their patients’ needs (Harmsen, Bernsen, Bruijnzeels, & Meeuwesen, 2008; Hudelson & Vilpert, 2009).

**Figure 1.1: Language proficiency in English by region in England and Wales, 2011**

Source: Census 2011, Office for National Statistics

Language barriers can adversely affect an individual’s ability to access and use health care services available to them and may contribute to health inequalities (Jacobs et al., 2007;
Jacobs, Shepard, Suaya, & Stone, 2004). For instance, evidence from US suggest that Spanish speaking patients, with LEP, are less likely to have cholesterol and blood pressure screening compared to English speaking patients (Jurkowski & Johnson, 2005). Latinas with LEP, are less likely to be offered various screening tests such as Pap Smear, mammogram, faecal occult blood test, and sigmoidoscopy (Goel et al., 2003). Language barriers would not arise if HCPs such as nurses were able to communicate with patients in their own language, something that is not always possible. Nevertheless, where possible, such provision can be priceless. This report presents the findings of a study conducted to explore bilingual nurses’ practices to provide language concordant care to patients from a shared linguistic background in acute NHS trusts hospitals in England. The study was conducted as part of Mary Seacole Leadership Award 2014.

1.1 Addressing language barriers to health care

Evidence suggests that two main approaches can be used to address language barriers. These include provision of appropriate language and interpretation services or encouraging language concordant communication between patients and HCPs such as nurses, doctors and Allied Health Professionals (AHPs).

1.1.1 Provision of interpretation services

Use of interpreters and translators is one way of minimizing the impact of language barriers (Flores, 2005), though, risk of communication errors and difficulties in establishing rapport limit the effectiveness of these services. Likewise, use of interpreters and translation services can be prohibitively expensive. For instance, a recent study reported that NHS Trusts spent £23.3 million on translation services in 2011 (Gan, 2012). The authors of the research could not provide a breakdown of the cost spent on interpretation services, but suggested that the interpretation cost is increasing as the cost of written translation is decreasing (Gan, 2012).
Communication Support Service provided interpreters for 30,000 consultations at a cost of over £1,000,000 in 2007/8…” (Gill, Beavan, Calvert, & Freemantle, 2011, p. e20837).

1.1.2 Encouraging language concordant communication encounters

Language is central to communication as it helps the speaker and the listener to understand each other. Language concordant communication refers to a situation where a clinician and a patient communicate with each other in the same language (Hull, 2015). Language also relates to individuals’ identity. The ability to speak a language, especially a secondary language, is influenced by many factors including stress and illness. Evidence suggests that, even bilingual people who speak English fluently, in situations of stress, illness and tiredness may feel more comfortable communicating in their primary language (Robertsa et al., 2007).

There are many advantages associated with language concordant communication and these include improved patient-provider relationship (Eamranond, Davis, Phillips, & Wee, 2009; Free, 2005; Gill et al., 2011; Traylor, Schmittdiel, Uratsu, Mangione, & Subramanian, 2010), better medication adherence (Manson, 1988), and better understanding and compliance with treatment (Fernandez et al., 2004). Language concordant communication also relates to fewer emergency department visits, lower cost of care (Carter-Pokras et al., 2004; Jacobs et al., 2007) and higher patient satisfaction (Ngo-Metzger et al., 2007).

Ensuring language concordant communication is considered an ideal response by those who believe that providing an interpreter—regardless of their interpreting skill—can never be as satisfying as direct communication (Eamranond, Davis, Phillips, & Wee, 2011). Two approaches can be used to enhance language concordant communication encounters between HCPs and patients. The first approach is to increase the number of minority language speakers who speak the official language of the country— in the UK, English. Encouraging LEP individuals to learn or improve their English has long been advocated but is not always
possible or practical. Moreover, HCPs such as nurses, doctors and others are bound by their respective professional code of conduct and are required to provide care to their patients regardless of their personal characteristics including ability to speak any particular language.

The second approach is to increase the number of HCPs such as nurses who speak the same language as their patients. Again, this is not an easy option; however, there are various ways to achieve this objective. For instance, nurses and other HCPs can be encouraged to learn other languages, though, there is a limit to how many language a person can learn. One of the easier and more convenient options may be to encourage bilingual nurses already working in the health care system to use their language skills. Another option may include increasing employment of bilingual nurses. However, any of these options require encouraging nurses to use their language skills and to speak to the patient in their language where possible.

1.2 Current situation and the need for the study

According to the 2011 census, there are more than 100 languages spoken in various UK cities such as Birmingham and London (Office of National Statistics, 2013). These languages are diverse—from regional languages such as Welsh and Irish, to other European languages such as French, Portuguese and Polish. The common languages spoken in the country include Arabic, Turkish, Persian, Kurdish, Urdu, Panjabi, and Bengali, Chinese, Vietnamese, Thai, Somali, Amharic, Tigrinya, Yoruba and Igbo. Figure 1.2 shows 20 largest main languages spoken in England and Wales in 2011 (Office of National Statistics, 2013).

Clearly, in a multilingual country such as the UK, providing language concordant care to every patient is not possible. However, this can be achieved in situations where a bilingual
HCP such as a nurse is able to speak the patient’s language. The NMC statistics, as shown in Table 1.1 demonstrate that, between 1998-2008, 73,162 overseas nurses registered with the NMC. The RCN labour market review (Buchan & Seccombe, 2012) states “Whilst there is not precise data on how many international nurses were recruited to, arrived in, and continued to work in the UK, between 1998 and 2006, there were approximately 100,000 new non-UK nurse registrations with the NMC across that period” (p. 11).

Figure 1.2: Twenty largest non-English main languages by number of speakers in England and Wales, 2011
### Table 1.1: Admissions to NMC Register by overseas country 1998-2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1,335</td>
<td>1,209</td>
<td>1,046</td>
<td>1,342</td>
<td>920</td>
<td>1,326</td>
<td>981</td>
<td>751</td>
<td>299</td>
<td>262</td>
<td>9,471</td>
</tr>
<tr>
<td>India</td>
<td>30</td>
<td>96</td>
<td>289</td>
<td>994</td>
<td>1,830</td>
<td>3,073</td>
<td>3,690</td>
<td>3,551</td>
<td>2,436</td>
<td>1,020</td>
<td>17,009</td>
</tr>
<tr>
<td>New Zealand</td>
<td>527</td>
<td>461</td>
<td>393</td>
<td>443</td>
<td>282</td>
<td>348</td>
<td>289</td>
<td>215</td>
<td>74</td>
<td>62</td>
<td>3,094</td>
</tr>
<tr>
<td>Nigeria</td>
<td>179</td>
<td>208</td>
<td>347</td>
<td>432</td>
<td>509</td>
<td>511</td>
<td>466</td>
<td>381</td>
<td>258</td>
<td>154</td>
<td>3,445</td>
</tr>
<tr>
<td>Pakistan</td>
<td>3</td>
<td>13</td>
<td>44</td>
<td>207</td>
<td>172</td>
<td>140</td>
<td>205</td>
<td>200</td>
<td>154</td>
<td>42</td>
<td>1,180</td>
</tr>
<tr>
<td>Philippines</td>
<td>52</td>
<td>1,052</td>
<td>3,396</td>
<td>7,235</td>
<td>5,593</td>
<td>4,338</td>
<td>2,521</td>
<td>1,541</td>
<td>673</td>
<td>249</td>
<td>26,650</td>
</tr>
<tr>
<td>South Africa</td>
<td>599</td>
<td>1,460</td>
<td>1,086</td>
<td>2,114</td>
<td>1,368</td>
<td>1,689</td>
<td>933</td>
<td>378</td>
<td>39</td>
<td>32</td>
<td>9,698</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>52</td>
<td>221</td>
<td>382</td>
<td>473</td>
<td>485</td>
<td>391</td>
<td>311</td>
<td>161</td>
<td>90</td>
<td>49</td>
<td>2,615</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,777</td>
<td>4,720</td>
<td>6,983</td>
<td>13,240</td>
<td>11,159</td>
<td>11,816</td>
<td>9,396</td>
<td>7,178</td>
<td>4,023</td>
<td>1,870</td>
<td>73,162</td>
</tr>
</tbody>
</table>
Presently, 20% of the nurses and 37% of doctors working in the NHS in England are of BME origin (Kline, 2014a). Only in London, 45% of the city population and 41% of the NHS staff belong to the BME community (2014b). While statistics about the nurses’ or HCPs linguistic capabilities is not available, it may be safe to assume that a majority of HCPs from BME communities are able to speak at least one language other than English. It is only appropriate and essential to use this resource effectively to improve the quality of care provided to patients with LEP from the same linguistic background for economical and patient safety related reasons.

The NMC registers and the NHS employ hundreds of overseas nurses who were educated in non-English speaking countries where they cared for patients in their own language. For the majority of such nurses, English is their second language. Therefore, it is only sensible to question: if these nurses were capable of assessing and caring for a patient in English, which is not their first/primary language, are they not also competent in assessing and caring for a patient with LEP from the same linguistic background?

There is ample research demonstrating effectiveness of language concordant communication between patients and HCPs in the clinical (specially outpatient) (Eamranond et al., 2009; Fernandez et al., 2004; Raynor, 1992; Wilson et al., 2005) and community setting (Khan, Benson, MacLeod, & Kingston, 2010). Research has also been conducted to explore the impact of language barriers on the provision of care by nurses (Fatahi, Mattsson, Lundgren, & Hellström, 2010; Tay, Ang, & Hegney, 2012; Taylor, Nicolle, & Maguire, 2013). However, literature about the effectiveness of language concordant care among nurses and patients with LEP is scant. There are many questions, for instance: How do bilingual nurses feel about providing language concordant care to patients from the shared linguistics
background? What facilitates or hinders their ability to provide language concordant care to patients? What do nurses think of the impact of provision of language concordant care on patients? How do organisational policies and practices affect their ability to provide language concordant care? Many of these questions remain outstanding and no research has been conducted to explore current communication practices of bilingual nurses, working in the UK, when dealing with patients from a shared linguistic background. Such knowledge can help develop effective communication approaches, policies and guidance to allow bilingual nurses to provide language concordant care to their patients with LEP.

1.2.1 Why was I interested in this issue

My interest in exploring this issue was a result of personal experience and observation that then led to informal communication with colleagues. As a nurse educated in Pakistan, I am confident in my clinical judgement, clinical assessment and ability to provide care. English is my fourth language, with Hindko, Punjabi and Urdu as my first, second and third languages, respectively. I have never had issues in assessing or caring for patients using any of these languages individually or in combination. While working in the UK as an RN, I recognised that communication in any language other than English (with fellow colleagues) was not liked or tolerated by English colleagues and I could understand their perspective that it can be alienating. It was not until I started working as a telephone triage nurse and realised that I was required to use telephone interpreters when assessing LEP patients who spoke Punjabi or Urdu, languages that I can use effectively. The experience was shared by other BME nurses in the organisation, as they were not allowed to communicate with the patients from the same linguistic background, in their primary language, but to use telephone interpretation services. The rationale behind these practices—as suggested by managers—was to ensure quality checks and the accuracy of information given by nurse, as such a call cannot be reviewed by English speaking nurses.
Here, it is also important to share experiences with interpreters. When communicating through interpreters, I noticed frequently that the interpreter’s translation of the question I asked or the response given by the patient was inaccurate. I could understand the interpreter’s and the patient’s language, therefore, I could notice these discrepancies. In such a situation, I could only paraphrase my question unless I got an appropriate response for recording purposes. I also noticed that the process was time consuming and expensive. The associated costs (time and money) could have been easily avoided if I assessed the patient in my primary language. I believe, such practices were unnecessary, time consuming and irrational. The organisation could have requested other bilingual nurses working across the organisation to review the call. In addition, other independent translation agencies could be used to review and assess the call in case it was necessary.

My interest developed in the area and I decided to explore it further. Communication with bilingual nurse colleagues working in various organisations revealed that bilingual nurses’ practices of providing language concordant care to patients vary depending on the culture of the organisation, clinical area, experiences and confidence of the nurses and attitudes of nurse colleagues working in the same area. I believe that such organisational attitudes and practices can be detrimental and may inculcate a sense of powerlessness, helplessness among bilingual nurses who may not feel trusted and respected by their colleagues. In addition, it is important to recognise that nurses are responsible to “…meet people’s language and communication needs…” (NMC, 2015, p. 7). Nurses are responsible for providing safe and effective care to their patients and are accountable for their actions and decisions (NMC, 2015). Therefore, if using language concordant communication (where possible) facilitates provision of safe and effective care to patients, nurses should be able to use their language skills.
Communication with colleagues, observations and personal experiences helped me develop my research question further and receiving a Mary Seacole Leadership Award provided the opportunity to explore this issue in detail.

1.3 **Aim and objectives of the study**

The aim of the present study was to explore current communication practices of bilingual nurses when dealing with patients with LEP from the shared linguistic background and to identify barriers and facilitators to the provision of language concordant care to patients across ethnic groups. The specific objectives of the study were:

1. To describe in detail for a diverse, multi-ethnic sample, bilingual nurses’ understanding and attitudes about provision of language concordant care to patients with LEP

2. To describe the current patterns of service in various NHS Trusts in England with regard to language concordant communication among bilingual nurses and patients with LEP from a shared linguistic background
METHODS

The study used a qualitative approach and involved a document review of policies related to language and interpretation services in various acute NHS Trusts in England, in-depth individual interviews and focus group discussions (FGDs) with bilingual nurses. This section aims to present details of the methods used to conduct this study.

2.1 Document review

A documentary review of interpretation and translation policies of 30 acute NHS Trust was undertaken. Currently, there are 155 (including 100 foundation trusts) acute NHS trusts in England. An alphabetical list of the names of all NHS Trusts was obtained (accessed on March 2015) from the NHS UK website (http://www.nhs.uk/servicedirectories/pages/acutetrustlisting.aspx) which showed 161 Trusts (Appendix A). For the review of interpretation and translation policies, 30 NHS acute Trusts were randomly selected. The process involved writing the name of each NHS Trust on a piece of paper, which was folded and placed into a bowl. Each piece of paper was drawn from the bowl to identify the name of the acute NHS hospital to be included in the document review. The interpretation and translation policy of the identified hospitals was retrieved from the hospital website. However, not all NHS hospitals had policies available on their websites. In such cases, another name was drawn using the same procedure. Once retrieved, each policy was read carefully and relevant themes were identified. Each policy was specifically reviewed to understand the guidance in relation to staff used as interpreters. In addition, if there was any specific policy or guidance about use of language by bilingual HCPs such as nurses, doctors and AHPs was explored. The plan was to retrieve and review policies of 25% (n=38) of the acute NHS trusts, however, data saturation was achieved following a review of 30 policy documents and therefore, data collection for document review was stopped.
2.2 Research design

A qualitative, exploratory design was used for this study. A qualitative approach is identified as a subjective but systematic method that can help a researcher explore, describe and interpret life experiences of the participants (Burns & Grove, 2011). It helps to understand a social or human problem and facilitates development of a complex but holistic picture of participants’ experiences and views about a particular phenomenon (Creswell, 2009). The approach was considered suitable for this study as not much is known about bilingual nurses’ views and practices related to the provision of language concordant care to patients with LEP.

2.3 Ethical issues

The study was reviewed and approved by the University of Sheffield’s Research Ethics Committee (Appendix B). The study was also subjected to appropriate research and development (R&D) approval process in the local NHS Trust. Potential participants were provided with appropriate information about the study in an information sheet explaining the study’s aims, objectives and procedures (Appendix C). Participants were contacted again (at least after 48 hours) to ask for their willingness to contribute to the study. If they agreed, an interview was scheduled. At the time of the interview, participants were encouraged to ask any questions they may have about the study prior to signing a consent form (Appendix D), a copy which was given to them for their records. Participation in the study was voluntary and every effort was made to ensure confidentiality and anonymity of participants.

2.4 Setting

The study was conducted in England, UK. Nurses, who participated in this study, were working in different parts of the country, including Sheffield, Bradford, Manchester,

2.5 Sampling and recruitment

2.5.1 Inclusion and exclusion criteria
To meet the objectives of the study, an RN who was able to communicate in a language other than English (in addition to English) was eligible to participate in the study. A nurse who could only speak English was not eligible to participate. Participants who contributed to individual interviews were not invited to participate in FGDs.

2.5.2 Sampling
A purposive and snowball sampling strategy was used to recruit participants. This was to ensure selection of appropriate participants who had the knowledge about the issue under study (Polit & Beck, 2008). Use of snowball sampling is useful in situations where participants are hard to find or recruit. Initially, participants were identified with the help of professional networks and, as recruitment progressed, each participant was requested to identify other nurses who may be willing to participate in the study. Once identified, potential participants were contacted through their preferred methods (phone/email) and the researcher explained the reason for contact. Appropriate information about the study, including the information sheet and consent form, was emailed to the potential participant. In case of no response, potential participants were contacted again, 10 days after initial contact.

2.5.3 Participant characteristics
Table 2.1 provides details of participants who contributed to individual interviews. Fifty nine bilingual nurses, including 32 female and 27 male nurses contributed to this study. Twenty six participants contributed to individual interviews and the remainder contributed to three FGDs. All of the participants were British nationals, though, the ethnic distribution
Table 2.1: Characteristics of the individual interview participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>23-50 years</td>
</tr>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
</tr>
<tr>
<td><strong>Ethnicity:</strong></td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
</tr>
<tr>
<td>Italy</td>
<td>3</td>
</tr>
<tr>
<td>Nigerian</td>
<td>3</td>
</tr>
<tr>
<td>Pakistani/British Pakistani</td>
<td>15</td>
</tr>
<tr>
<td>Polish</td>
<td>2</td>
</tr>
<tr>
<td>South Africa</td>
<td>1</td>
</tr>
<tr>
<td><strong>Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Diploma in Nursing</td>
<td>10</td>
</tr>
<tr>
<td>BScN</td>
<td>16</td>
</tr>
<tr>
<td><strong>Place of Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>2</td>
</tr>
<tr>
<td><strong>Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>15</td>
</tr>
<tr>
<td>Polish</td>
<td>2</td>
</tr>
<tr>
<td>Italy</td>
<td>3</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
</tr>
<tr>
<td>UK</td>
<td>3</td>
</tr>
<tr>
<td><strong>Language Proficiency:</strong></td>
<td></td>
</tr>
<tr>
<td>French</td>
<td>1</td>
</tr>
<tr>
<td>Gujrati</td>
<td>2</td>
</tr>
<tr>
<td>Hindko</td>
<td>2</td>
</tr>
<tr>
<td>Italian</td>
<td>3</td>
</tr>
<tr>
<td>Malayalam</td>
<td>2</td>
</tr>
<tr>
<td>Mirpuri</td>
<td>4</td>
</tr>
<tr>
<td>Polish</td>
<td>2</td>
</tr>
<tr>
<td>Pushto</td>
<td>1</td>
</tr>
<tr>
<td>Punjabi</td>
<td>7</td>
</tr>
<tr>
<td>Sindhi</td>
<td>5</td>
</tr>
<tr>
<td>Shona</td>
<td>1</td>
</tr>
<tr>
<td>Tamil</td>
<td>2</td>
</tr>
<tr>
<td>Urdu</td>
<td>14</td>
</tr>
</tbody>
</table>
of the participants varied as shown in Table 2.1. The age of participants ranged from 23-52 years. Participants completed their nursing education in Pakistan (n=40), Italy (n=03), Nigeria (03), India (n=04) and UK (n=09). The qualifications of participants were Bachelors of Science (BSc) in Nursing (30) and Diploma in Nursing. The majority of the participants were RNs in the adult branch (n=57). One participant was also an RMN and another one was a LHV. The job experience of the participants ranged from 2-23 years. The experience of working in the NHS acute hospital, for those qualified from other countries before joining the NMC register, ranged from 2-13 years. The experience of those who completed their nursing education in the UK ranged from 3-7 years. Participants who contributed to this study were working in various settings including medical, surgical, intensive care, cardiology, outpatient department and post-operative recovery units. Some nurses also had experience of working as agency nurses in acute care hospitals and nursing homes. Other than English, all participants were able to communicate proficiently in at least one language. Examples of languages, the participants could communicate include Arigidi, French, Gujarati, Hindko, Italian, Malayalam, Mirpuri, Ndebele, Pahari, Polish, Punjabi, Pushto, Sindhi, Shona, Tamil and Urdu.

2.6 Data collection

As mentioned previously, data were collected through a document review of interpretation and translation policies of various acute NHS Trusts (discussed above), 26 individual interviews, and three FGDs.

2.6.1 Interview guide and pilot interviews

A semi structured interview guide (Appendix D) was developed to facilitate data collection. Topics were informed by the study’s aims, objectives, and a review of the literature. Appropriate probes were used to elicit detailed responses from the participants during the interview. Prior to actual data collection, two pilot interviews with non-research participants
were conducted to determine the length, suitability, and appropriateness of the language of the interview questions. As a result of this exercise, a few probes related to participants’ perceptions about language barriers were identified and added to the interview guide. Data collected from pilot interviews was not used in the data analysis.

2.6.2 Conducting individual interviews

Individual in-depth interviews were conducted to explore language concordant communication practices of bilingual nurses when caring for patients with LEP from the shared linguistic background. Each interview lasted 50-75 minutes. The interview was conducted at a time and place convenient to the participant, while aiming for an environment with minimal disruptions. Depending on the participant’s preference, face-to-face and telephone interviews were conducted. Given the nature of the topic, face-to-face or telephone interviews were considered equally useful. Preference was given to face-to-face interviews where possible, though the option of a Skype or telephone interview was welcomed by many participants. Face-to-face interviews were conducted at either participant’s workplaces or a public space near their home or work. Data saturation was achieved after 24 interviews and a further two interviews confirmed this, therefore, no further individual interviews were conducted.

2.6.3 Focus group discussion

As shown in Table 2.2, three FGDs were conducted to explore perspectives of nurses about language concordant communication among bilingual nurses and patients with LEP. Two FGDs were conducted in Sheffield and one was held in Manchester. Each FGD was attended by 9-13 participants. Participants worked in a range of clinical specialities in various acute NHS Trust hospitals in Bradford, Manchester, Leeds, Stoke on Trent, Rotherham, Sheffield and Derby. Data saturation was apparent after two FGDs and data collection was stopped following the third FGD.
Table 2.2: Details of focus group discussions

<table>
<thead>
<tr>
<th>Focus</th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
<th>Focus Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>13</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Age of participants</td>
<td>28-40</td>
<td>30-52</td>
<td>25-45</td>
</tr>
<tr>
<td>Gender: Male</td>
<td>9</td>
<td>08</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>01</td>
<td>10</td>
</tr>
<tr>
<td>Setting</td>
<td>Sheffield</td>
<td>Manchester</td>
<td>Sheffield</td>
</tr>
</tbody>
</table>

Every effort was made to promote physical comfort of the participants. Tea, coffee and refreshments were offered to the research participants before or after the interview or FGDs. With participant’s permission, every interview and FGD was recorded using a digital recorder. All significant occurrences, such as a description of the setting, participant’s non-verbal behaviour, and any interruptions during the interview process were recorded. The questions were asked in a non-judgmental, non-threatening and culturally sensitive manner. Every effort was made to maintain confidentiality and anonymity of the study participants. For instance, code numbers and pseudonyms were used during transcription and analysis instead of participants’ real names. After the interview, I made notes of all significant features and events in each interview such as a description of the setting, the participant’s non-verbal behaviour, and any interruptions during the interview process. Such notes play an important part in ensuring rigour and the transferability of the research, as they can help the researcher to reflect on the interview process, contextual factors and other important points that may have arisen during the interview process. A reflexive diary was also kept throughout data collection and analysis.
2.7 Data analysis

A data extraction template was used to extract necessary data from each of the reviewed policies. Information about date to policy development, date of review, scope, guidelines about the process of communication, use of family members and children as interpreters, use of staff as interpreters was extracted using the form. The findings were summarised under appropriate themes using appropriate tables and figures.

For the analysis of qualitative data, all interviews and FGDs were transcribed verbatim. A thematic analysis approach which is known as an iterative, and an interpretive technique (Spencer, Richie, & O’Connor, 2003) was used. Each transcript was read and re-read to identify emerging themes. First, every line and sentence was given a code. Similar codes were then clustered into sub-themes that were clustered into themes and themes. The data in each interview transcript were compared and contrasted with data from other interview transcripts and FGD transcripts.

1.7.1 Findings consolidation workshop

Following preliminary data analysis, a finding consolidation workshop was arranged. The workshop was arranged to ‘piggyback’ on an existing group consisting of individual working as Equality and Diversity (E&D) champions/representatives of various NHS organisations. Members of the group include, nurses, managers, Human Resource (HR) representatives of various NHS organisations and other people interested in or responsible for equality and diversity related issues in various NHS organisations. The workshop was attended by 23 professionals. The findings of the research (document review and qualitative data) were presented with the aim of establishing if the findings were useful for themselves and their organisations. Using interactive group activities, workshop participants were encouraged to discuss the relevance of the findings to practice, ways through which findings
of the study can be used to improve practices, and strategies to overcome challenges to the provision of language concordant care to patients with LEP. Participants’ views facilitated consolidation of findings, and helped with identification and development of recommendations. The workshop also provided a platform to disseminate findings to a wide range of audience from various NHS organisations.

1.8 Rigour

For a study to be ethical, it has to be rigorous and trustworthy (Denzin & Lincoln, 1998). The trustworthiness of a qualitative study (Denzin & Lincoln, 2005; Lincoln & Guba, 1985) cover four elements which include credibility, transferability, dependability and confirmability. In this study, strategies used to ensure rigour included member checking, triangulation, and peer debriefing (Lincoln & Guba, 1985). In addition, appropriate information about the context in which study was conducted, findings and context of findings is described. This may help other researchers to apply findings of this study to other settings.
FINDINGS

In this section, the findings of the document review and themes (and sub-themes) emerging from qualitative data (individual interviews and FGDs) are presented.

3.1 Findings from document review

As mentioned previously, 30 randomly selected organisation’s interpretation and translation policy documents were reviewed. In the following, only pertinent findings related to language concordant communication are presented.

3.1.1 Scope and general characteristics

There was a variation in the names used for policies in different organisation. Names used include ‘interpretation policy’ language and interpretation policy’, ‘interpretation and translation policy’ and so on. All policies of all organisations were kept up to date and were revised regularly. All of the policies reviewed aimed to aid decisions about communications with LEP patients. The use of interpreters was recommended in situations where a patient: has LEP; does not understand the clinical information given in English; or their family or friend were unable to express themselves due to language barriers or conflict of interest. A few (n=6) trust’s policies also covered the process of arranging British sign language (BSL) interpreters.

3.1.2 Process of meeting language needs of patients

All of the policies reviewed for this study specified the process of providing interpretation services to patients. The process, which can be summarised in three steps, involved determining the need of interpretation and the type of interpretation required based on patient’s characteristics/situation (mental health issues, hearing impairment, and age. The second step was an assessment of the duration of the interpretation session. Telephone
interpretation was generally preferred unless the session was expected to last longer than 45 minutes. The third step involved determining if there was a clinical reason to prefer a telephone interpretation over face-to-face interpretation or vice versa. For instance, the face-to-face interpretation was preferred if the purpose of the meeting was to break a bad news to a patient and their family. Figure 3.1 summarises the process of provision of language and interpretation services as prescribed in policies of various organisations included in this study.

**Figure 3.1: Flowchart of process of provision of language and interpretation services**
3.1.3 Interpretation method

Face-to-face and telephone interpreting services were covered in policies of all organisations, however, use of telephone interpretation services was encouraged. Telephone interpretation services were considered accessible, easier to arrange (in unexpected and emergency situations), cost effective and time efficient. Characteristics of face-to-face and telephone interpretation, as identified in various policy documents included in the review is presented in Table 3.1

Table 3.1: Characteristics of face-to-face and telephone interpretation

<table>
<thead>
<tr>
<th>Face-to-face interpretation</th>
<th>Telephone interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Requires prior arrangement</td>
<td>• Can be arranged instantly. Average connection time 30 seconds</td>
</tr>
<tr>
<td>• Average meeting time lasts 60 minutes or more</td>
<td>• More than 200 languages are accessible</td>
</tr>
<tr>
<td>• Cost effective in situations where patients with a common language are block booked into the same interpretation session (though patients see HCP individually)</td>
<td>• Available 24/7 and 365 days a year</td>
</tr>
<tr>
<td>• Appropriate to use in situations such as child protection case conferences, safeguarding issues, working with survivors of torture and rape, bereavement and breaking bad news, when the client has a cognitive impairment or speech or hearing difficulties</td>
<td>• Appropriate to use for discussion needing up to 60 minutes or less.</td>
</tr>
<tr>
<td>• Appropriate and preferred method to use when the consultation involves therapeutic counselling</td>
<td>• Appropriate to be used for a speedy resolution to a situation</td>
</tr>
<tr>
<td></td>
<td>• Available when there is an immediate need such as emergency and urgent situations</td>
</tr>
<tr>
<td></td>
<td>• Appropriate to use when specific questions are asked which do not need exploration</td>
</tr>
<tr>
<td></td>
<td>• Ensure anonymity and therefore, some patients may prefer it, especially when discussing sensitive issues</td>
</tr>
<tr>
<td></td>
<td>• Avoid charges for cancelled appointments</td>
</tr>
<tr>
<td></td>
<td>• Only charged for the number of minutes used</td>
</tr>
</tbody>
</table>
3.1.4 Use of family and friends as interpreters

Use of family, friends and children as interpreters was discouraged in all policy documents, unless in an emergency situation where it was not possible to arrange for an interpreter. Reasons given for these, as outlined in Table 3.2, included the risk of inaccuracy and inadequacy of interpretation, lack of confidentiality, conflict of interest or lack of impartiality and risk of advice giving or advocacy.

Table 3.2: Reasons for not allowing family/friends and staff members as Interpreters

<table>
<thead>
<tr>
<th>Issue</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccuracy &amp; inadequacy</td>
<td>• May not fully understand the patient</td>
</tr>
<tr>
<td></td>
<td>• May change the information given due to lack of knowledge</td>
</tr>
<tr>
<td></td>
<td>• May not have the expertise and skills required to interpret information given in another language:</td>
</tr>
<tr>
<td></td>
<td>o May have difficulties with medical terminology</td>
</tr>
<tr>
<td></td>
<td>o May find it difficult to share bad news</td>
</tr>
<tr>
<td></td>
<td>o Misinformation may lead to misdiagnosis</td>
</tr>
<tr>
<td></td>
<td>• May find it difficult to acknowledge and communicate interpretation difficulties and may make errors</td>
</tr>
<tr>
<td></td>
<td>• May censor information that they think is too embarrassing, offending, inappropriate or shameful</td>
</tr>
<tr>
<td>Lack of confidentiality</td>
<td>• May not understand the importance of confidentiality</td>
</tr>
<tr>
<td></td>
<td>• The patient may not feel comfortable in disclosing information</td>
</tr>
<tr>
<td></td>
<td>• Presence of family member may have an impact on the patient’s right to confidentiality and privacy</td>
</tr>
<tr>
<td>Conflict of interest</td>
<td>• The family member may take a side of either practitioner or the patient and therefore may not pass all information</td>
</tr>
<tr>
<td>Advice giving or advocacy</td>
<td>• Family members may instruct the patient to what to say and how to say it</td>
</tr>
</tbody>
</table>
3.1.5 **Use of staff as interpreters**

In the majority (n=28) of the included policies, use of bilingual staff as a regular interpreter was discouraged. However, nearly all organisations allowed bilingual staff to communicate with an LEP patient, in their language, to ascertain basic conversation, such as greeting the patient, asking menu choices or obtaining basic personal information. Bilingual staff were allowed to communicate with any LEP patients, in their language, in an emergency situation or if it was in their job role specification. However, staff were not allowed to communicate to ascertain clinical or medical information, obtain consent or intervene in situations requiring decision-making.

3.16 **Use of registered HCPs as interpreters**

Among 30 organisations, whose policies were reviewed, only two organisations specifically mentioned registered HCPs in relation to their ability to communicate with their patients. For instance, a policy stated that “bilingual registered medical, nursing or allied health professionals staff may interpret on medical matters if they are fluent in the language concerned and with the patient’s consent” (Organisation 24). This suggests that, in the majority of organisations, nurses and other registered clinicians were required to use interpreters when assessing a patient, even when they themselves could communicate in that language.

In summary, in all organisations whose policies were reviewed, a preference was given to use telephone interpretation services. The majority of the organisations prohibited use of family, friends and children as interpreters. Use of staff as interpreters varied among organisations with most allowing bilingual staff to communicate with patients in their language to ascertain simple information such as personal details, menu choices or to communicate with the patient in emergency situations only.
3.2 Findings from the individual interviews and FDGs

As shown in Figure 3.2, a thematic analysis of the data resulted in the identification of three themes, which are named as ‘current situation and my perspective’, ‘when we speak the same language’, and ‘what helps or hinders’. Together, these themes explicate participant’s views about language concordant communication in clinical practice, its usefulness and impact on patients and nurses themselves and factors affecting the provision of language concordant care to patients. In the following, findings of the study in relation to each theme are described.

Figure 3.2: Themes and sub-themes

3.2.1 Current situation and my perspective (Theme 1)

This theme provides participants’ perspective about their daily work environment and conditions. The theme is further divided into three sub-themes, namely multi-ethnicities and my client group, multi-ethnicities and language barriers, and providing care through interpreters. In the following, each of these sub-themes are presented.
**Multi-Ethnicities and my client group**

This sub-theme describes participants’ responses about their patient population and their characteristics. Participants of the study provided care to a diverse patient population in terms of age, gender, ethnicity and health care needs as mentioned in the following three statements:

> Most of them are English; some of them are from Somalia, West Indies, Africa, Sudan, and Pakistan and from Arab countries, and China, from Taiwan. (Joshua, Nigerian Participant).

Another participant mentioned:

> I live in the Northwest part of England, where people from India, Bangladesh, Pakistan, Sri Lanka, and the EU [European Union] are settled and obliviously a majority of patients who come for treatment in hospital are English. (Fakher, Pakistani Participant).

Another stated:

> We get patients from diverse of ethnic backgrounds admitted to the ward... mostly White; they could be British, Irish, White, sometimes white from Europe. We come across many Pakistani, Bangladeshi, Indian, East, and South Asian patients. (Anna, Italian Participant)

The majority of the participants identified South Asian (Pakistani, Indians and Sri-Lankans) as the second largest group (after white British) to whom they provide care in their daily workday. Depending on the participants’ area or speciality of the work (medical, surgical, intensive care, cardiology, outpatient department, and post-operative recovery units), health care problems that their patients presented with varied.

**Multi-ethnicities and language barriers**

This sub-theme relates to communication issues that participants face when working with a diverse group of people with varied linguistic abilities and needs. Communication was identified as the most important aspect of care provision and an essential component of a
nurse’s professional role regardless of the clinical area or speciality a participant was working in. As one participant stated:

*Communication is the biggest part of our role. Isn’t it? And if you cannot communicate with your patient, it just creates lots of issues and affects patients experience of receiving care from caregivers* (Ahmad, Pakistani Participant)

The language barrier was identified as the biggest obstacle in providing adequate, appropriate, effective and timely care to many patients with LEP patients as one participant highlighted:

*... Those people who have not learned or speak English here or back in their country of origin, ... face many barriers ... we have to deal with language barriers in every other shift* (Noreen, Pakistani Nurse)

Some participants mentioned language barrier as a particular issue for the older BME population, who may have been living in this country for decades, but were not successful in developing their English language skills, as mentioned by one the participants:

*Most of the Asian patient who are 60 years and over do not speak English very well, because they came to the UK either in an old age or they did not learn English at all* (Pooja, Indian Nurse)

Another stated:

*If there are young patients, they obviously do not have a language issue, but... elderly! They don’t speak English very well or they can just speak a few basic words like ‘thank you’ and all that. Then it becomes difficult to communicate and provide care* (Anoosha, Pakistani Nurse)

However, some participants considered that language barriers might also affect relatively younger patients who may have immigrated to the country recently. For instance, two participants mentioned:

*We also face language barriers when providing care to younger patients for instance, Asian women or men who may have come to the country after marriage. Their English language skills are poor too* (Maya, British Pakistani Participant)

*These days, as a result of active migration from various EU countries, we provide care to many European patients with limited English speaking ability.* (Elsa, South African Participant)
Participants recognised that language barriers could cause many different issues such as missed appointments, difficulties in arranging appointments by telephone or even through written communication. One participant stated:

*There are lots of different people who come to us, they cannot really speak English as it’s not their first language. When we are booking, it is quite harder to book them because it is harder to communicate with them* (Alicia, British Indian Participant)

Another one mentioned

*I have been in situations where patients have not understood the reason for the appointment or procedure. They may have received an appointment through the post as a self-explanatory information leaflet, which I myself realize, is not very helpful. Papers don’t speak for themselves you know* (Fakher, Pakistani Participant)

Participants believed that a person who cannot speak English is not likely to be able to read information sent to them in English. Therefore, sending them information in English is not helpful. In addition, language barriers may make it difficult for such patients to understand instructions during care procedures, comprehend treatment regimen and side effects of medication, and communicating needs:

*People when you call them to say an Endoscopy procedure, I have seen on some occasions that people don’t inhale through mouth because they don’t understand the instruction and what it means* (Soha, Pakistani Participant)

Language barriers result in lengthening the process/care procedure for a given patient, even when an interpreter is used. Communicating with the help of an interpreter can be challenging, as it requires extra time of a clinician as well as a patient:

*Arranging an interpreter and communicating through an interpreter can take very long. It’s even more complicated when the patient is not fully conscious, how can you ask a semi-conscious patient to talk to an interpreter on the phone? So situation like this and similar are very common* (Dinesh, Indian Participant)

Participants mentioned that the situation requiring communication with a patient could also be very complex. For instance, in a situation where a patient is under stress, such as during a
surgical procedure or experiencing pain use of interpreters can be even more challenging as it required extra effort of the patient as well as a nurse or any other HCP.

Providing care through interpreters

This sub-theme describes the participants’ perspective on working with interpreters. Participants acknowledged the usefulness of interpretation services in dealing with language barriers and the provision of safe care to patients with LEP. The majority of the participants recognized limitations associated with use of interpretation service. These include arrangement difficulties, availability and accessibility of interpreter services, convenience, confidentiality and privacy related issues and impact on the patient’s comfort. One participant highlighting this stated:

Availability of interpretation service is time-bound and we have to book the interpreter for an hour... also it is not convenient because they can only be arranged at the certain times of the day. (Noreen, Pakistani Participant)

Another one explained:

It’s difficult to arrange an interpreter even through a telephone during the night or out of hours and this often makes it very difficult to communicate with the patient and we have to find other ways of doing so (Ellie, Polish Participant)

Participants mentioned that the inability to arrange interpreters could result in cancellation of appointments, or cause unnecessary delay in service provision resulting in increasing length of stay in hospital in some situations. One participant shared:

I remember a situation when we couldn’t discharge a patient on the day because of the unavailability of an interpreter who could explain the discharge process and home care instructions. So the patient had to stay in hospital for another day (Anna, Italian Patient)

As mentioned, most organisations prefer telephone interpretation services, however, there were various issues associated with it. Participants considered that it was difficult for many patients to comprehend information given on the phone. One participant shared:
We booked twice, a telephonic interpreter for an elderly Bengali patient and still she was not getting what the doctor wanted to tell her. At the end, we had to book a face-to-face interpreter (Maya, British Pakistani Participant)

Other situations where using interpretation service was difficult, as identified by participants, include when a patient was undergoing an invasive procedure, or when a patient was unable to concentrate due to anxiety, or pain. One participant explained:

In my experience, it’s much easier to explain the process in their own language especially during procedures. Poor patient may already be anxious and scared of the procedure he/she is going through and communicating through interpreter adds to stress, but I know it’s not always possible (Rashid, Focus group One)

Another stressed:

Well, it's complicated, in my area, which is post-operative recovery; it’s not practical or useful to talk to a patient who is coming out of the effects of anaesthesia, via an interpreter. It just doesn’t work (Dinesh, Indian Participant).

Participants considered that interpreters do not always understand the medical terminology and this result in misinterpretation resulting in miscommunication of the information, which is neither cost effective nor efficient. One participant mentioned:

On one occasion, we had a Polish patient who came with an interpreter. She was booked for cystoscopy but her interpreter told her that she was going for gastroscopy. The patient thought that we would be putting the camera from her mouth to stomach. But of course, this was not the case. So I think... they (interpreter) should have some training, especially for some specific procedures, but I don’t know how they do it (Fakher, Pakistani participant)

To summarise, this theme provided an overview of participants’ experience of providing care to patients from linguistically diverse background, dealing with language barriers and use of interpretation services. Participants considered that language barriers make it difficult for patients with LEP to effectively communicate their needs and use of interpretation services does not always help due to various challenges associated with it.
3.2.2 When we speak the same language (Theme 2)

The second theme aims to share participants’ experience of providing language concordant care to patients with LEP from a shared linguistic background. As shown in figure 3.2, the theme consists of sub-themes that attempt to explain impact of language concordant communication on patients and nurses as practitioners.

Figure 3.3: Theme Two: When we speak the same language

Impact on LEP Patients

As the name suggests, this sub-theme attempts to explain the impact of language concordant communication on patients with LEP. Participants considered that provision of language concordant care improves patients experience, increases their comfort, make them feel listened to and enhances their satisfaction with the health care service they receive. One FDG participant stated:

*I think a nurse’s ability to communicate with the patient in their language reduces patient’s anxiety as both the nurse and the patient may somehow have affiliation with the same culture, language or country of their origin* (Matthew, FG 2)
Another stated:

_When I speak to my patients in their own language, they feel more comfortable, secure and confident_ (Moon, Pakistani Participant)

Another shared their experience:

_I speak to patients in their language if I can. People come from all over the world with different cultures and languages, when you speak to them in their language, they feel most assured and would tell you their problems and needs comfortably._ (Adam, Pakistani Participant)

Participants mentioned that sometime, even those patients who can speak perfect English prefer to communicate in their own language, as they find it reassuring and less stressful:

_Once I met an Indian patient who could speak English very well, but wanted to would like to talk in Hindi. He was about 80 years old. He called me and asked me if I could speak Urdu or Hindi and when I said yes, he requested me to sit with him. He held my hand and started crying, he said that he was feeling lonely and he just wanted me to be there and speak to him in Hindi because he was just missing speaking his language_ (Nabeel, FG1)

Participants maintained that that speaking to patients in their language facilitates appropriate assessment of patients’ needs. In addition, it may help in developing rapport and a trusting relationship with the patient making them feel more comfortable in disclosing information to a nurse. This can then help in appropriate diagnosis and prompt treatment of the condition and enhances patient satisfaction with the services provided.

**Impact on self as bilingual practitioner**

This sub-theme describes the impact of language concordant communication on nurses as practitioners and there was a mixed response. All participants who contributed to the study were able to communicate in at least one other language. All participants acknowledged using their language skills to communicate with patients in the recent past (past six months). All participants of this study, felt comfortable and confident to communicate with their patients in their language when needed and considered that this can be very useful and reassuring helpful for their patients as one participant mentioned:
I am comfortable in speaking to patients in their own languages. I feel I can explain better about their care. I make sure they understand what’s going to happen in theatre or in the procedure, they are there for. They feel much relieved and it does enhance their recovery (Dinesh, Indian Nurse)

The majority of participants mentioned that they would communicate with the patient in their language if they considered it was beneficial for the patient. However, participants considered that, due to an absence of clear and supportive policies and lack or appropriate recognition of their skills, their ability to speak multiple languages results in extra pressure on them, especially when they have to act as interpreter for patients not in their direct care:

*Sometime it is hard to finish other jobs if you are going to interpret for another colleague. We are assigned 5-6 patients and if you are busy then it is not possible* (Anoosha, Pakistani Participant)

Some participant considered that ability to speak multiple languages adds to their workload, and makes them accountable for things not clearly articulated in their job description or organisational policies:

*When I come back to shift after my days off, they [colleagues] are waiting for me to translate many things related to patient needs and problems”* (Moon, Pakistani Participant)

Another mentioned:

*You have to protect yourself, you have not been provided with training in interpretation, you become more accountable, and you are not paid for that job* (Fakher, Pakistani Participant)

Some participants were concerned that, in the absence of clear guidance, nurses’ ability to communicate in other languages can disadvantage them and may contribute to deskilling especially if other colleagues and organisation started using them for only interpretation:

*If nurse started using their language skills, there is a danger that health team is going to abuse them by asking them to interpret for patients again and again, and this would put this staff in stressful position and staff will feel devalued for the purpose.* (Matthew, FG2)
It was also shared that some patients may attempt to manipulate or take advantage of bilingual staff. Patients may develop unrealistic expectations of favours and may ask nurses for preferential services and treatment. This was explained by one participant as:

_They would expect more from you when you speak to them in their own language. Patients try to engage you in their personal problems or drag you into irrelevant discussions and complain. Many expect from you to get them sick notes, etc._

(Noreen, Pakistani Nurse)

To summarise, participants considered that provision of language concordant care is useful for patients with LEP. Generally, bilingual nurses feel comfortable in using their language abilities when providing care to their patients, however, nurses recognise that this ability can be a source of extra work that may not be very useful for their career progression.

### 3.2.3 What helps or hinders (Theme 3)

This theme explains facilitators and barriers that encourage or discourage bilingual nurses to provide language concordant care to their patients as shown in figure 3.4.

**Figure 3. 4: Factors affecting language concordant communication**
Facilitators to language concordant communication

Participants of the study identified various facilitating factors that help them provide language concordant care to their patients with LEP. Analysis revealed that personal characteristics such as confidence in one’s ability, years of experience as a nurse, years of experience in the work setting, relationship with fellow nurses and line manager affected bilingual nurses’ ability to provide language concordant care. Participants who believed that as nurses, they were independent practitioners, responsible for their actions and decisions felt comfortable in using their language skills to provide language concordant care. Years of experience as a nurse in the UK and in their present work setting appeared to be positively associated with bilingual nurses’ willingness, confidence and comfort to provide language concordant care to their patients with LEP. Nurses working in settings requiring one to one interaction with patients felt more confident and comfortable in providing language concordant care to their patients with LEP. Examples of such settings include medical assessment unit (MAU), endoscopy unit, and operation theatre.

Participants reported a varied response from their colleagues. The majority of the participants stated that their colleagues generally are open and supportive of them communicating with patients in their language where possible and that many colleagues appreciate their ability to communicate in more than one language. One participant stated:

The multidisciplinary team appreciates my interpretation service and all doctors, physiotherapists, speech therapists and my nursing colleagues feel informed about the health needs of patients (Moon, Pakistani Participant)

Another mentioned:

... Especially doctors are very grateful when I do interpret for them (Anoosha, Pakistani Participant)
Participants also mentioned that other patients (white English speaking patients) generally are supportive and appreciate the nurses' efforts and abilities to speak to patients in their language. For instance, one participant mentioned:

*I find many English patient support and appreciate me when I speak to the patient in his or her own language who can’t speak English.* (Noreen, Pakistani Participant)

Participants highlighted that patients with LEP and their family’s positive reaction to nurses’ ability to communicate in the same language encourages nurses to continue to use their skills. Participants who felt well supported and respected by their colleagues, were much more comfortable and willing to provide language concordant care. Some participants mentioned feeling valued and positive about their language ability. For instance, one participant mentioned:

*I feel valued that I have been able to help patients as well as my colleagues by using my language skills* (Anna, Italian Participant)

**Barriers to language concordant communication**

All of the study participants expressed facing conflict and sometime arguments by some colleagues as well as managers when found interacting with patients in their language. They believe that some English speaking colleagues, managers and patients convey their disapproval of communicating in languages other than English.

While talking about nurse colleagues’ reaction to situations where nurses have to communicate in a language other than English, some participant shared sensing scepticism, lack of trust and unlikeness as articulated in the following quotes:

*Not everyone, but the majority of our white colleagues are often sceptical. Many feel as when myself and a patient are talking in another language, we are probably talking against them or about them, which is never the case* (Cecilia, South African participant)
They often don’t say anything, but you could see from their nonverbal behaviour and expressions that they don’t approve speaking with patient in a language other than English (Shona, FG3)

Another mentioned:

They (staff) don’t say anything but they don’t like it, their attitude shows it all (Solomon, FG1).

Once I had and Asian patients all she was speaking to me in Gujarati language and one nurse was working in the same ward. She [Nurse] did not understand what we were talking about and looked uncomfortable and sort of confused. So I felt that she wasn’t ‘comfortable with the situation. But not everybody, only some of them make you feel like that. (Sarah, FG3)

Some participants were questioned or discouraged by their line managers for speaking to patients in their own language. For instance, one participant stated:

It happened to me once, deputy manager objected when I was talking to patient in Urdu. He stopped me and said other people don’t understand and would not like it. (Adam, Pakistani Participant)

While talking about negative attitudes by White patients, two participants mentioned

I recall one patient who was making comments and later pulled the curtains while I was speaking to an elderly Asian woman in her language (Noreen, Pakistani participant)

Another stated

I remember one patient saying to us ‘if you can’t speak English, then go outside and speak to each other whatever you like (Dinesh, Indian Participant

However, such situations were experienced very occasionally and the majority of the participants considered that other patients are usually supportive of communicating with patients with LEP in their own language.

Organisational language and interpretation policies remained a central part of the discussion in each interview and FGD. Not having clear guidelines and policies about what’s
acceptable and what is not affected nurses’ comfort and confidence in using their skills to provide language concordant care to their patients. The majority of participants had very little knowledge about language and interpretation policy of their organisation and its impact on them. One participant stated:

I have not seen any policy that allows or does not allow the nurse to talk to the patients in their own language. (Nuveen, FG2)

Participants considered that line managers and other colleagues have limited knowledge or awareness of interpretation policies and it was often down to their personal opinion and interpretation of the policy. For instance, one participant stated:

It happened to me once, deputy manager objected when I was talking to a patient in Urdu. He stopped me and said that other people don’t understand and would not like it. The Other day another patient who was stressed, wanted to talk to me in his language, I went to ask the deputy manager who objected first, then he took me to regional manager who said I could communicate to the patient in his language and it’s not a problem as it’s the policy of the Trust. This clearly meant that my line manager was not aware of interpretation policy of the hospital (Adam, Pakistani Participant).

There was a lack of clear guidelines and policy specifically related to the nurses’ role and responsibilities in relation to providing language concordant care to patients with LEP. The majority of the participant didn’t seem to be aware of the prevailing policies and their impact on their practice. There was an implicit assumption that nurses were not allowed to speak to patients in their language, but this didn’t deter nurses communicating with patients in their language when required. Participants maintained that they were never approached or consulted during policy development or review process.

To summarise, various factors that have an impact on the nurses’ ability to provide language concordant care can be categorised as individual factors, patient related factors, and organisational factors. Individual factors (related to the individual bilingual practitioner), such as confidence, years of experience as a nurse, years of experience in the work setting,
relationship with colleagues and line manager. Patient related factors include expectation of patients with LEP and other attitudes of other patients and organisational factors encompass attitudes of other colleagues working in the same area, attitudes of managers, and organisational culture and organisational policies. As mentioned, the findings of the study were shared with a group of people involved in finding consolidation workshop. Participants of the workshop found findings useful and helped in the development of recommendation for practice and research.
DISCUSSION

In a multicultural and multilingual society such as the UK, bilingual nurses and other HCPs are an invaluable asset for the NHS, particularly when their language skills can be used to provide care to patients with LEP. The present study was conducted to explore current communication practices of bilingual nurses when providing care to patients with LEP. The study also aimed to identify barriers and facilitators to the provision of language concordant care to patients with LEP. The nurses who contributed to this study came from diverse backgrounds, cultures, age, gender, years of experience and language skills. All participants had experience of providing care to patients with LEP in their area of practice. The present study is unique as research on bilingual nurses’ experience of using their language skills to provide language concordant care remains scarce. In addition, research exploring perspective and experiences of BME nurses is also scarce. In the past, studies have been conducted to explore the impact of language barriers on provision of care (Bischoff & Denhaerynck, 2010; McCarthy, Cassidy, Graham, & Tuohy, 2013; Savio & George, 2013; Tay et al., 2012). However, nurses’ perspectives about factors affecting the provision of language concordant care to patient remain unexplored.

Consistent with previous research, the findings of this study suggest that using interpreters to provide language concordant care is not free from limitations, as the interpreters are not always aware of medical terminology and may find it difficult to explain it to a patient (Bischoff & Denhaerynck, 2010; Bischoff & Hudelson, 2010; Green et al., 2005). In addition, arranging an interpreter can be time consuming and costly. This finding contradicts previous research which suggests that use of interpreters can reduce the cost of care (Carter-Pokras et al., 2004; Jacobs et al., 2007). In addition, communication through interpreters is not always feasible, especially where a patient is under stress, experiencing pain or is under
the influence of medication or anaesthesia. In such situations, bilingual nurses who are able to speak the language of the patient can be very useful. The majority of previous studies have been conducted in outpatient departments (Hudelson, Dao, Perron, & Bischoff, 2013) or primary care settings (Elderkin-Thompson, Silver, & Waitzkin, 2001; Ngo-Metzger et al., 2007) or community based health centres (Green et al., 2005) where situations in which communication takes place is different and factors such as pain are absent and patients are alert and conscious. Interpreters are arranged for a specific time duration and specific conversations. However, nurses have to deal with patients throughout their stay in hospital; therefore, they have to be able to communicate with the patients. The present study provides important information about situations where provision of language concordant care can make a difference to a patient’s care experience. More research can be done to explore the relevance of the issue with nurses providing care to patients in specialised areas such as intensive care units (ICU), recovery rooms, and operating theatres.

The findings of the present study highlight the impact of language concordant care on patients and practitioners. Consistent with existing research, the findings suggest that provision of language concordant care to patients with LEP enhances their experience, comfort, and satisfaction (Ngo-Metzger et al., 2007), with the health care service (Eamranond et al., 2009; Free, 2005; Gill et al., 2011; Traylor et al., 2010). In addition, it makes them feel listened to and improves their understanding of and compliance with treatment (Fernandez et al., 2004). It may be useful to explore patients’ experiences of communicating via an interpreter. It will also be useful to explore patients’ perspectives about provision of language concordant care.
The findings also highlight the impact of provision of language concordant care on nurses as practitioners. While participants considered that provision of language concordant care was positive from a patient’s perspective and that nurses were comfortable and confident in using their language skills, they considered that their language skills were not recognised or valued in their organisation. Language skills were neither appreciated nor discussed in performance appraisals and there was no incentive attached to it. There is a lack of clear guidance and policies clarifying expectations in relation to use of language skills to provide care. This is consistent with the findings of the document review that revealed that, among 30 policies reviewed, only two explicitly allowed registered HCPs such as doctors, nurses and AHPs to use their language skills to provide language concordant care of their patients if they considered comfortable and confident to do so. Participants considered it unnecessary and time consuming to communicate through an interpreter when they—as clinicians—could assess their patients in their own language. However, lack of clear policies and guidelines affect their confidence and ability to use their language skills and raises concerns. For instance, participants considered that use of their language skills to provide language concordant care can add to their workload in situations where they may be used as interpreters only and that can lead to deskilling. Lack of clear policies also made participants concerned about repercussions of using their language skills in case a patient or their family misunderstood something and raised a complaint against them. However, there was a consensus that such issues can be easily managed by developing clear guidelines, which allow a practitioner to use their language skill appropriately when needed. In addition, it is important to recognise that miscommunication or misunderstanding can occur in any situation and in the absence of language barriers. As mentioned previously, nurses as registered practitioners are responsible for providing safe and effective care to their patients. They are accountable for their actions (NMC, 2015). As regulated practitioners, nurses
(other registered HCPs) are required to recognise and work within the limits of their competence. Considering this, nurses should be able to know their abilities and can work in the limits of their competence. Nurses are also required to work collaboratively with other professionals, recognise their skills, expertise and contribution and refer matters to them when appropriate (NMC, 2015). Language skills, therefore, should be considered as any other skills and nurses should be able to use their judgement to decide when to use their language skills and when to arrange for an interpreter in the best interest of a patient. Ultimately, nurses are accountable for the decisions they make, and if a nurse makes a wrong decision because of interpretation errors, the nurse will still be accountable. Participants considered that they were not consulted when language and interpretation policies are developed or reviewed. This is probably the reason that the policies are not always relevant and applicable to their situation. While developing or reviewing language and interpretation policies, involving HCPs, such as doctors, nurses and other registered professionals, especially those capable of communicating in more than one language would be useful.

Findings also identified various facilitators and barriers that affect the nurses’ ability to provide language concordant care. These include nurse’s personal characteristics such as age, years of experience as a nurse and in the current work setting, and relationship with colleagues and management. It may be that all of these factors contribute to the development of a nurse’s confidence in their knowledge, skills, and an ability to make and justify their decisions. Participants considered that communicating with patients in their language might result in increasing their expectations of what a nurse can do for them. They may expect favours from a nurse because of their shared cultural linguistic background. However, nurses need to be able to maintain a professional relationship with their patients
Findings suggest that, occasionally, other patients in the area did not like nurses speaking to LEP patients in their language and that their colleagues also conveyed disliking and unacceptance of bilingual nurses speaking in a language other than English. Such situations were more common when there was a lack of trust among colleagues or the bilingual nurse was new in the team or was not a regular member of the team (bank/agency staff). In such situations, bilingual nurses were reported to managers for communicating with patients in their language. It is important for bilingual nurses to develop their confidence as provision of patient-centred care should always take precedence. Creating opportunities where nurses working in a department could discuss and reflect on such issues may be useful in supporting bilingual nurses to develop their confidence in using their language skills. In addition, such opportunities may help other nurses to explore their attitudes, values and beliefs about provision of language concordant care. This will also help them understand the need for the provision of language concordant care to patients with LEP. Research needs to be conducted to explore non-BME nurses’ perspective about provision of language concordant care to patients with LEP. It may also be useful to explore how non-BME nurses feel when their BME colleagues communicate with each other or with their patients in a language other than English.

Attitudes of managers and support provided by them was also identified as an important factor affecting nurses’ practices of providing language concordant care. Findings suggest that managers and colleagues were generally unaware of organisation’s language and interpretation policies. Such unawareness contributed to variation in attitudes and practices.
of managers, with some being more receptive about provision language concordant care.
Finding ways to increase staff awareness about interpretation and translation policies may
help. As mentioned previously, it is also important to ensure that all staff members specially
HCPs such as nurses, doctors and AHPs are involved and consulted when developing
policies.
CONCLUSIONS

5.1 Strengths of the study

The present study explored an important issue affecting professional practices of bilingual nurses and patients with LEP. The qualitative nature of the study helped to explore perspective of bilingual nurses about provision of language concordant care. The study provided a voice to BME bilingual nurses who generally remained unheard of. The findings of the study may help improve communication practices of nurses and care experience of LEP patients. Review of language and interpretation policies of various organisations has helped in highlighting a lack of stakeholder involvement in the development of policies. In addition, the findings have also identified a mismatch between policies and practices and its impact on the practitioner’s confidence and ability to deliver appropriate services. All of these findings are important and may help in making appropriate changes in practice.

5.2 Limitations of the study

The findings of the study need to be interpreted cautiously. Due to the qualitative nature of the study the results cannot be generalised. It was not possible to explore the perspective of language and interpretation service managers/leads in various NHS acute Trusts due to limited time available for the study. Due to financial and time constraints, it was not possible to explore the perspective of other HCP.

5.3 Implication

The findings of this study have implications for research, practice, education and research.

5.3.1 Implications for nursing practice

- Bilingual nurses need to be competent and confident about their language skills. All nurses need to remember that they are required to act in their patient’s best interest, as required by the Code of Professional Conduct (Nursing and Midwifery Council, 2015).
Strategies such as exploring the importance of effective communication and language concordant care, and nurses responsibilities in relation to the provision of care to already marginalised or vulnerable patients such as those with LEP during organisational induction may be useful.

- Nurses need to be proactive in identifying ways to provide effective care to their patients; therefore, they need to be involved in policy making. Nurses should be encouraged to provide feedback about the usefulness or lack of usefulness of prevalent language and interpretation services in their trust.

5.3.2 Implications for organisations

- Language and interpretation policies should be revisited to assess their relevance to all staff members. All stakeholders, including nurses and other HCPs should be consulted when developing or reviewing policies.

- While revisiting policies, it is necessary to consider that language and interpretation needs of patients may vary depending on the health problem. While organisational policy should provide guidance, each clinical setting (unit/ward) should have its policy/guideline to meet the needs of their patients.

- Bilingual nurses and other HCPs with a remit for clinical assessment should be allowed to use their language skills to provide care to patients they are directly responsible for

- A register of bilingual nurses and other staff who are competent, confident and willing to use their language skills should be developed and kept in the clinical area. This may help in recognising language skills of staff, but will be very useful in identifying appropriate people with a specific language in out of hours or when arranging an interpreter is no possible/ difficult
• Nurses should not be penalised for using their own language skills. Neither they should not be pressurised to act as interpreters for patients for whom they are not responsible for against their will

• When possible, bilingual nurses should be assigned to provide care to those patients who cannot speak English but share same language

• Nurses language skills should be valued, recognised and remunerated

5.3.3 Implication for Education

• Recruit ethnic minorities (especially with language skills) to the professionals programmes to increase the proportion of bilingual nurses

• Ensure that all students, regardless of their ethnicity or language skills, understand the importance of patient centred care, and language concordant care. Values clarification exercises and reflective sessions where students are encouraged to reflect on their experiences of experiencing language barriers may help.

5.3.4 Implications for Research

• Further research is needed to explore perspectives of patients about their experiences of receiving language concordant care

• It will be useful to explore the perspective of White British nurses about providing care to patients with LEP. Their views about provision of language concordant care should also be explored.

• Findings from this study could be used to develop questionnaires to explore factors affecting the provision of language concordant care to LEP patients. Such questionnaire can be used to conduct a large scale survey.
Nurses are responsible for providing patient-centred care to their patients regardless of their personal characteristics including language skills. This necessitates effective communication between nurses and patients. Language barriers, however, can make it difficult for nurses to ascertain the needs of patients and consequently affect the care given to a patient. Providing language-concordant care can enhance the health care experience of patients with LEP. Bilingual nurses can play a very useful role by using their language skills to provide language-concordant care to patients with LEP. Not much is known about bilingual nurses’ perspective about provision of language-concordant care to patients from the same linguistic background. This study explored nurses' communication practices when providing care to patients with LEP, from the same linguistic background. The findings of the study highlight several factors that affect the nurses’ ability to provide language-concordant care. These include nurses, personal characteristics, attitudes of patients, colleagues and managers and organisational culture and organisation policies. A review of organisational policies ensuring involvement of nurses and HCPs is warranted.
References


Savio, N., & George, A. (2013). The Perceived Communication Barriers and Attitude on Communication among Staff Nurses in Caring for Patients from Culturally and Linguistically Diverse Background. *International Journal of Nursing Education, 5*(1), 141.


Appendices
### Appendix A

| 1. Aintree University Hospital NHS Foundation Trust | 41. George Eliot Hospital NHS Trust |
| 2. Airedale NHS Foundation Trust | 42. Gloucestershire Hospitals NHS Foundation Trust |
| 3. Alder Hey Children's NHS Foundation Trust | 43. Great Ormond Street Hospital for Children NHS Foundation Trust |
| 4. Ashford and St Peter's Hospitals NHS Foundation Trust | 44. Great Western Hospitals NHS Foundation Trust |
| 5. Barking, Havering and Redbridge University Hospitals NHS Trust | 45. Guy's and St Thomas' NHS Foundation Trust |
| 6. Barnsley Hospital NHS Foundation Trust | 46. Hampshire Hospitals NHS Foundation Trust |
| 7. Barts Health NHS Trust | 47. Harrogate and District NHS Foundation Trust |
| 9. Bedford Hospital NHS Trust | 49. Hinchingbrooke Health Care NHS Trust |
| 10. Birmingham Children's Hospital NHS Foundation Trust | 50. Homerton University Hospital NHS Foundation Trust |
| 12. Blackpool Teaching Hospitals NHS Foundation Trust | 52. Imperial College Healthcare NHS Trust |
| 13. Bolton NHS Foundation Trust | 53. Ipswich Hospital NHS Trust |
| 15. Brighton and Sussex University Hospitals NHS Trust | 55. Kettering General Hospital NHS Foundation Trust |
| 16. Buckinghamshire Healthcare NHS Trust | 56. King's College Hospital NHS Foundation Trust |
| 17. Burton Hospitals NHS Foundation Trust | 57. Kingston Hospital NHS Foundation Trust |
| 18. Calderdale and Huddersfield NHS Foundation Trust | 58. Lancashire Teaching Hospitals NHS Foundation Trust |
| 19. Cambridge University Hospitals NHS Foundation Trust | 59. Leeds Teaching Hospitals NHS Trust |
| 20. Central Manchester University Hospitals NHS Foundation Trust | 60. Lewisham and Greenwich NHS Trust |
| 21. Chelsea and Westminster Hospital NHS Foundation Trust | 61. Liverpool Heart and Chest NHS Foundation Trust |
| 22. Chesterfield Royal Hospital NHS Foundation Trust | 62. Liverpool Women's NHS Foundation Trust |
| 23. City Hospitals Sunderland NHS Foundation Trust | 63. London North West Healthcare NHS Trust |
| 24. Colchester Hospital University NHS Foundation Trust | 64. Luton and Dunstable University Hospital NHS Foundation Trust |
| 25. Countess Of Chester Hospital NHS Foundation Trust | 65. Maidstone and Tunbridge Wells NHS Trust |
| 27. Croydon Health Services NHS Trust | 67. Mid Cheshire Hospitals NHS Foundation Trust |
| 28. Dartford and Gravesham NHS Trust | 68. Mid Essex Hospital Services NHS Trust |
| 29. Derby Teaching Hospitals NHS Foundation Trust | 69. Mid Yorkshire Hospitals NHS Trust |
| 30. Doncaster and Bassetlaw Hospitals NHS Foundation Trust | 70. Milton Keynes Hospital NHS Foundation Trust |
| 31. Dorset County Hospital NHS Foundation Trust | 71. Moorfields Eye Hospital NHS Foundation Trust |
| 32. East and North Hertfordshire NHS Trust | 72. Norfolk and Norwich University Hospitals NHS Foundation Trust |
| 33. East Cheshire NHS Trust | 73. North Bristol NHS Trust |
| 34. East Kent Hospitals University NHS Foundation Trust | 74. North Cumbria University Hospitals NHS Trust |
| 35. East Lancashire Hospitals NHS Trust | 75. North Middlesex University Hospital NHS Trust |
| 36. East Sussex County Healthcare NHS Trust | 76. North Tees and Hartlepool NHS Foundation Trust |
| 37. East Sussex Healthcare NHS Trust | 77. Northampton General Hospital NHS Trust |
| 38. Epsom and St Helier University Hospitals NHS Trust | 78. Northern Devon Healthcare NHS Trust |
| 39. Frimley Health NHS Foundation Trust | 79. Northern Lincolnshire and Goole NHS Foundation Trust |
| 40. Gateshead Health NHS Foundation Trust | 80. Northumbria Healthcare NHS Foundation Trust |
|  | 81. Nottingham City Hospital NHS Trust |
|  | 82. Nottingham University Hospitals NHS Trust |
|  | 83. Oxford University Hospitals NHS Trust |
|  | 84. Papworth Hospital NHS Foundation Trust |
|  | 85. Pennine Acute Hospitals NHS Trust |
|  | 86. Peterborough and Stamford Hospitals NHS Foundation Trust |
|  | 87. Plymouth Hospitals NHS Trust |
|  | 88. Poole Hospital NHS Foundation Trust |
|  | 89. Portsmouth Hospitals NHS Trust |
90. Queen Mary's Sidcup NHS Trust
91. Queen Victoria Hospital NHS Foundation Trust
92. Robert Jones and Agnes Hunt Orthopaedic and
District Hospital NHS Trust
93. Royal Berkshire NHS Foundation Trust
94. Royal Brompton and Harefield NHS Foundation
Trust
95. Royal Cornwall Hospitals NHS Trust
96. Royal Devon and Exeter NHS Foundation Trust
97. Royal Free London NHS Foundation Trust
98. Royal Liverpool and Broadgreen University
Hospitals NHS Trust
99. Royal National Hospital for Rheumatic Diseases
100. Royal National Orthopaedic Hospital NHS Trust
101. Royal Surrey County NHS Foundation Trust
102. Royal United Hospitals Bath NHS Foundation
Trust
103. Salford Royal NHS Foundation Trust
104. Salisbury NHS Foundation Trust
105. Sandwell and West Birmingham Hospitals NHS
Trust
106. Sheffield Children's NHS Foundation Trust
107. Sheffield Teaching Hospitals NHS Foundation
Trust
108. Sherwood Forest Hospitals NHS Foundation
Trust
109. Shrewsbury and Telford Hospital NHS Trust
110. South Devon Healthcare NHS Foundation Trust
111. South Of Tyne And Wearside Mental Health
NHS Trust
112. South Tees Hospitals NHS Foundation Trust
113. South Tyneside NHS Foundation Trust
114. South Warwickshire NHS Foundation Trust
115. Southend University Hospital NHS Foundation
Trust
116. Southport and Ormskirk Hospital NHS Trust
117. St George's University Hospitals NHS
Foundation Trust
118. St Helens and Knowsley Hospitals NHS Trust
119. St Mary's NHS Trust
120. Stockport NHS Foundation Trust
121. Surrey and Sussex Healthcare NHS Trust
122. Tameside Hospital Foundation NHS Trust
123. Taunton and Somerset NHS Foundation Trust
124. The Christie NHS Foundation Trust
125. The Clatterbridge Cancer Centre NHS
Foundation Trust
126. The Dudley Group NHS Foundation Trust
127. The Hillingdon Hospitals NHS Foundation Trust
128. The Newcastle Upon Tyne Hospitals NHS
Foundation Trust
129. The Princess Alexandra Hospital NHS Trust
130. The Queen Elizabeth Hospital, King's
Lynn. NHS Foundation Trust
131. The Rotherham NHS Foundation Trust
132. The Royal Bournemouth and Christchurch
Hospitals NHS Foundation Trust
133. The Royal Marsden NHS Foundation Trust
134. The Royal Orthopaedic Hospital NHS
Foundation Trust
135. The Royal Wolverhampton NHS Trust
136. The Walton Centre NHS Foundation Trust
137. The Whittington Hospital NHS Trust
138. United Lincolnshire Hospitals NHS Trust
139. University College London Hospitals NHS
Foundation Trust
140. University Hospital Birmingham NHS
Foundation Trust
141. University Hospital Of South Manchester NHS
Foundation Trust
142. University Hospital Southampton NHS
Foundation Trust
143. University Hospitals Bristol NHS Foundation
Trust
144. University Hospitals Coventry and
Warwickshire NHS Trust
145. University Hospitals Of Leicester NHS Trust
146. University Hospitals Of Morecambe Bay NHS
Foundation Trust
147. University Hospitals of North Midlands
148. Walsall Healthcare NHS Trust
149. Warrington and Halton Hospitals NHS
Foundation Trust
150. West Hertfordshire Hospitals NHS Trust
151. West Middlesex University Hospital NHS Trust
152. West Suffolk NHS Foundation Trust
153. West Sussex Health And Social Care NHS Trust
154. Western Sussex Hospitals NHS Foundation
Trust
155. Weston Area Health NHS Trust
156. Wirral University Teaching Hospital NHS
Foundation Trust
157. Worcestershire Acute Hospitals NHS Trust
158. Wrightington, Wigan and Leigh NHS
Foundation Trust
159. Wye Valley NHS Trust
160. Yeovil District Hospital NHS Foundation Trust
161. York Teaching Hospital NHS Foundation Trust
Appendix B

04/02/2015

Parveen Ali
School of Nursing and Midwifery

Dear Parveen

PROJECT TITLE: Reducing communication barriers through Language concordant communication among patients and nurses from Black and Minority Ethnic (BME) Community

APPLICATION: Reference Number 002133

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 13/01/2015 the above-named project was approved on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 002133 (dated 03/01/2015).
- Participant information sheet 004335 (03/01/2015)
- Participant consent form 004336 (03/01/2015)

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Yours sincerely

Michelle Winslow
Ethics Administrator
School of Nursing and Midwifery
Appendix C
Reducing communication barriers through Language concordant communication among patients and nurses from Black and Minority Ethnic (BME) Communities

You are being invited to take part in a research project. Before you decide it is important for you to understand, why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. **What is the project’s purpose?**
The communication between nurses and patients is an integral part of the patient experience. It is often difficult for non-English speaking patients to communicate with health care providers, especially if their ability to speak English is limited. It may be more satisfactory for a patient to talk to their nurse in their primary language. No research has been conducted to explore current communication practices of nurses, of various ethnic origins, when dealing with patients from the shared linguistic background. Such knowledge can help in developing effective communication approaches, policies and guidance to improve provision of services to patients from BME backgrounds.

The project aims to explore current communication practices of nurses from BME background when dealing with patients with shared linguistic background and to identify barriers and facilitators to language concordant communication among nurses and patients across various ethnic groups.

2. **Why have I been chosen?**
You have been invited to take part in this study, as you are a nurse providing care to patients from different ethnic and linguistic background. We believe that you will be able to help us understand about how you communicate with patients with limited ability to speak English. We aim to talk to nurses from various ethnic backgrounds and therefore, requesting you to participate in the study.

3. **Do I have to take part?**
No. It is up to you to decide. We will describe the study and go through this information sheet, which we will then give to you. If you do want to take part, we will ask you to sign a consent form to show that you have agreed. You are free to withdraw at any time and without giving any reason.

4. **What will happen to me if I agree to take part?**
If you are happy to take part in this project, we will invite you to participate in an individual interview or a focus group discussion. The individual interview or focus group discussion will be scheduled at a mutually convenient date and time.

During the interview, a series of questions will be asked, but these will only be a prompt for the discussion since we are interested to hear your thoughts and opinions. Depending on how much you have to say and how much time you can spare, we expect the interview to last between 45-60 minutes.

We would like to hear about your views and personal experiences. However, if there is anything that you find upsetting, you should not feel any pressure to share anything that you do not want to, or anything that makes you feel distressed or uncomfortable. You may refuse to answer any question at any time. If you agree, we would like to record your interview.
5. **What will I get out of participating?**
There will be no direct benefit to you. However, taking part will help in finding ways to improve quality of services for the patients from BME background and with limited ability to speak English.

6. **Will I be recorded, and how will the recorded media be used?**
We would like to record the discussion, so that we do not have to write everything down and to make sure that nothing you say is missed. We hope you will agree to this. The audio recordings made during this research will be used only for analysis and for illustration in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

7. **Will my taking part in this project be kept confidential?**
Everything that you tell us will be treated with strictest confidentiality. Nobody other than the researcher will have access to the information provided by you. Neither your name nor any identifying information will appear on any written documents produced by the researcher. All the research materials will be kept in a password protected computer and the recording will be destroyed after the written document has been made. Any reports or summaries that are made will not have any identifiable information.

8. **What will happen to the results of the Project?**
At the end of the project, a report of the findings will be presented to the sponsors. The findings of the study will also be published in academic and scientific journals. Neither the report nor the publication will have any identifiable information.

9. **Who is organising and funding the study?**
The study is being organised and managed by a researcher from School of Nursing and Midwifery, University of Sheffield. The research is being funded by Royal College of Nursing as part of Mary Seacole Leadership Award.

10. **Who has reviewed the study?**
The research has been ethically reviewed and approved via School of Nursing and Midwifery, University of Sheffield’s ethics review procedures.

11. **What if I have a complaint about the study or the way it is being conducted?**
If you have any problems or questions in relation to the study, you can contact Dr. Parveen Ali via email (parveen.ali@sheffield.ac.uk) or telephone (0114 222 2046). Parveen will discuss it further with you to resolve the issue. However, should you feel that your complaint is not being handled properly; you can contact Dr. Tracey Moore, Head of Department, School of Nursing and Midwifery, University of Sheffield, who will then escalate the complaint through the appropriate channels. Tracey can be contacted by email (tracey.moore@sheffield.ac.uk) or telephone (0114 222 2056).

12. **Where can I find out more about the study?**
If you want to find out more about the study, please contact: **Dr. Parveen Ali**, Lecturer, School of Nursing and Midwifery, University of Sheffield, Barber House Annex, 3a Clarkhouse Road, Sheffield, S10 2LA; Email: parveen.ali@sheffield.ac.uk; Tel: 0114 222 2046

Thank you very much for reading this information sheet. A copy of this sheet is available for you to keep.
Appendix D

Reducing communication barriers through Language concordant communication among patients and nurses from Black and Minority Ethnic (BME) Communities

1. Tell me a little bit about yourself, your background, and your family. How would you describe yourself? (Age, background, your family, how long have you been here in the UK)
2. What languages do you speak fluently?
3. Tell me a little bit about your experiences of working as a nurse here in the UK? What area/field do you work in? How long have you been working there. Do you enjoy your work?
4. What kind of patients do you care for in a typical day? What kind of communication needs do they have? What is your experiences of communicating with patients while caring
5. Do you care of patients who speak your own language? What is your experience of caring for them? How do you communicate with them?
6. Do you talk to them in your common language? Is it helpful
Speaking my patient’s Language:
Providing language concordant care to patients with limited English proficiency

Parveen Ali, PhD, MScN, RN, FHEA

October 2015