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Improving Healthcare Team Communication with Limited English Proficiency Families in the NICU

Introduction

In 2018, 67 million people in the United States, or roughly 22%, reported speaking a language other than English at home (Russell et al., 2020). Multiple studies have found that language barriers are common in healthcare settings, creating disparities in care between individuals with limited English proficiency (LEP) and those with English proficiency. For families with a baby in the NICU, stress caused by the unfamiliar and chaotic NICU environment may be compounded by a family's inability to communicate with their baby's caregivers, further isolating immigrant parents and leaving them unsure about their baby's condition, treatments, and prognosis. Furthermore, families with LEP have been found to be less technically and emotionally prepared for their baby's discharge, potentially having a negative impact on the transition home, compliance with follow-up care, and the utilization of available resources, placing these vulnerable babies at even greater risk for adverse outcomes (Obregon et al., 2019).

The setting for this project was a 65 bed, university-affiliated, level IV NICU in a medium-sized Midwestern city. Despite having 24-hour access to professional interpreter services via telephone, video, or in-person for multiple languages, prior to this project there were few guidelines for appropriate use, leading to inconsistent and often inadequate communication between the healthcare team and families with limited English proficiency.

Literature Review

Lack of professional interpreter use in healthcare settings can lead to medical errors, higher rates of adverse medical events, worse post-operative pain management, decreased patient satisfaction, decreased trust in medical personnel and treatment received, decreased treatment adherence, increased length of hospital stay, and increased rates of readmission (Russell et al.,

2020) (Obregon et al., 2019). In the NICU setting, professional medical interpreters have been shown to greatly improve parent/staff communication and increase parent satisfaction.

Interpretation allows parents to ask questions and form trusting relationships with staff (Ardal et al., 2011). Solid parent-provider communication can result in better health outcomes by increasing parental empowerment and participation in their child's care (Walker-Vischer et al., 2015).

Despite the acknowledged advantages of using professional interpreters, studies in the United States and in Europe have shown that even when interpreters are readily available, they are frequently under-utilized. Healthcare providers, particularly nurses, often use bilingual staff or family members in place of professional interpreters for day-to-day interactions and care guidance with parents, while professional interpreters are more often used for communication with physicians (Kynoe et al., 2019). However, research has shown that use of family members and other untrained interpreters should be avoided except in cases of emergency due to the risk of incorrect translations secondary to inadequate language skill and/or medical knowledge as well as confidentiality concerns (Patriksson et al., 2019). The reasons for not using professional interpreters for communication with nursing staff included the convenience of using family members as interpreters, time constraints, cost concerns, unit culture, and lack of unit guidelines for interpreter use.

Ideally, bilingual healthcare providers would care for LEP patients and families, as studies have shown that when a patient and provider speak the same language, it leads to higher patient satisfaction, increased compliance, and better patient understanding and doctor-patient agreement on health behavior recommendations (Masland et al., 2010). However, there are not enough bilingual providers to care for the US's LEP population, making it necessary for

healthcare organizations to provide professionally trained interpreter services to this high-risk group. In-person, telephone or video interpretation services are available to varying degrees across healthcare settings, though study results have revealed pros and cons to all three and current evidence doesn't necessarily support that one mode is significantly better than the others in terms of patient satisfaction (Joseph et al., 2018). Simply increasing access to professional interpreters may increase patient satisfaction and improve quality of care. A systematic review by Boylen et al. (2020) suggests that professional interpreter modality should be chosen based on which is most accessible and readily available for interpretation of the required language, clinical context, patient preference, and cost.

Project Methods

The purpose of this project was to improve communication between the healthcare team and limited English proficiency families in the NICU using professional interpreters. Staff education and practice guidelines based on the results of the previous literature review were developed. Staff education focused on the importance of professional interpreter use, strategies for communicating effectively through an interpreter, and detailed instructions on how and in what situations to use all three available interpretation modalities (in-person, video, and telephone). Practice guidelines included identification of LEP families and documentation of their language preference and assistance needs in the patient's electronic medical record (EMR) as well as routine communication between LEP families and the medical team using an interpreter. Routine communication included an "orientation" to the NICU at the time of admission, communication during daily bedside rounds, and multi-disciplinary care conferences with families held at intervals to be determined by the medical team on a patient-by-patient basis. Documentation of interpreter use in the EMR was also outlined. This project was determined to

not constitute human subjects research; therefore, the protocol did not require submittal to and approval from the healthcare system's IRB.

Evaluation

After staff reviewed the education PowerPoint describing the proposed practice guidelines (Appendix D), they were given an eight question post-education survey that used a Likert scale to determine its effectiveness (Appendix A). The survey included space for written feedback such as comments, concerns, ideas on how to improve the communication process, and potential barriers to implementation. All respondents agreed or strongly agreed that after reviewing the PowerPoint, they understood how to document a patient family's need for an interpreter and their language preference in the EMR, as well as the importance of and the process for routinely communicating with these families using interpreters. All respondents also agreed or strongly agreed that the PowerPoint was clear, easy to understand, and applicable to their clinical setting. One respondent disagreed that they understood how to document communication using an interpreter in the EMR and one respondent disagreed that they understood how to use the video interpreter cart to orient new families to the NICU. Written comments were overwhelmingly positive; respondents said that the PowerPoint was informative and useful, and that the proposed practice guidelines would improve communication with LEP families. Suggestions for improvement were to include pictures of the "Interpreter Resources" flowsheet and of the laminated badge reference card to help staff identify them. This evaluation tool and feedback were used to make minor changes to the education PowerPoint, including adding the requested photographs.

Prior to the implementation of this project, no guidelines existed for identifying and documenting interpreter needs for LEP families in the NICU, and despite 24-hour access to

professional interpreter services via telephone, video, or in-person, there were few guidelines for appropriate use, leading to inconsistent and often inadequate communication with families with limited English proficiency. During the project period of August 2021 to November 2021, five LEP families were identified in the NICU. All five had a need for interpreter and preferred language documented in the EMR. A bedside log (Appendix C) was kept measuring compliance with practice guidelines, interpreter modality used, documentation in the EMR, and length of time of daily communication with family. Per EMR documentation, the two families where neither parent spoke English well were updated most often, on average every 1-2 days, and the video interpreter service was the most frequently used modality. Four care conferences were held between the two families as both had long-term NICU stays (greater than two months). The other three families had one parent who spoke English well enough to communicate with the care team and interpret for the LEP parent; those were updated with an interpreter when the LEP parent was alone as the LEP parent frequently declined a professional interpreter in favor of the English proficient parent when both were present. All three of these families had short-term NICU stays, so no care conferences were held. One family was never updated with a professional interpreter due to lack of interpreter availability for their preferred language (Pohnpeian).

Feedback was collected from staff during and after the project in the form of a post-implementation survey (Appendix B). Five staff nurses and 10 nurse practitioners participated in this survey, and feedback was overwhelmingly favorable. All respondents agreed that using the video interpreter during family “orientation” to the NICU and for communication with families during daily bedside rounds had been not only feasible, but much easier than expected. Barriers to interpreter use were lack of time due to high census/acuity and staffing shortages. Families not being present for bedside rounds led to decreased levels of communication as well, as staff felt

that accessing and utilizing a telephone interpreter was more cumbersome and less effective than using the video interpreter. Respondents felt that scheduling routine multi-disciplinary care conferences with LEP families using in-person interpreters enhanced families' understanding of their baby's diagnoses, plan of care, and the roles of the various members of their care team. Barriers to these care conferences were differing opinions on the definition of "routine" (this was intentionally left vague and at the discretion of the medical team to be determined on a patient-by-patient basis in the practice guidelines) as well as some uncertainty about the rules regarding in-person interpreters in light of visitor restrictions due to COVID-19. On one occasion, the nursing supervisor told a nurse practitioner that in-person interpreters were not allowed in the hospital due to COVID restrictions, which was not true.

Impact on Practice

This project improves family-centered care in the NICU by forming strong foundational relationships between the healthcare team and LEP families by way of routine, open, two-way communication using professional interpreters. The education and practice guidelines helped staff understand the importance and clinical relevance of using professional interpreters, how to use interpreter services effectively, and how to document communication with LEP families. Staff were overwhelmingly grateful for the education, and routine communication with LEP families improved as staff felt more empowered to use available resources. The convenience and ease of the video interpretation service was especially impactful. Going forward, these guidelines will hopefully create a culture shift in the NICU where communication with LEP families is a routine part of patient care, and all staff feel comfortable using available interpreter modalities.

Future implications for this project include review of the NICU's available translated materials to determine any additional needs and certification of staff members as interpreters in

order to provide LEP families with even more resources to decrease language barriers, improve family and staff satisfaction, and ultimately, improve patient outcomes. This project can be replicated in other healthcare settings if the appropriate interpreter modalities are available. The educational component is easily reproduced, shared, and accessible.

Conclusion

Language barriers are common across all healthcare settings, creating disparities in care between individuals with limited English proficiency and those with English proficiency. High-quality patient-provider communication forms the foundation of high-quality patient-centered care, making the use of professional interpreters essential. The results of this quality improvement project showed that the PowerPoint educational module and the new practice guidelines improved staff understanding of the importance of using professional interpreters for communication with LEP families. Staff became more comfortable with the available interpreter modalities and appreciated having a reference for questions regarding how to access interpreter services as well as how to communicate effectively using interpreters. This increased awareness and comfort utilizing interpreter resources was reflected by their solid use during the duration of this project and their continued use since its conclusion.

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