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The Lived Experiences of Acute-Care Bedside Registered Nurses Caring for Patients and Their Families with Limited English Proficiency

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THE LIVED EXPERIENCES OF ACUTE-CARE BEDSIDE REGISTERED NURSES CARING FOR PATIENTS AND THEIR FAMILIES WITH LIMITED ENGLISH PROFICIENCY

by

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ABSTRACT

The Lived Experiences of Acute-Care Bedside Registered Nurses Caring for Patients and their Families with Limited English Proficiency

by

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Approximately 8.6% of the total U.S. population is considered limited English proficient (LEP), a term that has been used by official US federal policy and will be used throughout this study. In a landmark report, the Institute of Medicine found that minorities received lower-quality health care than Caucasians even when insurance status, income, and other factors were equivalent. These differences were tied to issues such as bias, stereotypes and communication barriers between patients and their caregivers. In the hospital setting, registered nurses provide the most direct contact with patients and their families. Effective communication between patients and health care professionals is essential when providing quality health care.

The Joint Commission requires new patient-centered communication standards to be in place, which includes cultural competence and effective communication for the accreditation process, beginning in January, 2012. The literature indicates that language barriers have been associated with medical complications. Existing studies have explored LEP patients' experiences in health care. There are very few studies looking at registered

nurses' experiences with language barriers. In particular, the nurses' experiences with LEP patients and their families in an acute-care setting have not been examined.The purpose of this study was to describe, interpret, and gain a deeper understanding of the lived experiences of acute-care bedside registered nurses caring for patients and their families with LEP. Van Manen's hermeneutic phenomenological method guided the study. The phenomenology research approach provides the most meaningful ways to describe and understand the entirety of the bedside nurses' experiences. This study provided information regarding the lived experiences of acute-care bedside nurses caring for patients and their families with LEP that had not been revealed in the nursing literature. The meanings of the lived experiences were discovered through analysis of 40 acute-care bedside nurse interviews in one acute-care setting.

A convenience, purposive sample of 40 registered nurses who work in bedside care in an acute-care setting were interviewed. Each nurse had a minimum of 3 years of acute-care experience. The sample size was determined by data saturation. Four themes emerged from the data of this research including: Desire to Communicate; Desire to Connect; Desire to Provide Care; and Desire to Provide Cultural Respect and Understanding. Findings from the study have the potential to identify clinically relevant concerns, barriers to communication, resources for effective communication, and needs or concerns of the bedside nurses when providing care.

Strengths, limitations, and recommendations of the study are outlined. This research provides new information regarding the lived experiences of acute-care bedside registered nurses caring for patients and their families with limited English proficiency.

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DEDICATION

To my beloved husband and dearest friend, Gil, thank you for being my rock through this journey. I accomplished this the only way I ever would have, with you by my side. Your unconditional love, understanding, and sacrifice were my foundation. I am truly grateful. This work is dedicated to you.

To my dear children, Wiggles and Giggles, (otherwise known as Carson and Sierra), I love you so much. We have all grown through this experience. This will be Mommy's forth 'glad-u-la-tion' that we celebrate together. The future is dedicated to you. My prayer is that you care for people of every walk and land, just as Jesus would. I hope you hear Mahatma Gandhi's words, "…be the change you wish to see in the world." May you live the words of Mother Theresa, "It is not how much you do but how much love you put in the doing." I know you love learning as much as Daddy and I do. Share your gifts with others in need. Let's go explore ways to serve the sick and suffering, together, in Christ's love. And always remember, I love you more…

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CHAPTER 1

INTRODUCTION

This study is designed to explore ways in which acute-care bedside nurses' experience caring for Limited English Proficient (LEP) patients and families. For purposes of this study, the researcher used the LEP designation due to its use within federal policy and law as well as local policy in the research setting. Support for the cultural and linguistic needs of ethnic minorities may pose challenges for the nurses caring for this population. Compounding the work of providing care for an acutely ill patient with a language barrier, this care must be accomplished within shorter lengths of stay. Beginning in the 1980's, a shift occurred from a Medicare cost-based re-imbursement system to a prospective payment system for hospitals. This was followed by the implementation of utilization review programs and managed care plans. Along with advances in technology and outpatient services, these trends contributed toward a steady decline in the average patient's length of stay for hospital inpatient care (Stokowski, 2004). The average length of hospital stay in 1980 was 7.3 days (Stokowski, 2004), which has decreased to 4.8 days in 2010 (Centers for Disease Control and Prevention, 2013). The bedside nurse in acute care has been asked to provide for the needs of LEP patients and families during a shorter length of stay. This study provides a voice for acute-care registered nurses to express their experiences when caring for this patient population.

Background and Significance

Historically, the United States of America attracted immigrants from all around the world, the majority from Asia, Europe, and Latin America. The 2010 U. S. Census results report that more than 36% of the total population is composed of various ethnic minorities (U.S. Census Bureau, 2010). Of significance, 55 million persons (20.1%) speak a language other than English at home and 24 million (8.6%) are LEP (U.S. Census Bureau, 2010). Approximately 300 languages are spoken in the United States (The Joint Commission, 2010). It is estimated that this minority population will grow consistently to comprise almost 50% of the whole population by 2050 (U.S. Census Bureau, 2010). The most significant projected shift in population by ethnicity is a relative decrease in Caucasian residents and a relative increase of Hispanics and Asians is expected to become the fastest growing minority group (U.S. Census Bureau, 2010). While the United States is becoming an increasingly diverse nation, only 16.8% of registered nurses are of an ethnic minority (U.S. Department of Health and Human Services, 2010).

The increase in ethnic, cultural, and linguistic diversity in the United States has resulted in an increased need for language access services in health care settings (Jacobs, Agger-Gupta, Chen, Piotrowski, & Hardt, 2003). The American Community Survey estimates that 8.6% of the total U.S. population over 5 years of age speaks English less than "very well" (U.S. Census Bureau, 2010). LEP patients receive less than optimal health care (Hasain-Wynia, et al., 2009). In a landmark report, the Institute of Medicine (IOM, 2002) found that minorities received lower quality health care than Caucasians even when insurance status, income, and other factors were equivalent. The report found

these differences were directly tied to issues such as bias, stereotypes and misunderstandings between patients and their caregivers (Smedley, Stith, & Nelson, 2002). Interestingly, Giger and Davidhizar (2008) reported nurses and nursing students are rarely taught culturally competent assessment and care techniques.

The United States Department of Health and Human Services (2001) recognizes the importance of how healthcare organizations and their staff understand and respond to the preferences and needs of culturally diverse patients. When language barriers exist in health care, patients have more frequent visits to the Emergency Department, longer hospital stays with more return visits, increased costs due to more diagnostic tests, delayed diagnoses, increased medication errors, and lower patient satisfaction surveys (IOM, 2002; The Joint Commission, 2007). The 2007 Joint Commission report on hospitals, language, and culture recommends targeted strategies to provide effective care to a diverse American population (Wilson-Stronks & Galvez, 2007). In the hospital setting, nurses provide the most direct contact with patients and their families. Yet, there is little evidence that bedside nurses in acute-care hospital settings accommodate the patients' cultural beliefs and practices into nursing care (Giger et al., 2007; Pacquiao, 2007; Parucha, 2005; Siantz & Meleis, 2007). Lipson and DeSantis (2007) found the majority of undergraduate nursing schools did not include a separate course on cultural competence in the curriculum. Acute-care nurses cite a lack of organizational resources, time, and educational preparation as barriers to delivering culturally competent care (Taylor, 2007).

Beginning in the 1950s, the field of transcultural nursing was established by Madeline Leininger (Parker, 2001). As a pediatric clinical nurse specialist, she discovered the urgent need for nursing preparation to cope with the diverse cultures and backgrounds of her clients (Leininger, 2001). This realization led Leininger to complete her Ph.D. in social and cultural anthropology after which she developed the Theory of Culture Care Diversity and Universality (Parker, 2001). Considered a grand theory, assumptions include: (a) an expectation that identifying cultural differences leads to differences in nursing care expectations and practices, (b) cultural conflicts and stressors are inevitable in the transcultural nurse-client relationship, and (c) culturally competent care will promote client satisfaction with a greater sense of well-being (Tomey & Alligood, 1998). Leininger described one of the theoretical tenets as, "The worldview, multiple social structural factors, ethnohistory, environmental context, language, and generic and professional care are critical influencers of cultural care patterns to predict health, well-being, illness, healing, and ways people face disabilities and death" (Leininger & McFarland, 2006, p. 18).

Leininger established the Transcultural Nursing Society in 1975 with the "philosophical foundation that transcultural nursing is a discipline whose central and dominant focus is human caring. Caring is a universal concept that emerges from and is rooted in the context of diverse cultures. The Society upholds the rights of all people to receive culturally competent care" (Transcultural Nursing Society, 2012, p. 1).

Leininger's work inspired a significant body of research-based knowledge toward providing a more holistic approach to nursing practice. Transcultural nursing care

promotes meaningful and therapeutic outcomes. Continued global migration necessitates the need to provide transcultural nursing education, research, and development in the nursing profession (Douglas & Pacquiao, 2010). Today, many theories, models, and conceptualizations exist for transcultural practice including, but not limited to, Jeffrey's cultural competence and confidence model; Purnell's model for cultural competence; Giger and Davidhizar's transcultural assessment model; Spector's model of cultural diversity in health and illness; and Campina-Bacote's process of cultural competence in the delivery of health care services (Douglas & Pacquiao, 2010). Each of these models describes the need for effective transcultural communication including nonverbal, verbal, and health literacy (Douglas & Pacquiao, 2010). Transcultural communication skills are essential components of culturally competent health care (Gurman & Moran, 2008).

The American Nurses Association (ANA, 2012) is the only professional organization representing all of the registered nurses in the United States. The ANA promotes high standards of nursing practice, which includes addressing cultural diversity in nursing practice. In its summary statement originated by the Council on Cultural Diversity in Nursing Practice, Congress of Nursing, the ANA (1991) proclaims the importance of culture as one of the concepts in which nursing is based and defined. The ANA states that each client must be assessed for individual cultural differences and nurses must act as client advocates to promote culturally competent care (ANA, 1991).

In Nevada, 91% of employment is in the service sector (Nevada Workforce, 2012). The U.S. Census Bureau (2010) reports 28.2% of Nevada residents speak a language other than English at home, which is significantly higher as compared to the

U.S. rate of 20.1%. According to the Migration Policy Institute (2011), Nevada ranks Number 1 among the 50 states and District of Columbia for the highest growth rate of 398.2% increase in LEP population between 1990 and 2010. This significant increase in immigrant migration to Nevada resulted in a 12.3% increase of the population as LEP compared to 8.6% nationally (Migration Policy Institute, 2011). Therefore, the percent of LEP residents in Nevada is much higher than the national percentage.

Effective communication between nurses and LEP patients and families is essential to provide safe, culturally competent, and patient centered care (Andrulis & Brach, 2007; Markova & Broome, 2007). This is especially true for the LEP patient and family (Hasain-Wynia et al., 2009), as English is the predominant language used in the United States health care system. There is a gap in the literature, however, in describing the registered nurses' experiences and potential barriers when providing transcultural communication for acutely ill patients and their families. What is not known is how nurses experience the work of caring for patients and families with language barriers. This research study examined the lived experiences of acute-care registered nurses when interacting with LEP patients and their families.

Operational Definitions

For the purpose of this research, the following operational definitions are offered:

Culture: A composite of beliefs, practices, traditions, and learned values that may apply to an individual, family, or community (Leininger, 1991b; Schim, Doorenbos, Benkert, & Miller, 2007).

Cultural competence: A set of evolving practice behaviors that demonstrate cognitive, affective, and psychomotor skills necessary for guiding culturally congruent care (Green, 1995; Shim et al., 2007).

Culturally congruent care: Considered the goal or outcome of acquiring cultural competency skills. Such care is accomplished by assessing one's values, beliefs, and lifeways in order to provide more accurate and reliable knowledge on which to base care planning for the transcultural client. This holistic approach to nursing care includes the client's perception of his or her own culture and value system (Tomey & Alligood, 1998).

Diversity: Distinguishing factors such as gender, generation, ethnicity, race, and sexual orientation (United Nations Educational, Scientific, and Cultural Organization, 2002).

Ethnicity: A group of people who share a common and distinctive racial, national, religious, linguistic, or cultural heritage (Spector, 2004).

Family: The primary unit of socialization or basic structural unit within a community that plays a pivotal role in health care. Not necessarily genetic relations, but may be church members, neighbors, etc. (Wong, Perry, Hockenberry, Lowdermilk, & Wilson, 2006).

Interpretation: The process of oral rendering of one language into a second language and vice versa to facilitate the exchange of communication between two or more persons speaking different languages (Eubanks et al., 2010).

Limited English Proficiency: A patient's self-assessed ability to speak, read, write or understand the English language at a level that permits the person to interact

effectively with health care providers or social service agencies (U.S. Census Bureau, 2010). For purposes of this study, the researcher used the LEP designation due to its use within federal policy and law as well as local policy in the research setting.

Race: A local geographic or global human population distinguished as a more or less distinct group by genetically transmitted physical characteristics (Merriam-Webster, 2011).

Research Question

The primary research question for this research study was: What are the lived experiences of acute-care bedside nurses working with LEP patients and families?

Purpose of the Study

The purpose of this study was to explore the lived experiences of acute-care bedside nurses caring for LEP patients and their families. The discovery, documentation, and analysis of the emic, or insider's, perspective of caring for LEP patients and their families provides new knowledge as it relates to culturally based bedside nursing care. Findings from analysis of the participant interviews serve to identify potential barriers towards providing bedside care for LEP patients and their families.

Chapter Summary

This chapter presented the research study by introducing and explaining the background and significance of the topic, providing operational definitions of terminology used throughout the dissertation, and stating the research question and the purpose of the study.

CHAPTER II

EVOLUTION OF THE STUDY

Historical Context

The understanding that culture should be taken into consideration when caring for patients is not new. In 1894, Florence Nightingale stated, "It is a truism to say that the women who teach in India must know the language, the religions, superstitions, and customs of the women to be taught in India. It ought to be a truism to say the very same for England" (cited in Dobson, 1983, p. 53). Cultural competence is essential in today's health care settings (Giger & Davidhizar, 2008; Jeffreys, 2010; Sargent, Sedlak, & Martsolf, 2005). The cognitive process of developing cultural awareness requires knowledge and opportunities for application to clinical nurse practice settings. Developing cultural awareness, knowledge, and skill occurs through education and encounters with patients from culturally diverse backgrounds (Campinha-Bacote, 1999; Spector, 2004).

Title VI of the Civil Rights Act (1964) prohibits discrimination based on national origin or language by any institution receiving federal funds, including health care agencies. More recently, policy makers have recognized the growing impact of this increasing diversity in health care (McDowell, Messias, & Estrada, 2011). In 2000, President Clinton issued Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency* (Exec., 2000). This mandate requires all health and human services that receive federal funds, or are conducted by the federal government, to make every effort possible to accommodate the use of services for LEP

persons. This mandate includes a provision for the Department of Justice to monitor compliance by auditing existing services (Executive, 2000). The purpose of the Executive Order is to remove LEP proficiency as a barrier to participation of persons receiving federally assisted and federally conducted programs and activities (Lockhart, 2001).

The U.S. Department of Health and Human Services Office of Minority Health began a 3-year process in 1998 in which national representatives reviewed, compared, and proposed standards for cultural and linguistic competence. In addition to reviewing 30 policy documents, invitations for public comment and subsequent revisions resulted in the 14 standards published as *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, or CLAS Standards (U.S. Department of Health and Human Services, 2001). Four of the 14 CLAS standards focus on the provision of language access services. These standards are: (a) providing language access services during all business hours at no cost to the patient/consumer, (b) providing verbal offers and written notices of the right to language access services, (c) assuring the competence of language assistance provided by interpreters and bilingual staff, and (d) providing written materials and signage translated into appropriate languages (U.S. Department of Health and Human Services, 2001).

The renewed interest in advocacy for language access in health care provided an opportunity for the National Health Law Program, funded by the California Endowment, to form a national coalition of organizations whose purpose is to improve policies and funding for access to address the related issues (Huang, Ramos, Jones, & Regenstein,

2009). As a result of the coalition's work, the Language Access in Health Care Statement of Principles (Martinez, Hitov, & Youdelman, 2006) was published as a guide for use in achieving language access in health care at all levels of government. A total of 11 principles are included in the guide on the topics of access to language services in health care, funding language services in health care, education regarding language services in health care, assessing and evaluating language services in health care, and accountability for language services in health care (Martinez et al., 2006).

The Joint Commission launched a study in 2004 entitled, "Hospitals, Language, and Culture: A Snapshot of the Nation," which portrayed the perspectives of a national sample of 60 hospitals (Wilson-Stronks & Galvez, 2007). This was followed by a national study in 2006 of hospital language services entitled, "Hospital Language Services for Patients with Limited English Proficiency," which looked at the processes and resources in providing language services to LEP patients in the hospital settings. Many challenges were identified, including a lack of reimbursement for language services (Hasain-Wynia, et al., 2009). In August of 2008, the Joint Commission began an initiative to address the issues of cultural competence, effective communication, and patient- and family-centered care in hospitals. Surveyors were evaluating compliance with the new patient-centered communication standards as of January, 2012 (The Joint Commission, 2010).

Literature Review

Safety and quality of care. A review of the literature reveals issues identified with the delivery of safe and effective patient care including cultural differences,

language barriers, discrimination, ethnocentrism, and nurses' attitudes (Boi, 2000). When patients are limited in their English proficiency, communication barriers arise. Poor communication in health care can lead to tragic outcomes (Flores, 2006). Flores (2006) described three cases in which either language access was not available or was not accurate. In the first case, an interpreter misinterpreted a nurse practitioner's instructions to a mother of a 7-year-old girl with otitis media to put an (oral) antibiotic in the child's ears (Flores, Laws, & Mayo, 2003). The second case described a Spanish-speaking woman who tried to explain that her 2-year-old "hit herself" when falling off a tricycle. The physician misinterpreted two of the words as the mother saying, "I hit her" and, consequently, reported the mother to Child Protective Services for child abuse. Social Services sent an employee to investigate without an interpreter and had the mother sign over custody of her two children (Flores, Abreu, Schwartz, & Hill, 2000). In the third case, the misinterpretation of just one word led to a patient's delay of care, that resulted in a preventable outcome of quadriplegia. An 18-year-old Spanish-speaking male told his girlfriend he was "intoxicado" and collapsed. When the girlfriend repeated this to the paramedic, it was misunderstood to mean "intoxicated" instead of the intended meaning "nauseated." The hospital spent more than 36 hours working up the patient for a drug overdose, while the patient was suffering a subdural hematoma, secondary to a ruptured artery. Ultimately, the hospital paid a $71 million malpractice settlement to the patient (Flores, et al., 2003).

Language barriers in health care may result in detrimental outcomes including misdiagnoses, poor treatment decisions, a lack of trust between patient and provider, and

limited adherence to treatment plans (Derose & Baker, 2000; Javier, Wise, & Mendoza, 2007; Narari, Davis, & Heisler, 2008). LEP patients who do not have interpreter services are less likely to receive information on medication side effects, understand the instructions for taking medications, and are less likely to be satisfied with their care (Baker, Parker, Williams, Coates, & Pitkin, 1996; David & Rhee, 1998; Kuo & Fagan, 1999). Conversely, LEP patients who receive qualified medical interpreter services are more satisfied with their care (Lee, Batal, & Maselli, 2002).

To determine whether differences exist in adverse events between English-speaking patients and LEP patients in U.S. hospitals, adverse event data were collected from six Joint Commission accredited hospitals over a 7-month period, using the Patient Safety Event Taxonomy endorsed by the National Quality Forum. Approximately 49.1% of LEP patient adverse events involved physical harm compared to 39.5% for English-speaking patients. The researchers concluded that language barriers increase the risks to patient safety and emphasized the importance of LEP patients' access to qualified medical language interpreter services (Divi, Koss, Schmaltz, & Loeb, 2007).

A cross-sectional study (Karter, Ferrara, Darbinian, Ackerson, & Selby, 2000) examined self-monitoring of blood glucose for 44,181 diabetic patients who required pharmacologic treatment through Kaiser Permanente outpatient services. Participants completed a survey which included demographic, behavioral, clinical, and self-monitoring blood glucose frequency. While significant gaps existed between actual and recommended self-monitoring blood glucose frequency among most participants, a reduced self-monitoring blood glucose frequency in participants with linguistic barriers,

some ethnic minorities and lower education levels were evident. Approximately 26% of Hispanics and 30% of Asian/Pacific Islanders were identified as having difficulties communicating in English. In the multivariate statistical analysis models that included all ethnicities, having language difficulties was a significant independent predictor of less-than-daily practice among Type 2 diabetic patients with a *p*-value of less than .01 therefore, this finding is significant at the 99% level.

The need for safety and quality in health care is addressed in the Institute of Medicine's (IOM, 2001) report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. The purpose of this publication was to address the prevalent and persistent shortcomings in the American health care system by issuing a challenge to improve its quality and cost-effectiveness of health care, while providing increased responsiveness to patient needs and values. The IOM recommendations include six key areas of quality to address in policy and practice: care should be safe, effective, patient centered, timely, efficient, and equitable (IOM, 2001). Effective communication is critical when applying these key quality dimensions to the LEP patient to avoid delays in treatment and a negative impact on health outcomes.

Language access in acute care. Communication uses verbal, nonverbal, and visual symbols to create shared meanings. Communication can only be understood within the social and cultural context. Language, and language interpretation, is guided by values, beliefs, and perceptions (Eubanks et al., 2010). Cultural and linguistic needs of ethnic minorities offer unique challenges in health care where significant disparities exist (Baldwin, 2003; Bond, Kardong-Edgren, & Jones, 2001). Providing language

access for LEP patients and families is an essential skill in addressing cultural competency for acute-care bedside nurses (Giger & Davidhizar, 2008; Jeffreys, 2010).

Hurst (2004) conducted a qualitative case study analysis in a Neonatal Intensive Care Unit (NICU) setting in which audiotaped interviews and field notes were obtained of a bilingual (English and Spanish) Mexican American mother's self-described experiences. Narrative and content analysis revealed the nurses relied on this mother heavily for language interpretation services between the nurses and other non-English-speaking Hispanic mothers in the NICU. This study provided a depth of insight into the bilingual mother's experiences and concluded that nurses must become aware of resources needed to care for non-English speaking Hispanic families. Garret, Dickson, Young, Whelan and Forero (2008) explored the non-English-speaking patient's experiences with respect to cultural competence by interviewing adult patients in a hospital setting who identified language barriers as a common issue. These patients placed a positive value on information, involvement, engagement, kindness, respectful treatment, compassion, and ability to involve family. These elements of communication identified by non-English-speaking families are essential and therapeutic components of nursing care in acute-care settings.

Bernstein, Bernstein, and Dave (2002) investigated the effect of interpreter services at Boston Medical Center on the intensity of emergency department services, utilization, and charges. A retrospective chart review of 26,573 patients' medical records who were seen in the emergency department over a five-month period was conducted. Five hundred patients met the selection criteria, which included only patients who spoke

English, Spanish, Haitian Creole, or Portuguese Creole. Baseline characteristics of patients were described using means and frequencies. The Kruskal-Wallis test was used to evaluate group differences. The patients who were identified as LEP and did not receive an interpreter had shorter initial stays in the emergency department, were more likely to return to the emergency department for additional care, and had higher billing charges than the LEP-speaking patients who did receive interpreter services.

Language barriers can be challenging in any care setting. The Joint Commission looked at the use of qualified medical interpreters in hospital settings and found only 17% of the 60 U.S. hospitals studied did so, concluding that the language needs of LEP patients are not being adequately met (Wilson-Stronks & Galvez, 2007). In the presence of language barriers, a full history cannot be obtained and higher rates of diagnostic tests are ordered resulting in higher costs and treatment delays (Waxman & Levitt, 2000). Language barriers have been associated with medical complications (Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005).

Language barriers not only create stress and dissatisfaction among patients but impact health care providers as well. In a study measuring the impact of language barriers on acute-care medical professionals' stress levels, physicians and nurses described experiencing moderate to severe stress when caring for LEP patients. The stress level among nurses was found to be significantly higher than for physicians. Both physicians and nurses described language barriers as an impediment to the quality of care delivered (Bernard et al., 2006).

Patient satisfaction. A number of studies examined different aspects of patient satisfaction with care (Brach, Fraser, & Paez, 2005; Divi et al., 2007; Fernandez, et al., 2004; Kaiser Family Foundation, 2007). Baker, Hayes and Fortier (1998) evaluated the effect of language barriers on Spanish-speaking patients' satisfaction with their provider-patient relationship in an emergency room setting. The treating physician or nurse decided whether to call for an interpreter based on their subjective assessment of the patient's need. Each participant was selected after triage determined the need for care for a non-urgent medical problem. After the care was received, 457 native Spanish-speaking adult patients were asked if they preferred to be interviewed in English or Spanish. One week after the urgent care visit, a follow-up interview was conducted by telephone to assess patient satisfaction with the visit. In multivariate analysis, those patients who were not offered an interpreter but felt one should have been called had the lowest satisfaction with a *p*-value of < 0.001 demonstrating significance at 99%. These results supported the conclusion that language barriers can negatively influence patients' perceptions of provider care.

Research Method

Phenomenology was the research method used in this study. Phenomenology is ideal for exploring a topic about which very little is known, providing rich data and seeking understanding of the essence of the phenomenon under study (Creswell, 2005). Phenomenology is a qualitative research approach, which seeks to understand the meaning of the human's lived experiences with the purpose of describing a specific phenomenon (Polit & Beck, 2008). The central focus of phenomenological inquiry is to

describe the lived experience that represents what is true in the individual's life (Speziale & Carpenter, 2007). As a humanistic profession, nursing is committed to caring for all humans. Nursing seeks to understand the meanings and contexts of human experiences in a holistic manner. The phenomenology method attempts to describe and interpret perplexing human phenomena that are not easily quantifiable (Krasner, 2000).

Relevance to Nursing

Nursing is a profession that has a societal mandate to serve people. Given the growing proportion of U.S. residents with limited English proficiency, nurses must address the gaps in language access. The nursing profession needs more qualitative research to study transcultural nursing care. According to Streubert and Carpenter (2011), "Nursing encourages detailed attention to the care of people as humans and grounds its practice in a holistic belief system that nurses care for mind, body, and spirit. The holistic approach to nursing is rooted in the nursing experience and is not imposed artificially from without" (p. 87). The phenomenology perspective provides for the most meaningful ways to describe and understand the entirety of the bedside nurses' experiences (Streubert & Carpenter, 2011). There is an additional need to support transcultural nursing skills for the acute-care bedside nurse (Leininger, 1998). This study looked specifically at the bedside nurses' experiences when caring for the LEP patient and family. The bedside nurses' perceptions are valuable data from the insider's view of the lived experiences caring for LEP patients and families. The phenomenology research approach gives the professional bedside nurse in acute care a voice to describe the lived experiences of caring for LEP patients and families.

Experiential Context

The researcher's interest in the lived experience of bedside nurses caring for LEP patients and families is rooted in her own experiences. Over 5 years of transcultural nursing in foreign countries has yielded a sense of cultural humility and an expanded world view. Upon returning to the United States, the researcher experienced her own caring for LEP patients and families as a bedside nurse in maternal child settings. With a newly developed passion to be an advocate for patients with language barriers, the researcher became more aware of the LEP patients' needs when hospitalized both during the acute and discharged phases of care. These experiences led to the research interest in the needs of LEP patients and families in acute care.

Unexpectedly, in 2008, the researcher experienced being a mother of premature twins who received critical care in the Neonatal Intensive Care Unit (NICU). Over 12 weeks' time, the researcher came to understand the intense need for daily information regarding the status and plans for her twins. The researcher also observed that the Hispanic LEP mothers in the NICU did not receive as much interaction from the hospital staff and, although available, telephonic interpreter services were not used to communicate with these mothers.

Initially, the researcher's focus was an interventional study involving a variety of educational sessions for individual hospital units using a quantitative method. The interventional study was designed to increase the use of telephonic language interpreter usage for LEP patients and families. When investigating which interventions to design for the units in question, it became clear that the nurses' perspectives and experiences of

caring for this population had not yet been explored. The researcher began questioning whether interventions could be designed before hearing from the voices of nurses who actually do the work of caring for LEP patients and families. The obvious conclusion was to design a research study to hear directly from the bedside nurses to share what it is like to care for the LEP patient and families. It is possible that once these stories are heard, additional research can be designed to assist the nurses with care for those who experience language barriers in acute care.

Chapter Summary

This chapter presented a review of the literature regarding the historical context, safety, and quality of the growing need for language access for the LEP patient and family. A description of the research method selection and the study's relevance to nursing was discussed with concluding remarks regarding the researcher's experiential context and interest in the research topic.

CHAPTER III

METHOD OF INQUIRY: GENERAL

The research question, "What are the lived experiences of acute-care bedside registered nurses when working with patients and families with LEP?" required a qualitative inquiry to obtain the depth and richness of data from the insider's view of the phenomenon under study. A qualitative study is the best approach to engage in a dialogue with acute-care bedside nurses who are experientially knowledgeable about the topic and can provide a voice to their experiences. To study the lived experiences of the acute-care bedside nurse, the most suitable qualitative methodology is phenomenology. Phenomenology describes phenomena, or the appearance of things, as lived experience. Phenomenology is both a philosophy and a method (Streubert & Carpenter, 2011).

Phenomenology as Philosophy

Describing the patterns of human thought and behavior has been a quest of human scientists throughout history. Descartes' view of science was grounded in objective reality, supporting the notion that cause and effect explains all things. Kant questioned this view, proposing that one's perception is more than what is observed and, therefore, not all reality is explainable by cause and effect (Streubert & Carpenter, 2011). Phenomenology grew out of a criticism of the positivist world view which excluded human experience because "experience was neither observable nor quantifiable" (Scannell-Desch, 1992, p. 36). Dowling (2007) describes the initial presentation of phenomenology in pre-World War I in Germany. This philosophy challenged views of the day on the nature and origin of truth (Dowling, 2007, p. 132). Husserl became one of

the founding fathers of this philosophy believing the basic source of knowledge is derived from experience. Husserl described the aim of phenomenology as the rigorous, pure, and unbiased study of things, as they appear in order to arrive at an essential understanding of the human experience (Valle, King, & Halling, 1989). Dreyfus describes phenomenology as a philosophical movement dedicated to describing the structures of experience as they present themselves to consciousness, without recourse to theory, deduction, or assumptions from other disciplines such as the natural sciences" (as cited in Munhall, 2007, p. 114). "Phenomenology provides researchers with the framework for discovering what it is like to live an experience." (Streubert & Carpenter, 2011, p. 23).

Van Manen stated, "Phenomenology is the study of the lifeworld – the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize or reflect on it" (Van Manen, 1990, p. 9). Since people are tied to their worlds, it is only possible to understand them through this context. According to Van Manen, human behavior occurs in the context of four existentials (Van Manen, 1990, p. 101). These four existentials guided reflection throughout the research process. *Lived space* refers to that which is perceived in everyday life. This space may influence how people think or feel. The perceptions of space may have different meanings such as a church, home, airplane, or ocean. *Lived body* is the bodily world that represents one's personal landscape. Through our physical body, we reveal or conceal ourselves consciously or deliberately. For example, one might physically show romantic interest in another or conceal an undesirable physical feature of the body. *Lived time* is the human's perception of time.

Time may be experienced from the past or future and thought of as fast, slow, spent, saved, etc. *Lived human relation* refers to the relations humans share with others within interpersonal space. While we approach one another physically in our bodies, we form impressions, learn about each other, and even adapt how we interact with the other, such as how one would address a movie star versus an infant.

Van Manen's four existentials provide the context in which the study took place. A specific effort to consider the four lifeworlds was required throughout the study (Van Manen, 1990). It is the four life worlds through which the view of the lived experiences of acute-care bedside nurses caring for LEP patients and families were interpreted. This philosophical perspective and context gave direction to the study (Munhall & Chenail, 2008).

Phenomenology as Method

The goal of phenomenology is to describe lived experience. Experience is an individual's perceptions of his or her presence in the world at the moment when things, truths, or values are constituted (Van Manen, 1990). As a research method, phenomenology is a "…rigorous, critical, systematic investigation of phenomena (Streubert & Carpenter, 2011, p. 78). Descriptive phenomenology is a method which involves, "…direct exploration, analysis, and description of particular phenomena, as free as possible from unexamined presuppositions, aiming at maximum intuitive presentation" (Spiegelberg, 1975, p. 57). A student of Husserl, Heidegger became interested in the study of hermeneutics, or interpretive phenomenology (Rogers, 2005). Heidegger was primarily interested in answering the question: 'What is being?' (Polit & Beck, 2008).

Phenomenological questioning, reflection, and writing were methods developed by the French philosopher, Merleau-Ponty (Dowling, 2007). The interpretive phenomenology method seeks to discover relationships and meanings from the research data (Munhall, 2007). Canadian phenomenologist Max van Manen's phenomenological method embraces the written description and interpretation of the meaning of the phenomenon (Polit & Beck, 2008). Max van Manen is credited with the contemporary approach of researching the lived experience as a combination of descriptive and interpretive phenomenology (Dowling, 2007).

Van Manen's Phenomenological Method

Hermeneutic phenomenology applies descriptive and interpretative aspects of the meaning of the lived experience. This method involves the process of writing a description of the phenomenon from which the researcher makes interpretations of the meaning of the lived experience (Creswell, 2005). Hermeneutic phenomenology is a valuable method of study for phenomena relevant to nursing education, research, and practice (Speziale & Carpenter, 2007, p. 91). This method of hermeneutic phenomenology is described by van Manen (1990) as a systematic approach to study, describe, and interpret the everyday lived experience. This study used van Manen's hermeneutic phenomenological approach to discover the lived experiences of acute-care bedside nurses caring for LEP patients and families.

The six research activities of hermeneutic phenomenology (van Manen, 1990) served as a guide for this study. The following activities are not necessarily sequential as the steps may occur in any order or, even, simultaneously (van Manen, 1990).

The first phenomenological activity is described by van Manen (1990) as the decision to study a phenomenon of serious interest to the researcher and commit to examining that experience. The researcher's interest in understanding the variables and potential obstacles for acute-care bedside nurses when caring for LEP patients and their families was a result of five years' experience in transcultural nursing. A gap in the literature exists to understand the bedside nurse's experiences when caring for LEP patients and families in acute-care settings. The goal of this research was to seek a deep understanding of the meaning and significance of the bedside nurse's lived experience when caring for LEP patients and families. This research contributes to the understanding of the nurse's views and meanings of providing care for the LEP patient and families.

The second phenomenological activity involved the researcher in thoroughly exploring and investigating all components of the experience as it is lived by the participant, not as conceptualized by the researcher (van Manen, 1990). Through observation, guided interviewing, and reflective listening, the researcher became part of the participant's world with the intention of obtaining a deeper understanding of the experience. In the third phenomenological activity, the researcher reflected on essential themes of the true reflections on lived experiences with sincere thoughts of what gives the experiences special significance (van Manen, 1990). The fourth phenomenological activity is the art of writing and rewriting, which provided the researcher the ability to describe the phenomenon through writing (van Manen, 1990).

The fifth phenomenological activity is maintaining a strong and oriented relationship to the phenomenon (van Manen, 1990). This researcher became immersed in the interviews, descriptions, and meanings of participant reports in an effort to understand the experiences. The sixth, and final, phenomenological activity is to balance the research context by considering the parts and the whole (van Manen, 1990). In this activity, the researcher was mindful of the effects of the research on the researcher, the facility in which the research was conducted, and the participants. The significance of the individual interviews contributed to the whole of the study. It was important that the researcher remained focused on the overall goal of seeking a deeper meaning of the lived experiences of acute-care bedside nurses caring for LEP patients and families.

Methodology and Rationale

Spezial and Carpenter (2007) describe the lived experience as that which presents the individual's reality or perception of truth. It is this emic, or insider, view (Leininger, 1997) that reveals the deep meaning of experiences. This approach has been useful to nurse researchers as phenomenology is both a philosophy of being and a practice (Munhall, 2001, p. 125). Because the research question was about the experience of being the bedside nurse while caring for LEP patients and families, van Manen's method was appropriate. An unstructured interview design was utilized using open-ended questions to generate the data.

The facility agreement to conduct the study was obtained however, this agreement is not in this document so as to maintain confidentiality of the facility identity. After receiving Institutional Review Board approvals from the University of Nevada, Las

Vegas (UNLV) and the research hospital, participant recruitment occurred through researcher presentations at nurse staff meetings, flyers (see Appendix A) and electronic mail invitations. A summary was provided to the participants explaining the purpose, procedure, and time frames of the study. A date, time, and location for the first interviews were set in the initial telephone contact. During the first interviews, written informed consents were obtained (see Appendix B). Confidentiality was maintained at all times.

Demographic data were collected at the beginning of the first interview (see Appendix C). Digitally recorded individual interviews of approximately 30-60 minutes were transcribed verbatim using participant-selected alias names. Open-ended questions regarding the nurses' experiences in caring for LEP patients and their families guided the interview. Once transcribed, interviews were completed; a second interview appointment was made for participant checking (Polit & Beck, 2008). During the second interview, the participants read their transcribed interview for accuracy. Second interviews were 30 to 60 minutes in length. Corrections were received and the participants signed confirmation of accuracy forms (see Appendix C). Once the signed confirmations were obtained, thank you notes for participation were mailed and data analysis began using van Manen's phenomenological analysis approach (Van Manen, 1990).

Research Plan

A convenience purposive sample (Polit & Beck, 2008) of participants was selected. The goal of the sample size in a qualitative study is to reach saturation of information. The sample size is determined by the narrow focus of the purpose of the

study, while obtaining deep and meaningful information (Burns & Grove, 2009). Data collection continued until data saturation of the phenomenon was obtained.

Data Generation

The unstructured interview is the preferred technique for a study designed with the phenomenological method. The unstructured interview uses one or more open-ended questions to guide the conversation while providing participants with the opportunity to fully describe their experiences without expecting a defined response. The face-to-face interview allowed the researcher the ability to take field notes to describe nonverbal communication, tone, and other contextual observations that would not be captured by voice recordings, alone. These notes provided validation for important points during data analysis to facilitate appropriate emphasis on emerging themes. Interviews ended when participants believed they had exhausted their descriptions (Streubert & Carpenter, 2011). Data generation/collection continued until repetition of the descriptions, or saturation, was achieved.

Analysis Procedures

Phenomenological description involves classifying the phenomena by assigning themes after careful analyses. In order to implement van Manen's phenomenological method, analyses of the data was guided by the six steps as outlined.

Methodological Rigor: Trustworthiness of the Data

The goal of rigor in qualitative research is to accurately represent the study participants' experiences. Speziale and Carpenter (2007) described methodological rigor,

or trustworthiness, as addressing four issues: credibility, dependability, confirmability, and transferability.

Credibility. This term refers to activities that will produce accurate findings. The research findings must reflect the truth of the data and researcher's interpretations. Credibility was addressed by asking the study participants to validate report findings as a representation of their experiences (Speziale & Carpenter, 2007). Returning to the participants to check for transcription accuracy is referred to as participant checking (Creswell, 2005). By validating transcripts with the participants, the researcher was able to accurately describe the essence of the phenomena. Another method to address credibility of the findings is peer review debriefing. Peer debriefing allows peers to review various aspects of the study (Polit & Beck, 2008). The researcher requested members of the dissertation research committee to provide expertise, objectivity, and critical assessments. In addition, the researcher achieved credibility through prolonged engagement with the participants. Devoting sufficient time to collecting the data and understanding participant views are essential skills to facilitate building trust. By learning and understanding the culture of the people involved in the phenomena, it becomes more likely that accurate information will be obtained (Polit & Beck, 2008). The researcher worked at the research site facility for over 30 years, maintaining relationships and professional support.

Dependability and confirmability. Dependability refers to "evidence that is consistent and stable" over time and conditions (Polit & Beck, 2008, p. 36). Confirmability is the degree to which the study results are from the participant

descriptions and without researcher bias (Polit & Beck, 2008). Dependability and confirmability of the data analysis process was established by providing data as requested to the dissertation committee chairpersons and the qualitative research expert serving on the researcher's dissertation committee. This included, but was not limited to, interview audio tapes, audio tape transcriptions, the researcher's reflective journal (with evidence of bracketing), and the written audit trail with a coding scheme to show the location of supportive data for each theme. The audit trail established trustworthiness of the data by providing clear connections from the raw data to interpreted meanings with detailed examples (Streubert & Carpenter, 2011).

Transferability. This goal refers to the probability that the study findings have meaning to others in similar situations (Speziale & Carpenter, 2007). In general, qualitative researchers do not suggest their findings are generalizable. However, Guba (cited in Polit & Beck, 2008) describes qualitative researchers as often seeking understandings that might be useful in other situations. Transferability is established by providing thorough and thick descriptions of the research setting, observations, and participant expressions so that, when read by another researcher, they can provide information about the phenomenon with possible applications to other contexts (Streubert & Carpenter, 2011). Polit and Beck (2008) noted, "If there is to be transferability, the burden of proof rests with the investigator to provide sufficient information to permit judgments about contextual similarity" (p. 436).

In addition to the four major criteria to establish trustworthiness, other concepts of methodological rigor were addressed. Before beginning a qualitative study, the

researcher must be clear on her thoughts, suppositions, and personal biases on the topic. By doing so, the researcher is in a better position to approach the study honestly and openly. The process of journaling what one believes before and during the study gave the student researcher a frame of reference to differentiate potential perceptions and bias that may exist (Streubert & Carpenter, 2011). Phenomenological reduction was designed by Husserl to restrain the subjective perspectives of the researcher by asking the researcher to bracket (or bridal) and restrain one's presuppositions and perceptions to reduce one's view to the pure phenomena (Dowling, 2007).

Reflexivity is described as intentional or unintentional influence the researcher exerts. This is especially important when the researcher personally knows the participant(s). It stands to reason that the researcher holds views and values, which may influence objectivity of a study (Jootun, McGhee, & Marland, 2009). The researcher's views and values relate to this problem of providing care for LEP patients and their families with passion and bias. Having worked in non-English-speaking transcultural settings, the frustration and anguish of trying to communicate when not able to speak the local language is well known to the researcher. The researcher formed values based on opinions related to these experiences. The researcher experienced a heightened awareness for the need for effective communication with LEP patients and their families in the acute-care setting at the bedside nursing level of care. Additional views, values, and biases may exist based on these experiences.

Bracketing is the conscious process of putting aside one's own beliefs, not making judgments about what one has observed or heard, and remaining open to data as

they are revealed. Setting aside one's own thoughts means to be constantly aware of what one believes and trying to keep this separate from what is being shared by the informant (Streubert & Carpenter, 2011). Every effort was made to explore and bracket, or restrain, researcher bias and/or influence during the study (Polit & Beck, 2008). The researcher engaged in reflective journaling during all phases of the study to identify concerns and provide transparency (Speziale & Carpenter, 2007).

Chapter Summary

This chapter discussed the historical background of phenomenology. Phenomenology as both philosophy and method were discussed. Van Manen's hermeneutic phenomenological method was described, providing both descriptive and interpretive meanings of the phenomenon. Van Manen's four existentials and six phenomenological activities were defined. The research methodology and rationale are described. The participant sample, data generation, and analysis procedures were outlined. Issues of trustworthiness were defined and addressed to support methodological rigor.

CHAPTER IV

METHOD OF INQUIRY: APPLIED

Sample and Setting

Purposive sampling was used to recruit the participants needed for the study. The study population (Trochim, 2001) was registered nurses who provide bedside care in a 380-bed acute-care hospital in Nevada. Since the aim of the study was to understand the phenomena, the participants were selected for the purpose of describing an experience in which they have participated. The inclusion criteria for this research were registered nurses currently employed and actively working in a bedside nursing role who voluntarily agreed to participate in the study. A minimum of 3 years acute-care experience was required based on Benner's (2001) description of nursing competence at this level and to assure the nurse's exposure to patients and families of limited English proficiency. Participants were selected for the potential to develop a rich or dense description of the experiences of caring for LEP patients and families. Exclusion criteria were non-nurse personnel, nurses who do not work in direct caregiver roles in the acute-care setting, and nurses with less than 3 years of acute-care experience.

No predetermined number of participants was established for the study. A representation of each acute-care unit within three divisions was desired. Participant sampling continued until a repetition of discovered information and confirmation of previously collected data, or saturation, was achieved (Glesne, 2006). A total of 45 registered nurses contacted the researcher, and 40 participated in the study. Five of the

registered nurses agreed to participate in the study but either did not return telephone messages or did not arrive at agreed upon meetings for the interviews.

Corporate Context

The research site facility employs over 1,000 registered nurses in acute care. Each registered nurse received training on the policy and procedure for the hospital's language access tools upon initial hire and annually. The Language Access for Limited English Proficiency policy requires identification of LEP patients and family upon access to hospital services, identifying the LEP person's preference of language in verbal and written forms of communication, and using a qualified medical interpreter over 18 years of age. The policy discourages the LEP person's use of a lay person as interpreter but allows the patient to provide written consent if the patient insists. The only access to qualified medical interpreters in the research site hospital is a contracted telephonic interpreter system. Historically, the hospital did allow bilingual staff members opportunities to train and test to become qualified as medical interpreters while on duty. This was unsuccessful, however, as the leadership found unit 'A' asked the qualified medical staff interpreter to come to unit 'B' to provide interpreter services. The home unit, "A," was without their staff member during the interpretation time, causing lost productivity and strained relations. The hospital found that the benefit of training and qualifying bilingual staff members as interpreters did not outweigh the financial cost of training and lost productivity. Consequently, this practice was discontinued in 2009.

The facility's Language Access policy states the nurse is to contact the contracted telephonic interpreter company for all medical and legal interpreter services. The current

policy does allow a patient to provide consent for a self-selected lay interpreter if desired. To ensure accuracy of a patient-consented lay person's interpreter services, the nurse may place the interpreter telephone on speaker mode for the qualified medical interpreter to listen and to provide corrections as needed (L. Pistone, personal communication, February 5, 2013). The contracted interpreter services telephone is identified as *the blue phone* by most staff members and has two hand sets, one for each party. The contracted interpreter company provides over 170 languages. A projected LEP inpatient population of approximately 22% is based on service area zip code demographic data. The current use of interpreter services from the contracted company varies in hospital departments from 8-12% (Cyracom, 2011; H. Lane, personal communication, February 3, 2013). Hence, the qualified medical interpreter service in this hospital setting was grossly under-utilized.

Gaining Access

The researcher gained access to the participants through existing means available at the research hospital site. Advertising and recruitment of participants included communicating through flyers (see Appendix A) in nurse break rooms and presentations in nurse staff meetings. Invitations for participation were sent via the all-hospital electronic information newsletter with the researcher's contact information. The researcher allowed each participant to select dates, times, and locations of convenience for the interview meeting. Each participant had an individual date and time so that no participant knew of the others' interviews. Comfort, privacy, and confidentiality were maintained.

Ethical Considerations

All human subjects' rights were maintained during the length of the study. Prior to data collection, approval for implementation of this study was obtained through the Institutional Review Board at UNLV and the research setting hospital Institutional Review Board. Participation in the survey was voluntary. Prior to the interviews, informed consent regarding the purpose of the study, confidentiality, participant expectations, and the voluntary interview process was obtained in writing (see Appendix B).

Participant identification remained anonymous with fictitious names assigned to all interview transcripts. A master list identifying the nurses with their fictitious names was kept on the researcher's private password protected computer, and a hard copy was locked in a file cabinet. Upon completion of the data analysis, the lists were destroyed. The identity of the participants was known only by the researcher. Any information the participants provided will not be publicly reported in a manner that identifies them and will not be made accessible to others. There is no medical or health-related information shared that identifies a patient of family. All data were transcribed by the researcher and all personal identifying information was excluded from the transcription, data analysis, and research findings. All transcribed data was stored on the researcher's private password computer in a Microsoft Word program. Only the researcher and research dissertation committee members have access to the audio tapes of interviews and transcriptions. The audio tape data, written transcripts, researcher's reflective journal, and audit trail will be kept in a locked cabinet in the Principal Investigator's (PI) office

on the UNLV campus for a period of 3 years following the study's completion at which time all will be destroyed.

The participants of this study were subjected to no known risks. None of the participants had a reporting relationship to the researcher, which minimized the risk of coercion (Polit & Beck, 2004). The research experience may have had an effect on participants based on whether the descriptions of lived experiences portray negative or positive perceptions. The interviews lasted approximately 30-60 minutes for each of two interviews totaling up to 120 minutes. Possible perceived benefits to the participant included the satisfaction of participating in the process for identifying the acute-care bedside nurses' meaning of caring for LEP patients and/or contributing to the body of knowledge in nursing science. The participants did not receive remuneration for their time.

Data Generation and Analysis

Before beginning participant interviews, the researcher had to be open to her influence on the researcher's role in the inquiry. It is the researcher's responsibility to examine the influence on all aspects of the study through the process of *self-reflection.* Streubert and Carpenter (2011) suggested a growing body of information is developing regarding the therapeutic nature of qualitative interviews for the research participants as the value of being heard can be empowering. However, other participants may only choose to disclose what they think is socially or professionally acceptable. Unstructured, open-ended interviews provided participants with the opportunity to describe fully their experiences. Data collection was conducted by the researcher under the guidance of the

initial committee chair. The interview places and times were the most comfortable and convenient for the participants. The more comfortable participants were, the more likely they would share their experiences (Streubert & Carpenter, 2011).

The following summary (Glesne, 2006) was prepared for verbal description and read to each participant during initial telephone contact:

> I am currently conducting a research study through UNLV and have chosen the topic of the acute-care bedside nurse's lived experience working with limited English proficient patients and families. The research involves conducting a 30-60 minute interview, which will be recorded for accuracy in transcribing your thoughts. This will allow me to offer full attention to your descriptions without the distraction of taking detailed notes. A fictitious name will be assigned to your transcript. A second meeting of approximately 30-60 minutes will allow you to read the completed transcript, check for accuracy, and make amendments or additions if desired. The interviews will only be heard by me and are completely voluntary and confidential. It is important for you to know that your shared experiences are valuable and are not right or wrong. I am interested in your lived experiences and feelings when working with these patients and families. I am asking you to participate because I believe your experiences may be of interest for this research. You may cancel or stop the interview at any time without any consequence or judgment from me. Thank you for your consideration.

After receiving verbal consent, mutually agreeable dates, times, and locations for the interviews were determined. The researcher confirmed meetings by telephone the day before each appointment. The researcher arrived 15 minutes early to prepare for and greet the participant. Expressions of gratitude and appreciation were offered followed by a review of the purpose, topic, and process of the informed consent. Written and signed consent was obtained (see Appendix B). A demographic collection tool was completed by the participant (see Appendix C). The interview was conducted followed by expressed thanks from the researcher. A final assurance of confidentiality was provided and a second interview date, time, and location determined.

Data were generated through digitally recorded interviews, which were transcribed with a fictitious name assigned for each participant. During the second interview, the participant read the written transcript with opportunity to confirm accuracy or amend the transcript.

The purpose of the interview was to elicit the participant's story. The researcher's role was to be an active listener, allowing the participant to tell his or her story without interruption (Richards & Morse, 2007). Since the researcher is also an experienced acute-care bedside nurse, an unstructured open-ended interview method was selected (Speziale & Carpenter, 2007). This method allowed the participants to describe their experiences with as unstructured a process as possible.

Open-ended interview questions included:

1. Think back to a recent working day when you cared for a LEP patient and/or family. Tell me about your experiences.
2. When you arrive in the morning and see your assignment, which includes a LEP patient, what are your thoughts or feelings?
3. What are your experiences in providing care for this patient/family that are different from your experiences with English-proficient patients/families?
4. What benefits have you experienced when providing care for this patient/family that is different from English proficient patients/families?
5. What aspects of providing care are different for the LEP patient/family than English proficient patients/families?
6. What are your experiences when communicating with these patients/families?

7. How do your experiences differ when caring for LEP patients/families as compared to English proficient patients/families?

A commitment to the participants' subjective and experiential viewpoints supported the use of unstructured interviews. The aim of the study was to discover the emic or insider's view of the experiences when caring for LEP patients and families. Interviews were transcribed verbatim and reviewed by the participants for participant checking accuracy and trustworthiness, and analyzed using van Manen's six steps (Polit & Beck, 2008). Transcribed interviews were coded based on expressions of experiences (see Appendix E). As analysis followed data collection, ongoing analysis after each interview was conducted. Analysis of qualitative research involves a hands-on process. The researcher was deeply immersed in the data, dwelling on the transcriptions in a back and forth process of reading, analyzing, synthesizing, and discovering the themes which gave meaning to the phenomena (Basit, 2003). This cyclic nature of questioning and verifying was critical to the data collection and analysis. Similar data were clustered as structural units of meaning. From these clusters of meaning, emergent themes were constructed. A *theme* is defined as "an abstract entity that brings meaning identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (DeSantis & Ugarriza, 2000, p. 355). Once all themes relevant to this study were explicated, they were analyzed through the lens of van Manen's four existentials (see Appendix F). To relate themes and subthemes from participants to one another, statements from participants were grouped by topic in similar categories for continued analysis (see

Appendix G) (Streubert & Carpenter, 2011). The generation of rich descriptions provided the deeper essential meanings underlying the nurse experiences. Through these rich descriptions we come to know the experiences of others (Glesne, 2006). A description of the steps of data analysis was logged to provide a trail of the researcher's activities. An analysis table describing themes and subthemes from the data was prepared (see Appendix H). From this table, the over-arching essence was determined.

Chapter Summary

This chapter provided a description of the study population, research setting, recruitment of participants, and ethical considerations. A description of data generation and analysis were provided.

CHAPTER V

FINDINGS

The purpose of this study was to explore the experiences of acute-care registered nurses working with limited English proficient patients and families when providing bedside care. The primary research question used to guide this study was: What are the lived experiences of acute-care bedside nurses working with LEP patients and families? This chapter illustrates the meaning of the acute-care bedside nurse's experiences through an introduction to the participants, a detailed description of the data collection and analysis processes, and presentation of the overall essence, themes, and subthemes.

Description of the Participants

A total of 40 registered nurses participated in this study. Thirty-nine of the participants were female and one was male. The age of participants ranged from 25 to 62 years, ($\overline{x}$ = 43.15 years; median = 43 years). The number of years working as a registered nurse in acute care ranged from 3 to 34 years ($\overline{x}$ = 13.05 years; median = 10 years). The number of years working at the research site facility ranged from 3 to 34 years ($\overline{x}$ = 10.56 years; median = 8 years). Non-Hispanic participants comprised 95%, and Hispanic participants were 5%. The number of White participants was 80%, Asian 12.5%, and more than one race 5%. The participants who self-reported their primary language as English were 87.5% with 5% speaking Tagalog, 2.5% speaking Cebuano, 2.5% Chinese, and 2.5% speaking Korean (see Table 1).

Table 1

Demographic Summary of Participants

Characteristic	Range	Mean	Median	%
Age	25-62	43.15	43	
Years as RN	3-34	13.05	10	
Years at site	3-34	10.56	8	
Ethnicity				
Non-Hispanic				95%
Hispanic				5%
Race				
White				80%
Asian				12.5%
> 1 race				5%
Language				
English				87.5%
Tagalog				5%
Cebuano				2.5%
Chinese				2.5%
Korean				2.5%

Recruitment of the desired representation of registered nurses who work in each acute-care division was achieved. The critical care division includes Cardiac Care Unit (CCU), Telemetry (Tele), and Nephrology/Telemetry II (Neph) in which cardiac monitored patients receive a high acuity of care. The medical/surgical division includes Medical (Med), Oncology (Onc) and Surgical (Surg) units in which non-monitored, less acute patients receive care. The maternal/child division includes Mother/Baby (MBU), Pediatric (PED), Labor and Delivery (L&D), and Neonatal Intensive Care (NICU) units.

These divisions were selected because nurses are cross-trained to float within divisions outlining general patient populations. Table 2 presents the number of participants in this study who worked in the units/divisions described.

Table 2

Number of Study Participants by Hospital Unit and Division

Division	Critical care			Medical/surgical			Maternal/child			
Unit	CCU	Tele	Neph	Med	Onc	Surg	MBU	PED	L&D	NICU
Participants	4	3	4	4	4	4	5	4	4	4
Total		11			12			17		

The number of participants was an adequate sample size to achieve data saturation for overall representation with 40 acute-care registered nurses who participated in the study and division representation, (11 critical care nurses; 12 medical/surgical care nurses; and 17 maternal/child nurses) from the research site hospital. Participant recruitment ceased once saturation of the data were obtained.

Data Collection

All data collection was conducted by the student researcher under the guidance of the initial committee chair. The participant interviews were conducted over a 4-month period. Each interview was determined to be at a date, time, and setting for the convenience and comfort of the participant. Prior to each interview, the researcher met face to face with the participants at the research site hospital to answer questions about the study and obtain written consent. The participants were reminded that the study was

voluntary and that they could withdraw from the study at any time without consequence. The consent forms were signed and copies were given to the setting respective participants for their reference. During this meeting and after consent was signed, the demographic form was completed by the participants. A component of the demographic form allowed the participant to self-select an alias for the purpose of the study (see Appendix C).

The interview settings included a private office located in the research site hospital, public café, or by telephone. Each initial interview lasted between 30-60 minutes. The researcher took care before each meeting to exercise reflection of any bias and/or opinions that may interfere with receiving the realities of the participant experiences of caring for LEP patients and families. An initial greeting and social dialogue was followed by a review of the study purpose and appreciation for participation. The participant completed the demographic form (see Appendix C). A list of potential interview questions was provided to the participant to have an opportunity to think about the topics. When the participant indicated he/she was ready, the interview began. Interviews were audio-recorded using a digital recorder. A sincere effort was made to maintain a nonjudgmental response to participant accounts by conveying interest in words and body language. Once the initial interview was completed, a follow-up date, time, and location was determined for participant checking for the accuracy of the transcribed interview, as a means of enhancing credibility.

During the second meeting, participants were invited to offer any additional thoughts or feelings regarding their experiences in working with LEP patients and their

families. After the second meeting in which the participant could confirm accuracy or amend any portion of the transcript, a handwritten thank you note was given for their generous participation. Of the 40 participants, two nurses provided additional information which was recorded and transcribed, and a third meeting arranged for final participant checking. Confidentiality of the data and privacy of participants were protected and maintained.

Data Analysis

The recorded interviews were transcribed verbatim using a Microsoft Word format. Once participant checking was confirmed, data analysis was accomplished using van Manen's (1990) six-step phenomenological method. Data analysis began simultaneously with listening and observing during the interviews, followed by transcribing the interviews. Bracketing was maintained with the student researcher's reflective journaling activities, ensuring the interviewer did not consciously influence the participant replies. When participant checking was completed, the process of reading and rereading the verbatim transcripts, while the recordings were replayed, facilitated an immersion in the data which gave a context of *how* the participant was saying *what*. Each transcript was coded for significant meaningful units, or clusters, and van Manen's (1990) four life world existentials: lived space, lived body, lived time, and lived human relation (see Appendix E). The transcriptions were reviewed for emerging clusters of meaning using the selective or highlighting approach as described by van Manen (1990). With this approach, the text was read several times looking for specific statements that revealed something about the experiences. The highlighted statements were examined to

capture their meaning as clearly as possible into clusters. These clusters of meaning were categorized into subthemes. The highlighted subtheme statements were organized by subject into a master table (see Appendix F). Once the 115-page master table was completed with contribution from all 40 participant transcripts, a crosswalk table was designed to identify saturation of the data in relation to participants from each unit and division (see Appendix H). From the results of the crosswalk table, four major themes and an overall essence of the data were determined. Sample data were given to the initial PI and the doctoral research committee qualitative method expert for inter-rater coding, theme extraction, and essence reliability. Confirmations of final results were agreed upon by the student researcher, initial committee chair, and doctoral research committee expert. This collaborative process was necessary to ensure the interpretations were reflective of the participants' lived experiences. Each theme was written, examined, and rewritten for descriptions of the experiences in a manner which gave meaningful significance. Consent forms, digital recordings, transcriptions, coding, audit trail, and reflexive journal writings were available to each doctoral committee member upon request.

Essence, Themes, and Subthemes

The researcher identified four main themes that reflect the acute-care nurses' experiences when caring for limited English proficient patients and their families. The themes were: *desire to communicate*, *desire to connect*, *desire to provide care*, and *desire to provide cultural respect and understanding*. These main themes, along with their respective subthemes, led to interpreting the thematic essence or meaning of the

experiences initially as the desire to meet patient and family needs (see Figure 1). This overarching desire was described as concern, advocacy, effort, and wanting to care for or do for their patients and families with limited English proficiency. This common thread of the nurses' experiences is more specifically described in the desire to communicate, connect, care, and to seek cultural respect and understanding.

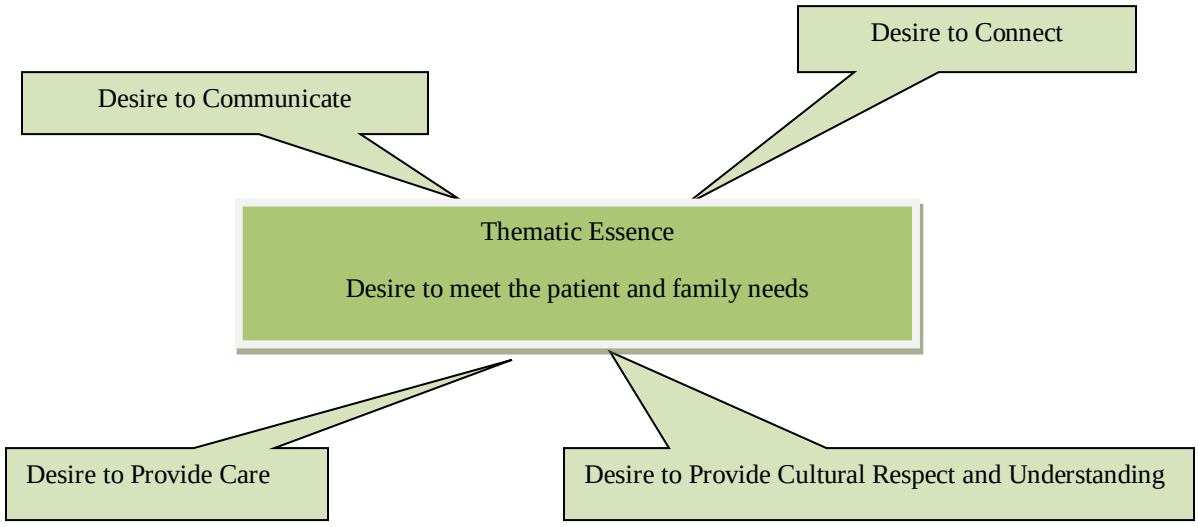

Figure 1. Initial thematic essence and themes of acute-care nurses' experiences caring for LEP patients and families.

Each theme is composed of subthemes as illustrated in Table 3. The desire to communicate was conveyed by statements regarding the use of verbal communication, such as Interpreter phones, while describing face-to-face communication as the best method. Nonverbal communication was a frequently mentioned tool used to meet the

desire to communicate. The desire to connect with the patient and/or family was expressed in terms of taking more time, needing more time, not being able to build as deep of a nurse-patient relationship, the desire to build trust, and missing out on the normal, everyday social chit-chat. The desire to provide care included meeting physical needs such as addressing pain or providing comfort, emotional needs by expressing empathy and advocacy, and concerns regarding the desire to provide education or increased safety and legal issues when a language barrier exists. Lastly, the desire to provide cultural respect and understanding was relayed in terms of wanting to know more about cultural competencies, wanting to observe cultural practices, and wanting to know how to support the patient and family needs in terms of family size and cultural awareness.

Table 3

Essence, Themes and Subthemes of Acute-Care Nurses' Experiences Caring for LEP Patients and Families

Essence: Desire to Meet the Patient and Family Needs			
Desire to Communicate	Desire to Connect	Desire to Provide Care	Desire to Provide Cultural Respect/Understanding
Verbal: Interpreter Phones Face to Face is Best Non-Verbal	Time Management Trust/Relationships/Chit Chat	Physical Comfort/Pain Education/Safety Emotional/Advocacy	Family Size Awareness/Benefits/Want More Education

Theme: Desire to Communicate

The first main theme was easily identified throughout the nurses' stories. The interviews began with the researcher asking the participants to think back on a day when he/she cared for a LEP patient and to describe that experience. Consistently, the participants shared experiences of trying to communicate in either verbal or nonverbal attempts.

Subtheme: Verbal using interpreter phones. This subtheme emerged quickly since this is the method most often used for language access communication by policy and practice in this facility. The majority of participants shared positive comments regarding the use of interpreter phones such as,

> The times I've used the interpreter phones was for Mandarin Chinese, which you know there's like not way in heck I could have done anything with that, and one was Hindu. And I was amazed at how well it works. It really isn't that frightening once you sit down and you call. (Susan, Med)

> I think that they're wonderful because then I can be confident that the patient was told exactly in the terms that I have described and been able to answer – ask questions back. (Rachael, Tele)

> We have interpretive service available to us 24/7 which is nice, especially now that we have the three way phone conversations. It allows us to watch the patient's response as we go through each point with them. We can see what they're getting hooked up on or what they do understand. I really like it because we can get the interpreters on, the company finds one that speaks the dialect that the patient speaks 'cause, for a long time we didn't recognize there was a huge dialect difference. And they have been wonderful about getting the right dialect and then they assign one personal interpreter if they can to that patient. So when I call back, I tell them I want this person's interpreter and they try to get ahold of that interpreter so there's also that bond of the familiar voice. (Karen, NICU)

Other participants shared mixed reviews of positive and negative experiences when using the interpreter phones,

> The phones work fabulously, it's just cumbersome – it's, you know, hard to hold the phone and find the phone and I think it's intimidating to patients to talk to a stranger on the phone about these personal issues too that they're not really sure that they're speaking to somebody on the phone. And then I think the husband then becomes uncomfortable because he wants to be in charge and so I'm speaking on the phone, the patient is speaking on the phone to this interpreter then the husband can't hear what they are saying so then he feels kind of left out of the loop. Once we do it a few times they get used to it and I do feel like it is the most effective in getting our point across as medical personnel – knowing that the information has been given correctly. (Rebecca, L&D)

> I think the one that sticks out in my mind the most is a lady that spoke Mandarin. I remember trying to use the blue phone because we had to go over vaccine information so I had to read off the entire vaccine information statement to her. And so we call on the blue phone and there is a lot of chaos in the room with the family and they're talking and trying to talk to her and I'm trying to talk to her, and I remember just having issues even understanding the translator on the blue phone because he had such a thick accent and so with everything else going on in the room it was a real struggle. And we were probably on the phone for an hour going over that vaccine information statement. We finally made it through to the end, but it was definitely a challenge. (Liz, MBU)

Subtheme: Face to face is best. While overall the telephonic interpreters were seen as helpful and necessary, the telephone was not seen as an equal substitute for an on-site interpreter who is physically present. This subtheme was also identified throughout all units as described by the following:

> It is easier to know that I am making sense with a physical interpreter because you get the extra added bonus of seeing their—you know the body language that is happening, you can see the facial expressions, you can see the interactions that are happening, you can see if they have that kind of quizzical look on their faces when they are talking about something and trying to process it. I mean, you get all of those cues back. (Kristi, Neph)

> I just feel like what is lacking right now is the convenience. I think people resist the blue phones because it is not as convenient as it could be. Sometimes, I think in the future maybe face-to-face would be the way to go. What's missing is face-to-face communication. Because communication is so visual and the interpreter is not there. So, I think in the future may be there will be video phones. (Heidi, MBU)

Subtheme: Nonverbal communication. For all of the hospital units, nonverbal communication was seen as an important component of assessment and expression of nursing care as described below,

> With my teaching, I use a lot of hand gestures. It is a different approach to a non-English-speaking individual because from the moment you walk into the room you can say hello and they may understand that, or a gesture, but from there, the English that is coming out of your mouth is not really doing the communication. So it is showing care in a nonverbal fashion. And I think that is a tool—a valuable tool as even if you speak English the nonverbal cues can really make or break a nurse-patient relationship. (Trent, Tele)

> Just recently, I had a Hispanic family that only spoke Spanish, and I actually did not have any problems taking care of them. I seemed to be able to pantomime and discuss what I needed and they had limited English to know some of the words that I was speaking, and I knew some of the things that they were saying. With my smiling and gestures, and with basic human kindness, it was an okay day, and they seemed to be very grateful for what I did. (Dawn, MBU)

> With communication there is the verbal and nonverbal always, whether there is a language barrier or not. So, I mean number one for me, I focus a lot on the nonverbal when I first come into a room and when I am first assessing the patient because that is first thing you do to make sure they are stable. I had a Mom come in last week and her Son had surgery. He was still asleep so I came in and she was sitting at the bedside crying. Just approaching her and simply rubbing her on the back a little bit kind of giving her the message that I am gonna take care of you too, and she started to smile. (Elaina, Peds)

Theme Summary

The first theme, "desire to communicate," revealed the very basic need between nurse and patient. The nurses shared their desire to understand their LEP patient and family's needs while wanting to communicate important information and nursing care, both verbally and non-verbally. Use of the telephone interpreter system was largely positive. The participants were in agreement that face-to-face communication is best.

Theme: Desire to Connect

The second theme emerged as participants shared challenges with their LEP patients, not being able to connect. This wanting, or desire, to connect was expressed largely as an experience that is different with LEP patients than English-speaking patients. The participants spoke of two subthemes within the context of a desire to connect: time management and building relationships.

Subtheme: Time management. In response to the question, "When you arrive at the beginning of your shift and you see your assignment includes a LEP patient, what are your thoughts or feelings?" Liz (MBU) replied,

> I think people making the assignments should take into account that these patients do require more time to properly care for them. So maybe some more thought going into if a patient is going home today that doesn't speak English we need to give you a lighter assignment to allow you the time that you are going to need to perform those duties. It is more time consuming and we try to do our best but you don't always understand the dynamics of the families. Sometimes it is more difficult to assess what is going on within the family, and it can be distracting because you are trying to communicate with the patient while the family is having side conversations in their own language.

Jane who works on the surgical floor shared,

> The first thing I think is, I need to manage my time for the day and how I need to prioritize. Depending on what is going on with that patient, I may choose to do their assessment, medications and education first. Or if they are content and medically stable, I may choose to do them last. The time that it takes to perform those duties in comparison to performing those on someone who is English-speaking is huge. However, I do make sure that the patient understands that they are not being ignored and I do check in with them to be sure their needs are met.

An LEP patient assignment may also impact other patients as Kayla from the Mother-Baby Unit explained,

> There is a lot more planning to do as you are trying to block out time, spend more time with that patient to make sure that you can use that blue phone and

> communicate with them. You really have to plan your shift much more. Sometimes it can be a lot more difficult for your other patients because when you do go into the LEP patient's room, you are in there for quite some time. You get the blue phone and make sure they get all of their questions answered and it is not a quick in and out, just checking in on the patient. So you have to plan it better, you have to have a real understanding of what is going on with their case and prepare to have things done and have what you need ready to go, such as the blue phone. It is a lot more planning!

Subtheme: building relationships. In this subtheme, the participants expressed a desire to connect with their LEP patients in the same way as they do with English-speaking patients by building trusting relationships as part of the care. A considerable value on everyday social chit-chat such as the weather was also shared.

> Just a couple of weeks ago, I had a really cute couple. They came in, and she was actually having some bleeding so she went to the Doctor's office to be checked out and the baby had a drop in the heart rate. The baby had a deceleration so she was sent over for further monitoring and evaluation, and the baby's heart rate was not reassuring on the monitor. So she needed to stay here and be induced. It was, I'm sure, a scary situation for them and you know, having to have this impersonal interaction using a phone and more frustrating for them than me. I always feel bad for them 'cause it is not the same. We got along great; they were very sweet. But I always feel so bad. It's like you are not giving your best care. I think they are less apt to call for help or questions and then not really having that intimate relationship or just not providing the best care…I guess it is not really getting to know them or them getting to know you or me. (Genny, L&D)

> It is the simple things. Such as the warm blanket from the oven, explaining the medication for pain or for nausea. It is those little things that build trust every day because these patients are going to be here a long time. Once you are given a diagnosis of cancer, you are paralyzed in your thinking, you have no idea what lies ahead. (Stacia, Onc).

> I can't create as big of a rapport with these patients. With English-speaking patients I can. You know, if they are having a bad day, or if the patient is really sick, I can use the communication tool of speech to help settle nerves and listen to their needs. I think, as a nurse, I am physically there for those English-speaking patients to allow them to get their concerns and issues taken care of. With non-English-speaking patients, my physical presence is there, but I can't really create a good enough of a rapport with them to make a huge difference. Although there is a lot of non-verbal communication, I think the power of speech can really help

> out with creating that rapport, the nurse to patient relationship that is so powerful. You just don't have that connection because of the language barrier. You don't share the life experiences. (Trent, Tele)

Other participants shared their experiences of the LEP patient having unconditional trust in the nurse as stated below:

> We are privileged that we are able to take care of other human beings during times of their life that are very vulnerable. And you think about the trust they give us and the latitude that we have with them, you know? Let me see this incision that might be in a very personal part of the body, and the trust that they have is implied because I am a nurse. To me, it is an honor that we are even allowed to do what we do. (Susan, Onc)

> They are there trusting the medical staff to be meeting whatever needs are there but they don't even really know what is going on. For the patient, it is a scary experience in that they are just relying on everyone else to do what needs to be done and do not know what is going on. (Holly, Surg)

Another expression of the desire to connect through building relationships is shared by the participants describing how they miss the small talk, or chit-chat.

> It is like you go in and you just kind of chit-chat. I don't know enough Spanish to chit-chat, to just say, "How are you doing?" or just make your patient feel more comfortable or relaxed and safe. I want my patients to feel like they are being cared for, and I think LEP patients are left out because I can't do that. (Kerri, Med)

> With English-speaking patients, you find out what they like to do, where they work and stories that are exchanged. You just get to know them better. When they are non-English speaking, you kind of get in the room and you say what you need to, just the bare minimum to get by. You don't have the ability to engage on a more personal level. So the – the chit-chat, the building the relationship, that is what is missing. (Jen, CCU)

> From a professional standpoint I do feel like it is kind of a silent day or that I am afraid to speak to patients because of the language barrier. It is like having a silent relationship. Twelve hours is a long time to be in an intimate setting, and I want to add so many things to my communication with my patient, to be more close. There is no social chit-chat. (Rebecca, L&D)

Theme Summary

The "desire to connect," described the yearning of participants to develop the kind of therapeutic relationships they enjoy with English-speaking patients and families. Participants identified the need to spend more time and prioritize the work because caring for LEP patients can take more time. The desire to connect with LEP patients by engaging in non-clinical conversations and expressing genuine care was highly valued by these nurses, including the small talk, or social chit-chat.

Theme: Desire to Provide Care

In this theme, participants discussed various challenges they face when wanting to provide physical, emotional, and educational aspects of patient care for the LEP patient and family. The following accounts are in reply to the interview question, "What aspects of providing care are different for the LEP patient and family than English proficient patients and families?"

Subtheme: Physical care. Many patients in the acute-care setting experience physical discomfort. The participants in this study stressed the challenges they face when trying to meet the physical needs of their LEP patients.

> You want to make them feel as comfortable as you can. You know, that is one thing—I make an effort to tell them if they feel that they need a family member to stay with them I let them know I will do my best to find a cot or chair to sleep in. That way, I know the family member can call me if my LEP patient needs anything, especially pain medication. (Gail, Surg)

> So, really, we will focus on pain. Pain is very, very important for a person in the hospital. I will try to use the faces chart or have them point to where it hurts. It is hard to understand their pain levels and trying to assess pain on LEP patients. They don't want to call or bother us so I am checking in on them more than an English-speaking patient. (Marina, Neph)

Subtheme: Emotional care. The participants frequently described a desire to provide care by meeting the LEP patient and family's emotional needs. Offering emotional comfort and being a patient advocate was emphasized as an essential component of nursing care.

> Making the patient feel comfortable within the hospital environment whether it is through the use of education, humor, hugs or hand holding is important to me….I worry about taking good care of them. I think, in the end we can take care of the body because we are taught to take care of the body. Yet, so much of taking care of the body is taking care of the mind as well. So, I worry about my deficiencies rather than their limited English. When I walk into that room in the morning, and

> I know they don't speak English, I worry more about my deficiencies rather than their proficiencies. It becomes a focus during the day to make sure I spend extra time with that patient and find the resources I need to do so. Sometimes what we do to patients is frightening. We are poking holes in these people and putting things in their penises, it can be horribly frightening. (Susan, Med)

> I try to always think about what it would be like if I was on vacation somewhere and I had to go into the hospital in a foreign place and I have no idea what they are doing, why they are doing it and who they are! So, I always try to put myself in that frame of mind before I go in and work with those patients, put myself in their shoes. (Rachael, Tele)

> There is a universal language of "I am here for you, what can I bring you." It is so important to try and make them these LEP patients as comfortable as possible. No matter where you are, whatever country you are in, if you are kind to somebody and if you show that person that you are trying to understand their language, doing your best to help them, it shows. It seems like kindness is a universal language that we understand in each other. Meeting the emotional needs can be as important, if not more important, that the physical. (Dawn, MBU)

Subtheme: Education and safety. In this subtheme, the participants shared the desire to provide care through education and safety measures. Education was viewed as an integral component of safe outcomes for their patients as explained in the comments below.

> I always wonder, "Are they going to be safe? Are they going to understand when they go to the pharmacy what to take, when to take it and how?" I think if we are not educating them, they are going to end up right back here with us again. It puts the patient at risk for not understanding what you are teaching them. What is the best way to educate this person? What is the best way to teach this person and how should I include their culture? I had a patient who came in twice to talk to me after discharge because it was very difficult for them to understand their medications. So I gave them a list of what they should take in the morning, noon, and bedtime. I had to - literally had to write it on each of the medications on the cap just so they would know. Imagine how it is for that person? If they are going through chemo or have blood pressure issues…Some of our patients go home with ten to fifteen medications. How are they going to manage that at home? It all depends on the education we have provided for them. (Laine, Onc)

> The language barrier makes it really difficult to give the care you know they need. We do a lot of education and if I can't talk to my patient and educate her on the stages of labor, breathing, pain medication options and breast feeding or what to expect on discharge, I feel like I can't do my job. I don't like that because I love my patients and want them to have the best outcome, to know what to look for and when to ask for help. I would be scared having a baby in Mexico if no one could tell me how to take care of myself and my baby in my language. (Rebecca, L&D)

> Well, one thing is that sometimes, the LEP parents will try to be so polite and will say, "Yes, yes" to things but you know they don't know or understand. So it is important to be sure they are repeating back the information to you and can demonstrate giving a medication or verbalize the steps using an interpreter. It is hard to understand how much they understand. (Karen, NICU)

Theme Summary

The "desire to provide care" was a theme that described the efforts, awareness, and struggle to care for LEP patients' physical, emotional and educational needs. Expressions of frustration and fear were mixed with wanting to do the right things for their patients to ensure the best outcomes.

Theme: Desire to Provide Cultural Respect and Understanding

In this final theme, the participants revealed the desire to learn more about cultural competencies related to providing health care while conveying a sincere respect for our diverse patient population. The two subthemes that emerged were family size and the awareness of wanting more education on providing culturally respectful care.

Subtheme: Family size. This subtheme emerged as a response to the question, "How are your experiences different when caring for LEP patients as compared to English proficient patients?" Overwhelmingly, the participants highlighted the greater family size in LEP patients as described below.

A lot of my English-speaking patients won't have very many visitors at all or they will have one or two at a time, not 10 at a time. I mean, we get some parties going in some of these rooms and you have 10 people in there! They bring pizza and the works! What is great about that is they are being supportive to the ill person. They are helpful with the nursing staff much of the time. If the patient needs something like to get up to ambulate to the bathroom, they are willing to help. They take responsibility for their family member and want to be involved with bathing, etc… English-speaking patients definitely do not. They just say, "We will let the staff do those things." By and large, the Spanish-speaking patients and Filipino patients that we typically have will see more visitors. And they all want to know what is going on so it is a juggling act. But I don't think it is problematic, even with ten people in a room. We definitely get some dedicated families surrounding the sick patient and helping in every way they can. They also try to keep the patient's spirits up, coming in and hanging out with them. All day and all night you know there is always somebody with the sick person. You know, if I was in the hospital, I don't think I would have that. People are not coming in to sleep on the floor in my hospital room. (Stacie, Med)

A lot of the non-English-speaking people have greater family contacts than we do. There are always crowds of people in the Tongan rooms. The Vietnamese rooms have multiple generations hanging out. The Hispanics too, and I think that is of great service to the patient. I know for a fact that it drives some of the nurses crazy (laughter). I just like to be able to move around in the room but that support is so important for the health and well-being of the patient. So rather than complaining about it, I just put myself in their place and think, "This is another level of support for what I do for the patient." The more the merrier, as long as they are not disturbing anybody else. And the patients really appreciate that. It makes them feel comfortable and they heal faster. When my father was dying, I was allowed to come to visit him once a day and then he wanted me out of the room. It was a very private thing for him and at times I felt like, maybe, other cultures have it better – have it right. Because you know that support and love is very important. (Susan, Med)

Well, the big one that always jumps out is that they have a lot more family to care for them and there is usually a large amount of family that wants to come in the room. They do help out a lot. It can be helpful and challenging but you have to have a lot more patience because they don't understand. You want to educate as many as you can because when the patient goes home, the more help they have, the better for them. It is such a benefit to appreciate their culture and the family support they have (Tamera, CCU)

Subtheme: Awareness, benefits, and wanting more cultural competency education. In this subtheme, participants clearly expressed a desire to provide culturally

competent care, recognized the benefits of including cultural considerations in their patients' care, and the nurses' own needs for more education on how to provide culturally respectful nursing care.

> There are always cultural boundaries that you need to consider because, depending on where the patient is from, they may have different types of food that they would prefer and are not eating because the food is not to their liking. The way they want their water can be culturally different. For example, cold water or soda should be avoided in older persons or women in childbirth. In Korean tradition, women in childbirth should avoid cold water for a month after childbirth. Cold water during this period is very harmful in teeth health. In the Los Angeles area where many Koreans live, the hospitals provide the hot brown seaweed soup for them which Koreans believe is a healthy food for women in childbirth. Those hospitals have a high reputation with Korean people. (Aeju, Tele)

> I did have one Spanish-speaking patient who had a diabetic foot ulcer and he did not speak any English at all. Hispanics historically have a hard time managing their diabetes because of their cultural diet because it is so rich in carbohydrates. I give most of my teaching to Hispanic diabetics. They really don't like our food. Food is a big deal to anybody in the hospital but the Hispanics patients hate our food. Hate it – hate it (laughing). And they always want stuff from home. (Stacie, Med)

> I want to make sure that the family knows the condition of their child. And most of the time it is that their child is going to be okay. I think that not only do you have language barriers, but there are a lot of cultural barriers. A lot of times, they feel like their child is going to die. It is a very common finding that once the parents learn to trust me and what I am telling them, their first question is if their child is going to die. (Kim, Peds)

> The main thing I often think about with these patients is that I wish I had something else I could use to learn about and respect their cultural needs. I would like to see more culturally competency programs and policies. Just being able to increase the awareness of how important this is and being able to include culture in our care would be amazing. I feel like a lot of the time we just ignore it. (Elaina, Peds)

Theme Summary

The desire to provide cultural respect and seek understanding was described the the participants. Expressions of understanding the benefits of culturally relevant nursing care and interest in learning more about how to include culture in nursing care were well stated. The experiences noted in family size and the need for awareness with ongoing cultural competency education were described.

Overall Essence

The final step in van Manen's research activities is to consider the parts in relation to the whole (Van Manen, 1990). In moving through the participant experiences that explicate the subthemes it became apparent that desire, which is common to the four themes, was more deeply embedded than first realized in describing the overall essence. Throughout the majority of these examples, what shines through is that the caring attitude of these nurses toward their patients and families goes deeper than just wanting to help. They sincerely took on the cloak of compassion relative to the situation in which they found themselves with their patients. Their concern for understanding was evident in their desire to communicate, to connect, to provide care, and offer cultural respect and understanding in such a way that exuded empathy. Therefore, the overarching essence of the experience for these nurses was that of empathic care, as shown in Figure 2.

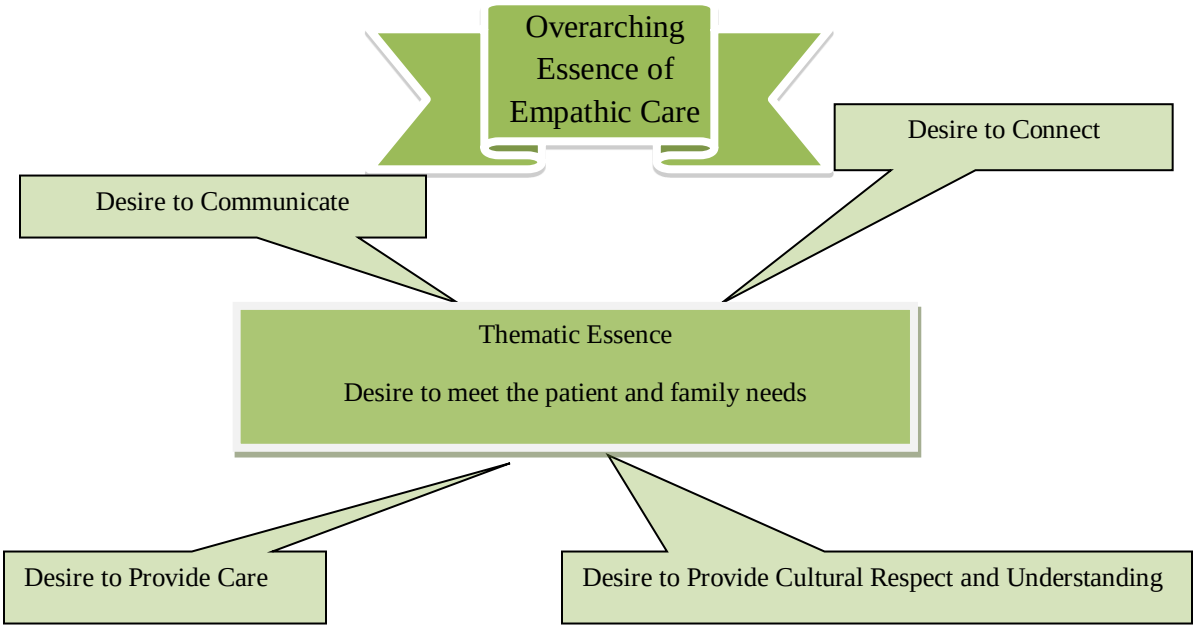

Figure 2. Overarching essence, thematic essence, and themes of acute-care nurses' experiences caring for LEP patients and families.

Chapter Summary

This chapter presented the findings, beginning with an introduction to the participants and describing how the data was collected. The analysis provided a picture of acute-care bedside nurses as they experienced caring for limited English-speaking patients and their families. Even though their stories provided unique aspects, many of the components were interrelated and overlapped. Each interview was viewed as a distinct account of this experience while the emerging themes assisted the student researcher in moving towards a rich understanding of the experience of caring for LEP patients and their families in the acute-care setting. The participant experiences provided data from which four main themes and ten subthemes emerged. Each theme and subtheme contributed to the thematic essence of a desire to meet the LEP patient and

family needs, which in turn resulted in an overarching essence of empathic care.

CHAPTER VI

DISCUSSION

Discussion and Interpretation

This phenomenological study explored the experiences of 40 registered nurses with a minimum of 3 years' experience in acute care and who have cared for Limited English proficient (LEP) patients and families. The data provided rich, thick descriptions of the nurses' stories and offered insight into what it is like for nurses to care for these patients and families. Four major themes emerged as essential to understanding the lived experiences of these nurses. The analysis revealed an overall essence of desire to care for the patient and family needs. The participants in this study described their experiences with caring for LEP patients and families in a passionate and heartfelt manner. Each person's story was unique and yet, somehow, common experiences were shared of the longing for, wanting, or desire to meet the patient and family needs. Even though today's acute-care nurse is challenged with increased workloads of very sick patients, these registered nurses conveyed sincere expressions of desire to communicate, connect with, and provide care for their LEP patients while offering cultural respect and understanding. Some of the nurses expressed these desires as frustrations when they were not able to meet patient and/or family needs. The overwhelming message was that these nurses care very deeply for the patients and families under their care. The participants understood the value of verbal and non-verbal communication while appreciating the need for face-to-face communication in intimate settings or with difficult conversations. The nurses expressed the desire to have more time to connect with their patients and families,

sharing the importance of building trusting relationships through accurate medical communication and social chit-chat. They also shared their desire to provide for the physical, emotional, and educational needs in order to ensure safety for the patients, families, and the nurses, themselves. The nurses' voices clearly conveyed a deep sense of job satisfaction when expressing the desire to provide cultural respect and wanting more education to seek improved cultural competencies.

As the nurses described the challenges and humor involved with larger family size, a sense of admiration, and even envy was expressed. While workloads and family size may increase and interpreter equipment, time to do the work and educational opportunities may have decreased, the passion these nurses have for their work is impressive. The universal language of kindness was expressed through the overwhelming desire to care for patient and family needs. Whether the nurse was or was not able to meet the needs of their patients and families, the motivation, determination, and desire remains.

Return to the Literature

The purpose of returning to the literature was not to justify the findings for the nurses' experiences, as the data is the evidence for practice. The purpose of returning to the literature was to identify any additional publications that may be related to acute care nurses caring for LEP patients and their families. A literature search for the terms: cultural competency; acute care, registered nurse, language access, LEP, and ASL was conducted using on the following electronic data bases: CINHAL; ERIC; Academic

Search Premier; Proquest; PubMed; and Medline. As was found in the initial literature review, there were no new research studies on this topic with these populations.

Implications for Nursing

Education. Education is essential to ensure that nurses provide for the care of LEP patients and families. The need for cultural considerations in the nursing process needs to be addressed in academic and staff development curricula. The participants in this study clearly spoke of a desire to have more education to improve cultural competencies, understand how to use interpreter services, and provide culturally respectful care.

Practice. The data from these 40 interviews dispel any possible notion that nurses do not want to take the time or effort to provide for LEP patients and families. Clearly the desire is present. Rather, a look at organizational systems may suggest opportunities for improvement in support of the nurses' expressed desires to provide the care needed. Issues identified by the participants in this hospital included not having enough interpreter phones, needing to include language barriers in an acuity system for the purpose of workload assignments, the presence of on-site interpreters or, perhaps, video remote interpreters to provide the face-to-face communication that is needed. An expressed concern for patient safety and barriers to patient teaching in oral and written formats were discussed.

Research. The literature indicates little is known about the lived experiences of acute-care nurses when caring for limited English proficient patients and families. With the rapidly changing demographic makeup of our society, there is a critical need to

understand the impact and solutions to providing safe and effective care for those with language barriers. Patients who require acute care are in need of the highest degree of accurate communication and culturally relevant care. Replication of this study to explore lived experiences of nurses working in other health care settings would be appropriate. Opportunities for continued research based on the results of this study include additional qualitative research in other acute-care settings, and exploring the lived experiences of other health care providers. Interventional studies including but not limited to education, technology, and workloads need to be explored further. Mixed method design studies to assess interventional outcomes with lived experiences are also indicated.

Strengths and Limitations

Strengths of the study include the provision for acute-care bedside nurses to tell their stories of experiences when caring for LEP patients and families and the opportunity to explore new knowledge. The findings serve as a guide to design interventions to address gaps and barriers in the care of LEP patients and families in acute-care settings. A potential limitation of the study is researcher bias. The researcher's perspectives and experiences as an acute-care nurse may influence the interview process and/or objectivity during the analysis phase. Since these researcher experiences may also lend credibility and trustworthiness for the participants in the study, reflexive exercises were completed to identify possible concerns. In order to assess expressed educational needs of the participants, additional questions need to be asked on the demographic data form such as, "Have you taken an academic course(s) related to culture and nursing care?" or, "Have you taken a continuing education course(s) related to culture and nursing care?" If so, a

determination of what year, for how many academic or continuing education credits, and whether they have proved helpful or not would add to the body of knowledge. While the sample scope and size were significant, a limitation of this study is that the participants were recruited from one hospital. In addition, the participants self-selected or, volunteered. It is possible that the self-selection process to volunteer might be from greater degree of concern for the LEP population than other nurses Due to the single hospital research site, results may not be generalized.

Recommendations

The purpose of this study was to describe the experiences of acute-care registered nurses who care for LEP patients and families. Within this purpose, the researcher was interested in potential barriers or solutions to providing safe, effective, and culturally relevant care for this population. This study contributes to the knowledge base within the field of acute-care nursing staff development and academic education for schools of nursing that prepare nurses for acute-care employment. This study was unique in that the focus of the interviews was directed toward the lived experiences of acute-care nurses who care for limited English proficient patients and families. This research brings forth new knowledge upon which to design further research. Overall, the findings from this study reinforce the need to give acute-care nurses a voice to share their experiences and ideas for solutions to the challenges they face in the care they provide.

Chapter Summary

This chapter presented discussion and interpretation of the study findings. Implications for nursing related to education, practice, and research were identified.

Strengths, limitations, and recommendations were outlined. This research provides new information regarding the lived experiences of acute-care bedside registered nurses caring for patients and their families with limited English proficiency.

APPENDIX A: RECRUITMENT FLYER

NURSES WANTED FOR RESEARCH STUDY

The Lived Experience of Acute Care Bedside Nurses Caring for Limited English Proficient Patients and Families

- **Are you a Registered Nurse working in acute care at the bedside?**
- **Have you worked in this facility for at least 3 years?**

If you can answer YES to the questions above, you are invited to join this research study. Your participation may contribute to a better understanding, from your perspective, of the experience of bedside nursing when caring for limited English proficient patients and families.

Should you volunteer to participate, you will be asked to commit to a minimum of two interviews, lasting approximately one hour each, at your choice of location.

Your participation is entirely voluntary. You may decide to withdraw from the study at any time and for any reason. Your employment at Saint Mary's Regional Medical Center will not be affected in any way based on your participation in or withdrawal from this study.

Complete confidentiality will be maintained at all times during and after your participation in this study. Your name and/or any other personal identifiers will not be used to associate you with this study.

If you are interested in participating or would like more information regarding this study, please contact:

Jami-Sue Coleman Ph.D.(c), RN, MBA

(775) 530-1715 **jamisuecoleman@charter.net**

Dr. Yu Xu, Faculty Chair (702) 895-3175

APPENDIX B: INFORMED CONSENT

UNLV
UNIVERSITY OF NEVADA LAS VEGAS

INFORMED CONSENT

Department of School of Nursing

TITLE OF STUDY: The Lived Experience of Acute Care Bedside Nurses Caring for Limited English Proficient Patients and Families

INVESTIGATOR(S): Dr. Yu Xu, PhD, RN, CTN, CNE, FAAN

CONTACT PHONE NUMBER: (702) 895-3175

Purpose of the Study
You are invited to participate in a research study. The purpose of this study is to describe, interpret, and gain a deeper understanding of the acute care bedside nurse's experience when caring for limited English proficient patients and families.

Participants
You are being asked to participate in the study because you are a registered nurse who has worked a minimum of three years in acute care bedside nursing in this facility.

Procedures
If you volunteer to participate in this study, you will be asked to take part in a minimum of two AUDIO-recorded interviews conducted by the student investigator, lasting approximately one hour each. The interviews will be conducted at the time and location of your choice. No interviews will be conducted during work time. During the interviews you will be asked questions about your experiences as the bedside nurse caring for limited English proficient patients and families. It is important for you to know that confidentiality will be maintained at all times and your participation is entirely voluntary.

Benefits of Participation
You may not experience any direct benefits to you as a participant in this study except the satisfaction of participating in research. However, we hope that learning about the experience of being a bedside nurse caring for limited English proficient patients and families will facilitate better understanding of how to recognize and meet the needs of bedside nurses, limited English proficient patients, and families.

Participant Initials _____

1 of 3

Risks of Participation
There are risks involved in all research studies. This study may include only minimal risks. This study may include only minimal risks. It is unlikely that any of the interview questions will make you uncomfortable or distressed however it is important for you to know that you will not be expected to answer any question that makes you feel this way. It is also important for you to know that you may end an interview and/or withdraw from the study at any time, for any reason, without negative consequences.

Cost /Compensation
There will not be financial cost to you to participate in this study. The study will take approximately 2 hours of your time. You will not be compensated for your time.

Contact Information
If you have any questions or concerns about the study, you may contact Yu Xu PhD, RN or Jami-Sue Coleman MSN, RN at **775-530-1715.** For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794 or toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Voluntary Participation
Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality
All information gathered in this study will be kept completely confidential. Interviews will be audio-recorded and transcribed by the researcher. No reference will be made in written or oral materials that could link you to this study. Separate files of interviews, transcripts, and demographic data will be stored on a password protected computer in a locked office at UNLV for 3 years after completion of the study at which time, the information gathered will be destroyed.

Participant Consent:
I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

_____ _____
Signature of Participant Date

_____
Participant Name (Please Print)

Participant Initials ____

I ALSO AGREE TO HAVE MY INTERVIEWS AUDIO-RECORDED

Signature of Participant _____ Date _____

Participant Name (Please Print) _____

Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.

APPENDIX C: DEMOGRAPHIC INFORMATION

Demographics Form

1) Name (Alias) _____

2) _____ Age 3)_____ Male_____ Female

4) Race (please check one):
_____Hispanic _____Non-Hispanic

5) AND:
_____ American Indian or Alaska Native
_____ Asian (includes Chinese, Filipino, Japanese, Korean, Asian Indian, Thai)
_____Asian (other than above categories)
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White
_____Unknown
_____More than one Race

6) Primary Language _____

7) Other language(s) spoken/understood_____
_____

8) Initial nursing education
_____ Associate Degree
_____ Diploma
_____ Bachelor's Degree
_____ Other _____

9) Highest nursing education earned
_____ Associate Degree
_____ Diploma
_____ Bachelor's Degree
_____ Master's Degree
_____ PhD
_____ Other _____

10) Other education degrees _____

11) Number of years working:
_____ as a registered nurse
_____ in acute care
_____ in this facility

APPENDIX D: CONFIRMATION OF TRANSCRIPTION ACCURACY

Please initial the statement which applies to your transcript review:

_____I have read the transcript of my interview and find it to be accurate

_____I have read the transcript of my interview and request the following changes:

_____ _____

Signature of Participant Date

_____

Participant Name (Please Print)

APPENDIX E: SAMPLE OF CODED TRANSCRIPT

Gail-Surg

D: Demographic LS: Lived Space LB: Lived Body LT: Lived Time LHR: Lived Human Relation

Red: negative connotation Black: neutral connotation Green: Positive connotation

F: Feelings T: Time R: Resource Cu: Culture Co: Communication L: Legal/Safety

Interview	Codes/Notes	Existentials
Jami: Gail, thanks so much for joining me this morning. I appreciate it very much. Can you tell me without naming the hospital which unit you work.		
Gail: I work on a **surgical unit**.	**D: Surgical**	
Jami: Surgical—so what kinds of patients or conditions would you care for on that unit.		
Gail: Mostly um surgical patients, um we do care for a lot of ortho as well as just general surgery –type patients. And patients that come in with infections and some medical issues, colitis, bowel issues, that type of thing.		
Jami: So quite a variety.		
Gail: Pretty much, yeah. I would say so.		
Jami: Um hum. Have you had an opportunity to care for patients and families who have limited or no English speaking?		
Gail: Yes.		
Jami: And so what was that like for you as the nurse to care for them?		
Gail: It's—**it's frustrating**—actually. But it's also a lot—it **very time consuming** because you **have to go find a translator phone**, which is really nice—I actually like that. That's really very nice, but sometimes **you worry because you don't know if it's even the translator on the blue phone is understanding what you want to ask the patient**. So it's—it's frustrating but yeah—mostly frustrating honestly speaking. You **just kind of—kind of dread it in a way**. But **as the night usually goes on we are able to understand each other and able to communicate things—that um you know it's just—it's—it's just very time consuming**—that's another thing it's—	**F-:Frustrating, Worry, Dread, Mistrust** **T-:Time consuming** **T+: Understanding improves with time over shift** **R-, Co-: Not sure if communicating with translator** **Co+: Better with time** **R-: Find a phone** **L:If translator is understanding**	**LT: Increased time required to find phone and go through interpretation process** **LHR: Trusting accuracy of translation process** **LT: Time/duration helps/improves communication**
Jami: So—frustration on the part of how		

much time—extra time it takes.		
Gail: Yes.		
Jami: And then other elements to the frustration—wondering whether or not the communication is—		
Gail: **Yes—am I getting the full assessment? Am I missing something? Why are they feeling this way (pain, nausea, etc…); is the translator translating it appropriately? That's what's kind of scary. I mean am I getting this—through to the patient?**	**F-: Scary** **L: Is communication accurate, safety** **R-: Is translator reliable**	**LHR: Ability to provide care in similar relationship as English speaking, relationship with translator/patient**
Jami: Okay. And so—you say it takes extra time		
Gail: Yes.		
Jami: But also the element of **time through the period of a shift** —you are able to move more towards **a more comfort level or better communication or—getting communication back and forth.**	**T+: Improves the communication over a shift** **F+: More comfort with Co+:Improved with time**	**LT: Struggle with time constraints, busy assignments, investment of initial time pays off later in shift**
Gail: Yes.		
Jami: How does that—how does that work for you then throughout the—the shift. How do you develop that?		
Gail: Um, usually through **just trying very hard to communicate. Also usually these people have family members-that are there to help translate. But um sometimes you don't want to do that because of the medical issues. And so you're not sure—I mean it's so much easier to use the family honestly speaking—you get into a rut and you've got like three other call lights going off—you don't want to grab the—cause you have to pick up the phone, introduce yourself, you know—so you—you utilize sometimes the family members probably when you shouldn't and you're asking them certain medical questions which you're not sure if that's really the way they're translating it. So, but as the shift goes on they feel more confidence that I am utilizing a translator or their family. They feel much more comfortable I think with their family translating.**	**L: HIPPA, easier with family but not confidential** **T-:Takes time to get on blue phone when busy** **F+: Pt's comfort using family. With time, more comfort using phone translator** **T+: Over shift, comfort improves with translator**	**LHR: Protecting patient privacy rights, following policy/procedures in relationship to employer & laws, wanting patient to be able to communicate** **LT: Busy, requires extra time, juggling many patients and needs, gets easier over the shift (12 hours)**
Jami: Gail —do you think their comfort level that they have gained with you is that you're using the translator, or that you're—you're efforts speak—more—that you care.		
Gail: Yes. I think that's it. That they—that **I'm taking the time to try to communicate. Also, a lot times I try to speak their**	**T+: results in better communication** **F+: effort, empathy, care,**	**LHR: Building relationship by communicating care,**

language. Whatever Spanish I know—and this is mostly Spanish—Of course I can't understand other languages—But **I try to communicate to them in their language, and I think that makes them feel more comfortable that I'm giving it an effort**—instead of getting frustrated and—and not trying with them. So that makes them more open telling me more about the condition that—their—pain that their in—or other types of conditions that they might have during the assessment.	**Pt more comfortable**	**effort, trying, sensitive to communication needs**
Jami: So can you think back to a relatively recent specific patient and family and kind of—talk to me about how that experience went for you.		
Gail: Yeah, um I recently took care of a lady that had—I'm trying to think—she had like a hernia repair—and she was um—I think it was hernia repair—and she was completely just Spanish speaking-Did not understand any English—fairly young—so that was kind of shocking to me that a person of her age would not know any English at all. Being in this country—you would think—you know and actually she was working—she had a job—yeah so, um and um I had her husband was at the bedside, he didn't know a lot of English, but he was able to understand a lot, but she was—she was—she was doing okay, but she was kind of having some bowel issues and I was trying to explain to her you have to walk, you have to move, **and hand signals help a lot –with communication with her, but it was—it was challenging, because like I said her husband didn't know as much and then I couldn't find the blue phone so it was like, oh my God, cause we have—we only have one blue phone on our unit and so that was really frustrating. I don't know where it was, it was in another room, so I really had to utilize the husband and a lot of the times too we utilize our CNAs—because a lot of them to speak Spanish**—so we grab them and have them translate as well—but that was very recent, where it was like **oh, I can't find a phone I'm hoping that I'm—I'm—this lady's understanding me and her husband and it seemed to get through to her**—I mean she was walking and doing everything she should and she showed me certain things that were going on with her and we knew how to communicate she needed something for pain—	**R-: Can't find phone, have to use hand signals** **F-:Frustrating, had to use husband or nurse's aide, unsure of understanding**	**LS: Efforts to provide needs with all possible resources and persons, unable to find phone when needed.** **LHR: Conflict between providing communication for patient by going against policy (using family or staff) and frustration of not finding phone/using approved service/process**

that's was a big thing is the pain issues. So um yeah it was—**it was an okay experience, except for not finding the blue phone—anywhere.**		
Jami: And so you worked around by trying to find other ways to –		
Gail: Oh yes—yes.		
Jami: Um what do you think are the—are the differences than for your providing care or what you observe in our English and non-English-speaking families?		
Gail: Oh my gosh, I know there's a big diff—**you can really uh emotionally get in touch with person that can speak your language. You do more, I don't know you—I don't want to sound not caring—but you can't—you can really get on a different level with an**	**F-: Can't provide same care/connections**	**LHR: Hard to build relationship or connect**
Jami: You connect.		
Gail: Yes, **you can joke with them you can really—you get a good rapport with someone that speaks your language. I don't know, and it just seems like we just do much more detailed assessments. I mean I hate to say that, but you're really asking a lot of questions with your English-speaking patients as versus your Spanish speaking you're very much trying to get the basics and the basics of what they're feeling—the basics of what—and like I said it's a time factor a lot when you have 6 patients and** –it sounds terrible, but -	**F-:Can't joke with, build a rapport. Can't provide as detailed care.** **Co-:Can't get more than the basics** **T-: Takes more time to provide care with language barrier**	**LHR: Can only provide basics, unequal care for those with language barriers**
Jami: Is there—is that taken into the acuity at all?		
Gail: **No. No, not that I know of. I try to make it you know part of the acuity, but I don't think that's really—I don't think they—they you know see how many Spanish speaking patients there are and then how many you know which nurse has these Spanish speaking patients.**	**R-: LEP not considered extra time need in assignments**	
Jami: Okay.		
Gail: I don't think so. No.		
Jami: Any other differences that you've observed or experienced?		
Gail: Um—you know it's just—just the way you communicate. **It's just a much more thorough assessment you catch things a lot easier with your own language. Whereas the Spanish speaking people they just—I don't know, sometimes they—they'll talk to you and they'll think you're understanding them and they're—and it—you know I'm going**	**L-: Easier to miss something or misunderstand symptoms, potential for errors**	**LB?: Concerns of not being able to tell what is going on physically with patient due to language barrier ie: pain, suffering, need for medications…**

oh my gosh please don't say anything cause I don't know if I'm catching onto this, you might miss something. A lot of the times we miss certain things. Things could get missed with them. Where your English-speaking you know it's very simple not to miss things cause you're—you're understanding. So and sometimes you know they might be suffering more the you know the Spanish your other language—because they just don't know how to tell you what they are feeling. They don't know it's actually pain related and if they could give you the exact symptoms you could narrow it down to yeah you need more pain medication; you need more of this certain medication—		
Jami: Okay.		
Gail: So that's another thing.		
Jami: Um what other kinds of languages have you had an opportunity to care for?		
Gail: Um, a long time ago a Chinese speaking, French—I had French speaking lady and Japanese. I had a Japanese patient—		
Jami: And how did those go?		
Gail: Oh my gosh, we had—they always have a family member with them—with the Jap—the oriental people—always, so it was actually okay. I mean it—it wasn't that bad.	**C, R+: Japanese/oriental have family interpreters with them**	**LHR: Asians: family as interpreters are present**
Jami: Um hum—okay.		
Gail: At all.		
Jami: Um so let's say you shown up for the beginning of your shift and you see that you have in your assignment a non-English-speaking patient, what starts to go through your mind, or how are you already processing to plan for your shift?		
Gail: The blue phone.		
Jami: Okay.		
Gail: **Making sure we do have a translation phone in there. Making sure that they know that I will try my very best to you know help understand them. And then I'm also thinking oh my gosh this is going to take so much more time. It sounds terrible but –You do think that way, but you want to make them feel as comfortable as you can. I—you know that's one thing—I make an effort to tell them. And if they feel that they need a family member to stay with them I let them know I will find you know if they need to sleep in a chair or a cot I will do my best to help them out. And it makes me feel more comfortable that they have a**	**R+: Phone** **F+: Care, Help, make pt/family comfortable, accommodate family needs, at ease/comfort with giving care** **T-: Takes so much more time**	**LHR: Family presence is important, need to support in hospital with comfort, bed, etc…** **LS: Accommodating physical space for family; hospital environmental space**

family member with them. So that makes me feel a little bit more at ease.		
Jami: Um, can you—can you describe that a little bit more what makes—what makes that a comfort for you?		
Gail: Because **I know that they have lived with this person. They know this person very well and if something is wrong, they will be able to tell me you know this is what she just said—this is what she's feeling that type of thing. And I don't feel so —you know what if I'm going to miss something—miss a critical um**	**F+: Family knows/sees things, can detect changes** **F-: Fear of missing something, patient safety**	**LHR: Family presence may be important in patient safety, positive & helpful**
Jami: So you see the family member is helpful to both you and the patient?		
Gail: Yes.		
Jami: Okay.		
Gail: Yes, definitely.		
Jami: So, Gail, can you think of any uh benefits of positive aspects of caring for our non-English speaking?		
Gail: **To practice my Spanish speaking skills. And actually they're really kinda—it's kinda neat to talk another culture, it really is kinda neat. You know just learning about their culture and what—how they describe certain things. I mean that's—I think that's pretty interesting.**	**F+: enjoys learning Spanish, cultural differences, interested**	
Jami: So how much does culture influence what their needs are? Or how you go about caring for them?		
Gail: Oh my gosh a lot.		
Jami: Can you describe that a bit?		
Gail: Some of them are very stoic they don't feel that they should report that they're hurting I mean pain is just a very cultural thing. A lot of them feel that they need to hold it in; that they need to tough it out. Certain—and then certain ones are you know some of them they express pain. They express sickness in a totally different way than like what I would do—they're very boisterous and you know—they're—you know what I'm saying? They're very loud and so yeah culture has a big—	**Cu: perceptions of pain stoic vs expressive/boisterous/loud**	**LB: Perceptions/expressions of pain/physical discomfort vary between cultures**
Jami: Expressive, yeah.		
Gail: Yes, has a big thing to do with it how they express themselves. So yeah, I've seen that on the two—I mean like a different the Japanese I mean a lot of them are very, very stoic, they hold it in so I have seen that very much in different cultures. Absolutely.	**Cu: Japanese stoic with pain**	
Jami: And—and then pain being a very big		

issue on your unit.		
Gail: Yes.		
Jami: Um can you—can you think of any other experience on an experience level for you as a nurse of—of trying to care for the patients through your shift.		
Gail: Um hum.		
Jami: Of um anything that's unique or different than say for the English speaking?		
Gail: You know I can't		
Jami: Okay.		
Gail: Just the—		
Jami: So mostly the time.		
Gail: The time factor—		
Jami: Frustration and the—and the—the discomfort of knowing whether you're –you're communication is full and clear. Is that –what I—I've heard correctly.		
Gail: I think so—yeah.		
Jami: Any other thoughts that –that you'd like to share as we try to understand the bedside nurse's experiences for this—for these kinds of patients—anything that we can learn from you Gail?		
Gail: Well, you know um just that we do like caring—I mean we do like caring for the different cultures. I mean I find it kind of interesting—pretty interesting on how each—each particular um nationality deals with different issues. I just find that pretty interesting.	**F+: Like caring, interested**	
Jami: Okay. Is there anything that you can think of that you would like to have to help you with these families that we don't provide or that you've thought, gosh I wish we had it--		
Gail: Just the ability to communicate. That's the big—I mean something simple, something much more—it would be so nice if I could just talk to into something and it just talks back to them, instead of –I mean I like the blue phone. It's kind of nice, but you have to go through this whole you pick it up, they're on the –it just would be nice if I had like a little something I could hold and say okay can you —you know like translates. I could say what I need to say and it translates right to them. That would be really awesome. But I know that's—I mean that is technology but that's—with the future.	**R-: Need better tools with easier process for translation**	
Jami: But who knows that might be you know—somebody might be working on that. It seems like as close as a direct		

communication—as possible.		
Gail: Another thing I noticed—**some physicians they don't take a lot of time with these people—they don't take a lot. They don't—all they do is speak English to them – they do not take the time to find out if they even understand. They don't find the translator phone. They don't even ask us for it. I've noticed that too. It's really frustrating. Especially when the patient says I have no idea what they just said and they can't actively participate in their care. And they're—they're so—they're just in the dark. I can't even imagine**. I mean you showed us a film I think—Of how that would feel if you're sitting there in the ER and you're -- all this garbled and I think that's what they—they feel especially when the physician comes in.. **Now there are certain physicians that will speak their language, but I've noticed some of them do not take the time to try to even explain or try— They just won't, they're too rushed. They'll just say okay this is what we're gonna do and they don't even take the time to find out if the patient even understands them. They'll go in, they'll give them informed consent, but they have no idea if they understood it. And so here we are stuck as nurses trying to translate, read the entire consent—operative consent to them and hope that they understand what in the world they're getting into. That's another point—yeah that has been really upsetting to me. If you know you offer the doctor—here can you—can you take this phone? And a lot of the hospitalists yes they are great at that, but some of the surgeons—oh my gosh. They will not take the time.**	**L-: Dr's don't use phone or make efforts for reliable communication, don't provide informed consent** **T-: Dr's are too rushed to take the time** **F-: Really upsetting that surgeons take the time, can't imagine how scared pt's might be, frustrating**	**LHR: Physicians are not developing the relationships with LEP patients. Struggle to meet patients' needs but not confront Dr's.**
Jami: So you would be comfortable witnessing that consent?		
Gail: Oh my gosh no—**I would not. Because I don't know—I mean a lot of the times they go oh I thing I understand. And I send them down to the OR just explaining to the OR nurse what exactly happened and that they did not get the proper consent.** So--	**L: Won't witness consent unless informed consent is given with interpreter, makes OR nurse ensure it is done before surgery**	**LHR: Takes advocacy role seriously, follows legal rules and wants best for patient**
Jami: Um hum. So you're seeing a huge gap in comfort level or the use—the u—the physician's use of interpreter services .		
Gail: Yes. Yes. There's certain physicians do speak Spanish and a lot of the hospitalists	**F-: Nurses have to**	**LHR: Pt's scared,**

will use that translator phone which is really nice, **but the surgeons are not that great about it. So that is—that is an issue that we as nurses we have to pick up the pieces from that and they're scared. I mean the patients are scared, what are they going to do to me?**	**comfort scared patients who do not understand Dr's. Pt's don't know what to expect, what is going to be done**	**unable to understand what Dr. will be doing. Nurse tries to identify with patient feelings.**
Jami: Cause you're the advocate for the patient.		
Gail: **Exactly. So we're the ones that are behind that trying to explain to the patient it's going to be okay; this is what they're going to do—yeah. So that's really frustrating.**	**T-: Nurse has to take more time doing Dr's job for what Dr. should have communicated.** **F-: Really frustrating** **F: Advocacy, promoting safety, wanting patient to know their care, wanting to do what is right/legal**	**LHR: Nurse fills the gap for Dr's gap of communication.**
Jami: Thank you for sharing that that's a – really important point and possibly another research study. Anything else you can think of Gail that –that would help us as we try to learn from you?		
Gail: Oh **I'm glad you guys are trying to learn from us at the bedside.**	**F+: Appreciates getting to share experiences, wanting to be heard**	
Jami: You have a lot to share. You're the ones who do the work—so.		
Gail: Yeah, no problem I hope I gave you some information—that you can use and that's great.		

APPENDIX F: CLUSTERS/SUBTHEMES BY EXISTENTIALS

Lived Space	Lived Body	Lived Time	Lived Human Relation
Resources Verbal Interpreter Phones Face-to-face Non-Verbal Family Interpreters Staff Interpreters Family Size Written Materials	Patient Pain Comfort	Time Takes More Time Manage/Prioritize Time Equal/Unequal Care? Acuity	Trust Lack of Trust Implied Trust
Hospital Rooms Environment Education Safety	Culture Practice Health/Healing Spiritual Food/Water		Relationships Building Rapport Not Connecting Chit-chat Patient Confusion Effort/Empathy Gratefulness Doctors Personal/Professional Growth , Benefits

APPENDIX G: SUBTHEME SAMPLE STATEMENTS BY SUBJECT

LIVED SPACE			
SUB-THEME	**CLUSTERS**	**COMMENTS**	**LOCATION**
Resources	**Interpreter Phone** **Positive/helpful**	**...But most people are very good about using the phone and um it's very helpful. They translate really well and uh I am able to answer questions the patient has that they haven't been able to ask, and that kind of stuff with the phone.**	**Holly-Surg, p. 1**
		It is certainly very good, the blue phone. I—I find it very uh helpful and um—um most of the time uh um they it's really very good for the patient. I can—he can use the other –uh the two phones for talking and I can just tell them you know like just talking to the patient and they using the and the interpreter will talk to the patient as well.	**Desiree-Surg, p. 1**
		…we are very happy we can telling the phone line – telling them you just translate to them this is what kind of medicine, what we want a give it to them, because we cannot pre-know the hand out to them. Be we still can communicate, but before we cannot. So the blue phone to us is really, really great help.	**Marina-Neph, p. 2**
		…the times I've used it once was for Spanish, once was for Mandarin Chinese, which you know there's like no way in heck I could have done anything with that, and um ah was—and once was Hindu. And I was amazed at how well it works. It really isn't that frightening once you sit down, you call them, it's hard to get all the codes set up, but once you—once you're actually linked up and the person is cognizant enough—the patient is cognizant enough of how to deal with the phone and to understand that they to talk into the phone-and to understand that they have to talk into the phone and they—then the person will talk to me and talk to them it works great.	**Susan-Med, p. 5**
		… it was a Hispanic family, um, patient was vented. I don't remember the diagnosis though. But there was lots of family and um in order – the family didn't speak English either -- I mean it was – there was like one or two or people that did but they were in school so it was very limited when they could come and help translate to their own family member. So I used the blue interpretation phone with the Hospice and PMA because they needed to be able to speak to the family that was in the room. So we just kept the phone in there just because it made it easier, but not only did we use it just for the communication with the physicians and I to speak with the family during the day, but there was actually the patient coded. And so we needed to talk to family emergently in the middle of the night and use the phone for that as well. And so that's the only time I've ever had to use it…Because the docs came in in the morning and so we made the phone call in the morning and before they got off I made sure that I talked to them and said that this is what your plan is going to be for the day. This is what the doctor said so if it was an x-ray or if it was, or if we had – and I know he had dressing changes – I'd explain the dressing change – we're going to do it around this time barring anything happening. So they kind of had a clear idea of what was going to happen through the day so that when they came in and there was no need for verbal contact they understood what I was doing. But the phone was always there if we needed to talk to each other… Cause the care boards came out when I graduated. And so I don't write in Spanish so for me I have to write it in English. But they didn't understand it so when we would do the communication in the morning I would go through my – what I would do for any other patient bedside report. I	**Tami-CCU, p. 1,2**

		would explain – this is what we are doing. This is what the board is, this is what your expectations are today, anything that you want – you know, just the entire care board from who is your doctor, the date, the nurse, the supervisor, if there was any CNAs, respiratory therapists, case managers, and how they could facilitate the board for them themselves. And we did that with the phone. Just so that the day was easier and they knew where to look for things and they knew that they could write on it too.	
		… the language phone, um it's better than the other facilities uh that I have worked at, probably because the technology has improved.	Cheryl-CCU p.1
		I think that they're wonderful because then I can be confident that the patient was told exactly in the terms that I have described, um and been able to answer—ask questions back.	Rachael-Tele p. 2
		No, the phone is excellent, but I wish it would start in labor and delivery. You know how many times I get people that come over they want to use the dad and the dad works. You know sometimes these dads work three and four jobs they are not available for you. For protection of the hospital and myself I use the phone.	Arlene-MBU p. 2
		It takes more time, um a lot, and then you—again you have to kind of judge without communicating with the patient their level to how you want to talk—you know speak to them,	Kayla-MBU p. 2
		We have interpretive services available to us 24/7 which is nice, especially now that we have the three way phone conversations. It allows us to watch the patient's response as we go through each point with them. We can see what they're getting hooked up on or what they do understand. I really like it because we can get the interpreters on, they find one that speaks the dialect that the patient speaks cause, for a long time we didn't recognize that there was a huge dialect difference. And they have been wonderful about getting the right dialect and then they assign one personal interpreter if they can to that person. So when I call back I tell them I want this person's their interpreter and they try to get a hold of that person, so there's also that bond of the familiar voice and I was able to utilize that last year on one of our um non-English-speaking patient.	Karen-NICU, p.1,2
	Good for important/hard/ urgent	I use the phone cause I want to make sure that they get it, like especially if I have like teachings like foley teaching or wound care teaching, so I make sure that I use the blue phone for that.	Desiree-Surg, p. 2, 3
		…and if there is a problem you know then I go searching for the blue phone because I need to make sure that they understand medically what is going on… you know if the doctor needs to ex—you know I won't –I can't explain procedures the doctors are supposed to do that. But we have to get the blue phones for the doctors.	Kerri-Med, p. 2
		Having a language barrier uh you know either there is somebody that speaks English enough in the family to deal with some of the more basic things and then um I—I find myself reaching for the translator services when I have to discuss something medical… when you get into talking about things like surgeries and things and stuff that's too complex for me to try and tackle. I guess it's good to know that limitation, right coming out of the gate—Cause your conversational Spanish class from college is not going to teach you those medical translation things.	Stacie-Med, p. 1
		You know admissions you definitely you want have uh you know English-speaking people or the—or the translator phone – cause some of those history questions you're just not going to be able to get the nuance of without some help.	Stacie-Med, p. 5
		I'm thinking oh my gosh how would I explain a rapid response	Stacie-Med, p. 7

		to these people. Like in a rush. How do I explain what is happening? And um like I can just imagine trying to code somebody in a room with ten relatives in it—that would be problematic. Because getting—getting the blue phone set up at that point that's going to be challenging.	
		… for big things like that we always have the blue phone that is wonderful you know the interpreters are great we can communicate with – they can ask questions. And we can talk to the English-speaking family and reiterate and make sure that the family understands, make sure the patient understands. So for the big things like you know, the admission, the discharge instructions, any informed consent, those big hospital like um chunks – the blue phone is great and works.	**Stephanie-Neph, p.2**
		If it needs to be more of an in depth, like getting consents, um or you know if the doctors are going to be talking about certain types of procedures, then the blue phone will be used.	**Jen-CCU p. 2**
		Well it's for when your—we round with our doctors so if there is any language barrier then the blue phone is used strictly to explain everything where there is a communication barrier. We provide cots as a family member fluent in English always stays if there is a language barrier. When you're talking chemo um I just really haven't had a patient who completely did not understand English. So, I'm limited there. But if that was the case, yes the phone is always provided in the room. And absolutely the doctor –it's a two way system, and the family and from the diagnosis to the drugs to checking for pain. Everything is thoroughly covered. When you're talking about the drugs and the side effects and the—what to expect with lab results and their lab counts and some that are newly diagnosed and are going to be in the hospital for a month they really need know what to expect. So yes, absolutely	**Stacia-Onc p. 1,2**
		And, yeah – we – I think we yeah, we had a patient just recently that um a Chinese patient that we used the phone with and it was great cause you know the translation is more clear on the medical terms. Cause, you know, we were able to get an assessment that was definitely better you know than trying to piece meal it together by their chart and that type of thing.	**Darcy-:L&D. p. 3**
		Um the phone, I think, has been um – I mean that works fabulously actually. It's just – it's cumbersome—it's, it's you know to hold the phone and get the phone and I think it's – it's intimidating to patients to talk to a stranger on the phone about these personal issues too that they're not really sure that they're speaking to somebody on the phone and so, and then I think the husbands then become uncomfortable because they want to be in charge and so I'm speaking on the phone, the patient's speaking on the phone to this interpreter then the husband can't hear what they're saying so then he feels kind of left out of the loop. Um, I – I like the phone. I think I could – it's the most effective – I mean we get things done but then it's -- a little bit cumbersome then to get the phone, dial the phone number, get the translator, get it to the patient and say okay now I need you to do this, okay now we're going to do that and then the doctor comes in and then he wants to tell more information, so we gotta get the phone, dial the code, get the interpreter do it all again and give it back to the patients. So once we do it a few times you know they get used to it. But I do feel like it's the most effective in getting our point across as medical personnel – knowing that the information has been given correctly…. So um the phone has been helpful to prepare a patient if it is more emergent – like for a C-section, or um you know getting consents um to get um lab work if they've been treated at a different facility. Um, so it is – I mean it's been	**Rebecca-L&D, p. 2,3**

		helpful more just to explain, explain things. Sometimes patients are in for pre-term labor, so to really teach them about their discharge what they need to do rest, hydrate, you know they have a urinary infection, they need to take you know an antibiotic, you know how many times – I mean so trying to explain that and making sure they understand in their native language I think is really important, because it's hard for us to get that across. And, and like I said again, just explaining it to another family member I am not a 100% sure that they even understand what we're saying so making sure that we actually communicate with the patient on the phone versus the husband I think is really – really important to communicate with the patient.	
		Yeah, cause then it was –if it was anything medical or you know needing consents or anything like that we use the phone and that worked,	**Genny-L&D, p. 2**
		Yeah. We have parents that come in two, three, four times a day--and it's hard to get out the phone every time they come in just to tell them um to change the diaper and take the temperature. And to get out the phone, and get the interpret—you know and get everybody on the line, just to tell them to change a diaper. Yes. For the big stuff, the big education stuff I usually use the phone.	**Tricia-NICU, p. 2**
	Negative phone experience	**It is okay as long as we don't discuss uh medical technical terms. The translators seem to have a difficult time with medical terminology. And I found—I started out my career in Phoenix and we rarely used blue phones there because they had Spanish speaking interpreters…. I don't know—as long as they keep it simple. And –I—I need to use lay terms. It just is a problem. I mean I feel like that's a function of nursing anyway to bridge the gap between what the physician is saying and everyday language. So that they are able to understand.**	**Sheryl-Neph, p. 1,2**
		Um, it can be challenging, definitely, because there is that language barrier there. Um, we do have the blue phones that we can use for translation. I remember in one instance though the translator phone, most of the time um, you know they always have the dialects, but there was one instance where the dialect um they didn't have it on the translator phone. So there were um family members that would kind of relay the messages um uh if we needed the patient to do certain things for us, to squeeze our hands, or you know tell us what day and time you know to see how oriented they were. Um we'd have family relay those messages.	**Jen-CCU p. 1**
	Challenge	**I think the one that sticks out in my mind the most is I had a lady, um that spoke Mandarin, I believe, um no English whatsoever, with her or her family, and I remember trying to use the blue phone because we had to go over vaccine information so I had to read off the entire vaccine information statement to her. And so we call on the blue phone and there is a lot of ciaos in the room with the family and they're talking and trying to talk to her and I'm trying to talk to her and I remember just having issues even understanding the translator on the blue phone because he had such a thick accent and so with everything else going on in the room it was a real struggle. And we were probably on the phone for an hour going over that vaccine information statement. We finally made it through it, but it was definitely a challenge.**	**Liz-MBU p. 1**
		Um, hum – I – I know that a lot of the patients have had care in the doctor's offices and they have people that speak Spanish in the doctor's offices. I think to let family members know that there's not always somebody that speaks Spanish in the hospital. Because sometimes we get patients that come into	**Rebecca-L&D, p. 5,6**

		the hospital and they'll say "Nobody here a speak a Spanish" and you know and it's like no, we don't have that service here. You know because we're trying to communicate with them and they are getting tired of translating the family members – you can tell after a while they're getting frustrated with having to translate everything that then say back to us – you know "Why don't you have somebody here that speaks Spanish?" Why do I have to translate everything? Get somebody here. So, I think that having doctors' offices or – I don't know. I mean and patients just to know that that's not – we don't always have somebody that's immediately available or whatever to speak Spanish for you – or in – or in your native language. And, um – so I think in the doctors' offices they have a lot of people that will speak Spanish. Exactly. Cause they think that they're going to come in and they don't have to speak English—because there is going to be somebody provided for them –That will help them. So I think that um in some of the doctors' offices where they see you know different – and – I—I mean I think a lot of medical assistants are coming in – and you know. In my doctor's office they had someone – the medical assistant come in and speak Spanish and have front desk people and –you know –So um I think – you know—we have the blue phone, but I mean I just think that that patients who are in the doctor's offices maybe they can tell the patients – when you go to the hospital they might not have somebody that speaks Spanish like they do here in the office, that you might need to bring an interpreter with you. Or you know we – or they'll have an interpretation phone that they'll be using. So, just to educate them just a little bit if they don't speak English.	
		Yeah, I think for the most part when I have used them they appreciate hearing in their own language because they can understand even though they do speak some English. I have heard some feedback though that it—um it's a little more formal and one of my patients um said they have a hard time understanding them because they're so formal.	Tricia-NICU, p. 2
		It's easier to know that I am making sense with a physical interpreter there, because you get the extra added bonus of you can see their – you know the body language that is happening, you can see the facial expressions, you can see the interactions that are happening, you can see if they have that kind of have that quiz—you know quizzical look on their face when they are talking about something and trying to process it. I mean you get all of those cues back. It's like well what exactly is she trying to say, and then you can delve more into it as where if you just are on the phone you're like does your stomach hurt? No, okay.	**Kristi-Neph p. 5**
		Um, you know mainly just getting Spanish speaking nurses in there. We do have a couple on night shift and you know we get a lot more information when we do have someone who can sit there and talk to them and chat with them in their own language. So I think that the best thing that we can do to provide better services for them is to have a more multi-lingual staff.	**Stephanie-Neph, p. 3**
		I'm sure it would be great to have trans—like actual a physical translator— An in house person. Um, and I think that would help because then the family would also be able to be in on the conversation versus just when you have the two people on the phone it's really mostly focused on them um if you had that other person in the room it kind of brings them back in so it's more family centered.	**Rachael-Tele p. 2,3**
		I just—I feel like the—what's lacking right now is convenience. Um, I think people resist um the blue phones because it's not—it's—it's convenient, but it's not as convenient as it could be –	**Heidi-MBU p. 4**

		Sometimes, and then also I think in the future maybe um face—it's—what it's missing is face interface, a facial interface. Like uh a lot of communication is visual and the interpreter is not there. So, I think in the future maybe there'll be video phones.	
		… getting video conferencing— for some of our patients and I honest—in some ways I think that would be a really good idea to have a different person you know. Cause you know when you're talking on the phone a lot of time I—I see that the patients don't look at you. And you know they're just paying attention to the phone so you can't even give um you know through hand gestures or kind of showing type things in your hands they are more focused on the phone—and you know not seeing who you're talking to when you are trying to give teaching—So you can see kind of from our cue to see what also it's a lot easier when you—you know instead—seeing those visual cues from even the translator to see if you know you need to change kind of read off of them. So I thought that would be interesting.	**Kayla-MBU p. 4**
		Um, I did have someone who was um, I want to say they were Vietnamese or Taiwanese or something – I can't remember, um, but I did, I was able – we didn't have the Cyracom phone then and you'd try and use a lot of sign language so that they can kind of get what, what you're after, like trying to get the patient up walk if they are a new surgery and so you kind of use sign language. And then simple phrases like "okay" and "up" and using your arms to motion that they need to get up and then use your fingers as in the walking motion so that they can walk. And they, they look at you and you have to look at them in the eye and try to explain the best way that you can what you need. And I have, have been blessed enough to do okay.	**Bea-Peds p. 1**
		Well, it would just be nice to have 24 hour um person – A live person for interpretation. Uh to come – I think – rather than just being on the phone, especially if it is something where I'm point – you know -- to something. It's something where active like a procedure Uh – cause you know if I am saying this right here and I am pointing to it you know that – that would – that's a little hard for the um the person on the Cyracom phone to interpret because they are not seeing what I'm pointing to.	**Shawn-Peds p. 3**
		For me I think if we had the ability to have someone in person on the floors I just think it would so much more effective just because you can get that verbal and non-verbalizing sometimes hanging on to a telephone and talking to somebody on the other end on the telephone and very far away and very distant and very re-removed doesn't bring that comfort and doesn't start you know that trust that you want to have between um a patient, their parents and stuff…like for instance if there's a situation where a kid is more critical and you're very busy I mean for instance I had a few months ago I had a patient who basically we were trying to kind of trying to decide—decide if we should code him or not. The doctors were in the room, lab was in the room, the extra people were there, there were two nurses in there so we're all communicating to each other in English and it's kind of you know it's—it's a more fast paced talking, we're taking blood pressures, we're taking vital signs and so the parents know something is going on, but at that point in time we have to focus on you know how critically ill this child is and have to clinically take care of this kid before we can explain anything. So for that entire you know 5 to 10 minutes when we're trying to do what's best for the child clinically the parents are left sitting there not knowing what's going on because there's not somebody in the room that can say hey this is what's going on we have to wait until after we're done	**Elaina-Peds, p. 3,4,5**

		clinically taking care of the patient to pick up the phone and then get on the phone with the parents. But that just adds more stress to them at that point. Whereas if we had somebody could call who could come into the room who could kind of you know talk to them more on the side—and explain to them what's going on in their own language they would probably you know be more at peace with what's going on and not have that fearful anxiety.	
		I do think that if you can have a face-to-face translator, which it's—it's just not practical, but I—I do think that that can or could be helpful, more helpful thank on the phone.	**Kim-Peds, p. 6**
		Um, I would love to have a – a medical um interpreter for my patients for my whole shift. In house – yeah. That so – I think that would be just wonderful that I we had you know a medical person that could communicate and I knew that you know they were getting you know my point across	**Rebecca-L&D, p. 5,6**
		I have worked with um I can't remember the name of it, but it's an interpretation or interpreter service but they have the computer screen where you actually can see the interpreter in live feed. And so it's almost- Yeah and they're on little rolling mobile carts and so it's kind of like having just an extra person in the room and so I think that that makes it a little bit more personable. Um I also think that if somehow it was more aware in the community, you know when you come in for hospital care you know it—it would be helpful to bring and interpreter, and also to prepare them that a lot of times there aren't Spanish speaking people that are certified –you know I think that if they knew that even if we did have Spanish speaking staff, if they're not certified , which is very rare, that there isn't anyone there to actively you know communicate that they will be communicating through these phones. They might be you know more willing to try and find an interpreter bring with them. Cause it might, you know in their eyes it might enhance their experience as well. I think a lot of the community thinks that when they get here they can just ask for someone who speaks Spanish, but it's not that easy.	**Genny-L&D, p. 3**
		I think it would be nice to have, especially Spanish seems to be um more common, even if we had a physical person that could come to the unit and translate for us, I think that was much more effective when we had person to person—So I know they wouldn't always be there, but it would be nice if there was even just one person in the hospital that you could call and have them come. All the time. You know—Even at night would be nice because I feel like I feel a little bit more personable than talking on a phone.	**Tricia-NICU, p. 4**

APPENDIX H: THEMES/SUBTHEMES BY UNIT/DIVISION

Green: Saturation Red: No Saturation

Theme	Subtheme	Critical Care			Med/Surg			Maternal Child			
		CCU	Tele	Neph	Med	Surg	Onc	MBU	L&D	NICU	Peds
Desire to Communicate	Interpreter phones	x	x	x	x	x	x	x	x	x	x
	Face to face is best	x	x	x	x	x	x	x	x	x	x
	Family as interpreters				x	x		x			
	Staff as interpreters			x	x	x				x	
	Need better technology					x					
	Need written materials				x						
	Non-Verbal Communication	x	x	x	x	x	x	x	x	x	x
Desire to Connect	Time Management	x	x	x	x	x	x	x	x	x	x
	Increased work load				x	x				x	
	Trust/ Building Relationships/Social Chit-chat	x	x	x	x	x	x	x	x	x	x
	Relationships with Dr.'s			x	x	x	x			x	
	Barriers/Patient Cognition		x	x	x	x					
Desire to provide Care	Physical: Provide Comfort/Address Pain	x	x	x	x	x	x	x	x	x	x
	Emotional: Empathy/Advocacy	x	x	x	x	x	x	x	x	x	x
	Education/Safety	x	x	x	x	x	x	x	x	x	x
Desire to provide Cultural Respect, Understanding	Family Size	x	x	x	x	x	x	x	x	x	x
	Awareness/Benefits/Want more education	x	x	x	x	x	x	x	x	x	x

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