Barriers to Using Certified Interpreters in the Hospital Setting: The Hispanic Bilingual Nurse Experience

By

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Abstract

Introduction: The law requires that certified interpreters are available to translate information to patients regarding their healthcare. However, due to the perceived barrier of time, Hispanic bilingual nurses are regularly called upon to fill this gap in communication. This study investigates the Hispanic bilingual nurse's perspective on being pulled from their primary assignment for the purpose of translation for patients other than their own. Little is known about the perceptions of bilingual Hispanic nurses and the use of their bilingual abilities with limited English proficiency, primarily Spanish-speaking patients despite the availability of certified interpreters.

Purpose: The purpose of this study was to gain knowledge about Hispanic bilingual nurses' perceptions and experiences translating while providing nursing care for limited English proficient, Spanish-speaking patients in the acute care setting. Hispanic is defined as someone of Latin American background often Cuban, Mexican, or Puerto Rican, living in the United States (Merriam–Webster, 2018). Bilingual in this study refers to the Hispanic Registered Nurse that speaks Spanish and English fluently. Understanding their experiences will provide important data for improving patient-centered nursing care and establishing policies that support not only limited English proficient primarily Spanish-speaking patients, but also bilingual Spanish proficient nurses.

Methodology: A qualitative methodology using individual semi-structured interviews was conducted to understand better how Hispanic bilingual nurses perceive their experiences of translating for patients while providing nursing care at the bedside.

Results: Qualitative interview data identified four main themes: (1) motivations to translate or speak Spanish, (2) challenges to translate or speak Spanish, (3) experiences providing care for limited English proficiency Spanish-speaking patients, and (4) impact on nursing care workload. From these themes, positive experiences and challenging situations were described.

Conclusion: Legal mandates surrounding certified interpreters in the hospital setting exist but are not always utilized. Hispanic bilingual nurses are asked to assist with translation. This sets the tone for a complex scenario for both the patients and the nurse involved with translation.

Recommendations: Practice: Offering a standardized bilingual exam and certificate is a strategy for ensuring that clear communication is taking place between healthcare providers and patients. **Health Care System:** Further, this is an opportunity for bilingual nurses to be recognized for their valuable contributions to patient care.

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Introduction

In the United States, there is an under-representation of Hispanic Registered Nurses compared to the size of the Hispanic population, with 16% Hispanics in the U.S., only 3.6% are registered nurses (Morales, 2013). The under-representation of Hispanic bilingual nurses (HBNs) to the U.S. population can be problematic in the hospital setting where certified interpreters may not be utilized. “All health care facilities are required by law—including the Civil Rights Act and updated regulations in the Affordable Care Act—to provide patients who do not speak English with an interpreter” (Minority Nurse, 2018). There are patients who primarily speak Spanish and do not speak English.

In the acute care setting, the pace can be fast, and although there may be certified interpreters available, they are not always used. When there is a bilingual family member at the bedside, often they are utilized for the convenience of the physician, nurse or patient to communicate their needs or answer any questions from either party (Chen, Youdelman, & Brooks, 2007). Some registered nurses may be bilingual in English and Spanish. Bilingual nurses can also serve as translators to communicate very important information from physicians who do not speak the language (Minority Nurse, 2018). On occasion, a physician may request a Hispanic bilingual nurse to translate for their patient. Due to the disproportionate amount of primarily Spanish-speaking people to Hispanic bilingual registered nurses, there are often gaps in meeting the translation needs of patients. Further, these requests for Hispanic bilingual nurses add an additional responsibility when already caring for a full load of patients.

One way to address this issue is to train and utilize more certified interpreters. Flores et al. (2003) discovered that when ad hoc interpreters such as family members,

friends, or untrained medical or non-medical staff were used, a greater risk of having errors with clinical consequences occurred. Ad hoc interpreters were 77 percent more likely to commit errors compared to errors made by hospital interpreters at 53 percent. The National Council on Interpreting in Health Care [NCIHC] (2018) defines a qualified interpreter to be someone who has been trained with a high level of proficiency in at least two languages and that they adhere to the *National Code of Ethics and Standards of Practice*. There are various methods that certified interpreting services could offer to patients. Interpreters can be available in person, via video conferencing, or a two-way telephone system (Locatis et al., 2010). When qualified interpreters are not used, omissions occur. For example, there have been documented cases of omitting vital information about a chief complaint and omission of medication instructions that can have clinically significant harmful outcomes for patients.

Background and Significance

In California, 43.9% of people aged five years or older speak a language other than English at home (U.S. Census Bureau Quick Facts: California 2017). Spanish is the language in the highest demand, particularly in Texas, California, Florida, and Illinois. A 2006 national survey found that 80% of hospitals interacted with LEP patients frequently (i.e., daily, weekly, monthly) with 43% of hospitals reporting daily encounters and 20% of hospitals reporting weekly encounters (Baurer et al., 2012). There are significant numbers of limited English proficiency patients in the U.S. who need translators when seeking healthcare. Policies have been created to protect and serve the needs of LEP patients. For example, in August 2000, former President Clinton issued Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency*,

which directed all federal agencies to ensure that their programs provide equal access to language services for LEP individuals (Chen, Youdelman, & Brooks, 2007, p. 364). Further, Title VI of the Civil Rights Act of 1964 obligates all health care organizations in the United States that receive federal funds to make language services available to LEP patients. One of the regulations that followed is Section 504 of the Rehab Act of 1973.

More recently, under Section 1557 of the Affordable Health Care Act of 2010, the Department of Health and Human Services Office of Civil Rights further strengthened and clarified that their obligations are not only required to provide language services but are also required to ensure that they are of useful quality (Burkle et al., 2017). Thus, it is the law that hospitals provide access to language services for people with limited English proficiency. This means that certified interpreters should be available at all times to translate information about patients' healthcare. In an exploratory qualitative study examining twelve California public hospitals, Baurer and colleagues (2012) found that despite knowing that professional interpreters have the best skills to interpret, clinicians frequently under-utilize them.

Problem Statement

The definition of Limited English Proficiency (LEP) is a minimal ability to speak, read, write, or understand the English language (Divi, 2007). The LEP patients' quality of care suffers, and more interpreter errors occur with untrained ad hoc interpreters. Having a nurse who is bilingual, rather than using a family member to translate, can be crucial (Minority Nurse, 2018). Inadequate interpreter services can have serious consequences for patients. Divi (2007) conducted a pilot study to examine differences in adverse events between English proficiency and LEP patients in U.S.

hospitals and found that 49.1% of LEP patient adverse events led to physical harm compared to 29.5% for patients who spoke English. According to Flores (2005), "trained professional interpreters and Certified Bilingual health care providers may positively affect LEP patients' satisfaction, quality of care, and patient outcomes" (p. 255).

The literature demonstrates that certified interpreters are under-utilized (Baurer et al., 2012). In order to provide the best care possible to all patients, it is important to understand why interpreters are under-utilized and what barriers may exist to accessing these services in the acute care setting. Some barriers include perceived time constraints to accessing an in-person certified interpreter, a lack of knowledge about how to access an interpreter, or an onerous process in accessing video or over the phone interpreter.

Bilingualism is imperative in the clinical settings to meet the unique cultural, bio, psycho-social needs of multicultural patients (Minority Nurse, 2018). Specifically, in California, there is a demand for Spanish-speaking medical interpreters. The imbalances of supply and demand, coupled with the perceived time constraints of accessing a certified medical interpreter, disproportionately low amount of Hispanic bilingual nurses, as well as the fast pace and acuity of patients, creates significant risk for poor patient outcomes. Therefore, learning about Hispanic bilingual nurses' perceptions and experiences of translating for Spanish-speaking patients in the acute care setting may provide important data for improving culturally sensitive, patient-centered care and establishing policies that best serve limited English proficiency patients and bilingual nurses. At the end of the day, being bilingual or having bilingual nurses on staff is all about culturally sensitive patients' nursing care, safety, health promotion, and comfort (Minority Nurse, 2018).

Literature Review

A literature review was conducted to investigate knowledge concerning barriers to using certified interpreters in the hospital setting. Key words used were: barriers, interpreting services for Spanish, challenges, interpreting services, translation, bilingual, bi-lingual, translation services in nursing, interpreter services in California public hospitals, and bilingual nurses. Databases used for this study included: Google Scholar and Scopus. The major areas identified included: under-utilization of certified interpreters, the risks associated with improper communication, and the benefits of language-concordant care. These subject areas are discussed below.

Under-utilization of Certified Interpreters

Hispanic bilingual nurses are often called upon by their colleagues to provide interpreting services for patients. Wros (2009) conducted a phenomenological study with 27 Hispanic nurses. Each of the 27 nurses stated that they had been asked by a colleague to translate, which indicated that there was a general expectation of HBNs to translate regardless of their fluency in Spanish or training in interpreting. In Morales's (2013) study on "Lived Experiences of Hispanic New Graduate Nurses," a new graduate nurse described her experience with being bilingual and being pulled from primary assignments to translate (Morales, 2013):

> "As a new grad, I felt like stuff would get dumped on me because there were so many Spanish-speaking clients or patients...It opens the door to being taken advantage of in terms of being used for your ability to speak the language." (Heather)

The literature reveals some of the multifaceted barriers existing in utilizing certified interpreters. Factors such as limited time, a cumbersome process in using the telephone or video interpreting, and quality of interpreting were discovered. Proper communication tools are crucial, but it can be a difficult task to manage. Sometimes a word-for-word interpretation style can miss the context or emotion behind what the patient may be trying to reveal. Alternatively, a lack of trust may not fully reveal what it is that the patient should be sharing or is trying to say.

An often-quoted rationale for using family members or untrained staff to interpret rather than a certified interpreter in the hospital setting is the perceived barrier of lack of time. The hospital setting is a fast-paced environment filled with acutely ill patients. When there is a limited English proficiency patient who needs medical care, assistance with communication can be challenging. Often, the healthcare provider will choose the fastest most convenient option in communicating with these patients.

In an observational study that Burkle et al. (2017) conducted, they found that wait times for interpreting services in a busy hospital and clinic setting may be a barrier to using certified interpreters. They determined that the mean wait time for in-person interpreters was 19 minutes but could extend up to 100 minutes. Additionally, they found that wait times for an interpreter could risk a delay of procedures.

Burbano O'Leary, Federico, and Hampers (2003) also found that one of the most common reasons cited for not using hospital interpreters was waiting time. The responses included that the interpreters were difficult to get a hold of and were labeled as not translating medically very well. As a result of the perceived barrier of time, Burbano et

al. found that residents reported using the patient's family members to interpret more frequently than hospital interpreters.

In instances where a LEP patient requires language services, the certified interpreter may not be available at the exact time the provider requires this assistance. Despite the mandates available for such services, the provider may not find it feasible and chooses to have this communication gap filled by family members or ad hoc interpreters such as Hispanic bilingual nurses. This can be detrimental if the interpreters are being used for explanation of procedures or consent forms because neither option has been deemed as qualified to interpret such information.

Understanding Quality Interpretation

It is not only important to provide a certified interpreter to explain the plan of care, procedures or provide consent for procedures, but it is equally important to have qualified interpreters. When LEP patients receive an interpretation from a non-qualified interpreter, there is a risk of miscommunication or misunderstanding, which can ultimately lead to compromised patient care and poor outcomes.

In a qualitative study of 62 pediatric residents from the University of Colorado's Department of Pediatrics, Burbano O'Leary et al. (2003) assessed the impact of Spanish proficiency on communication with patients and their families. They found that it was a risk for family members and patients to not understand key diagnostic and medication information. Interestingly, despite the residents viewing hospital interpreters as being effective, Burbano O'Leary and colleagues found that residents reported using family members over hospital interpreters due to waiting time, lack of availability or cumbersome communication.

Flores et al. (2003) audiotaped encounters in a pediatric clinic and found that errors made by ad hoc interpreters were significantly more likely to have potential clinical consequences than those made by hospital interpreters. The omission of information ranging from drug allergies, key information about past medical history, crucial information about their chief complaint, instructions regarding antibiotic dose, frequency, and duration, are also common errors that were discovered in this study.

Ali and Johnson (2016) conducted a qualitative descriptive study of 59 nurses working in acute care hospitals in the U.K. There were 26 individual in-depth interviews and three focus group discussions. All participants revealed feeling comfortable and confident when providing language-concordant care, meaning when they both speak the same language. Ali and Johnson found that language-concordant care improves the patients' experience by increasing their comfort. The participants in their study also shared that at times it could be challenging to finish their primary jobs when they are asked to interpret for a colleague. Another challenge discovered in this study was the lack of clear guidelines and policies surrounding speaking to patients in their native language.

Villalobos et al. (2016) pursued a study consisting of 458 Spanish-speaking patients seen for behavioral health services at a Federally Qualified Health Center (FQHC) in Arkansas. The focus was to explore how the use of trained interpreters related to therapeutic alliance in integrated behavioral health care patients with LEP. This study used quantitative as well as qualitative data collection methods. Behavioral Health Consultants (BHC) or both monolingual and bilingual status were assessed. Patients reported that the benefits of seeing a bilingual BHC were enhanced privacy, increased therapeutic alliance, increased trust and understanding as well as enhanced

communication. They also studied the BHCs reports and discovered that their common benefits to language-concordant care were enhanced accuracy of communication, enhanced rapport, and an increased sense of collaboration with their patient.

When the health care provider is bilingual, there may not be the same urgency to find a certified interpreter because of the mentioned value it has such as providing comfort for the patient. This, in turn, can also be a barrier to using a certified interpreter in the hospital setting.

Quality interpreting can have different meanings depending on the lens it is viewed from. Some of the literature describes quality interpretation to be associated with skill and training. There is also the perspective of the patient, where comfort is associated with quality interpretation. Therefore, quality interpretation should include both the skill of interpreting that requires specialized training but should also include a trusting relationship to allow a sense of comfort for the patient as this adds quality for the patient.

Styles of Interpreting

Interpreting may be thought of as a skill that is uniform. However, many may not be aware that there is a variation in styles of interpreting. The style of interpreting can be an organizational preference, but can also be a patient's preference. "Speaking to patients in their native language isn't only about the words; it's also about their culture" (Minority Nurse, 2018, p. 1).

Because of the increased amount of limited English proficiency patients, there are occasions where the bilingual nurse is utilized by either the physician or fellow staff members (Elderkin-Thompson, Cohen Silver, & Waitzkin, 2001). When the bilingual nurse is doubled up as the interpreter for patients that are not in their direct care, quality

of care for all patients involved, directly and indirectly, are compromised. If the nurse were doubling up on duties, this could pose a danger to their English-speaking patients, as they would have their time with their nurse limited due to the additional workload of their nurse assisting in translating for the LEP patient. Also, the type of interpreting required in medical encounters is more complex than is conceded. Interpreting requires the ability to extract meaning rapidly and to conceptualize it in another language. Although bilingual nurses may be used to interpreting, when they are untrained they use "proximate-consecutive" interpreting where they allow the speaker to finish before interpreting what they can remember, and repeat to the patient in Spanish in third-person tense. "Simultaneous interpreting" is the method used by professional interpreters in which they repeat the clinician's and the patient's information almost instantly, and the interpreter speaks in the first-person tense (Hornberger et al., 1996).

Mueller et al. (2011) conducted a qualitative study to understand the practices of bilingual staff that interpret as a secondary part of their job. The bilingual staff members were from a Federally Qualified Health Center that served a population of approximately 473,000 of which 56% were Latino and 17% Asian. Over 50% of the patients served were of limited English proficiency. Focus groups were held to understand what the interpretation practices were. They found that there were variations in the style of interpreting. The styles included: close rendition alternative, interactive alternative, and the adaptive alternative.

Close rendition alternative is a more straightforward approach to translating where the interpreter speaks word-for-word what the provider is saying and what the LEP patient is saying. Interactive alternative occurs when the interpreter engages discussions

between the provider and the LEP patient by initiating questions and providing summary translations. Adaptive alternative occurs when the interpreter adapts their style of interpreting based on the situation. Each of these styles was found to be appropriate and was supported by organizational policies and language complexities. For example, a closed rendition would be an interpreting style where the interpreter translates word-for-word. Some organizations may require that of interpreters.

The National Council on Interpreting in Health Care encourages interpreters to translate "messages accurately and completely, without adding, omitting, or substituting" (Mueller et al., 2011). However, the California Healthcare Interpreting Association encourages the use of other interpretation alternatives, that interpreters clarify the meaning of terms and also provide simplified explanations of technical terms and expressions when appropriate (Mueller et al., 2011). The organization for which the interpreter is working for may or may not specify the type of translation to provide. The study by Mueller and colleagues supports the idea that the use of the closed rendition method does not always achieve the best communication results.

Trust can be a factor in the optimal quality of interpreting. The patient may or may not relay important information. The patient should trust interpreters so that the utmost accuracy in their history is provided. The participating interpreters in Mueller et al.'s (2011) study shared that they used a variety of styles to gain the patients' trust. Without trust, the patient may not feel comfortable opening up to share vital information or feel comfortable in asking questions. Given the nature of interpreting for a culture that historically has difficulty in trusting healthcare providers, this may also be a factor in why Hispanic bilingual nurses are often utilized at the bedside and thus an additional

barrier to using certified interpreters where a trusting relationship may not have been built.

Trust, also known as *confianza,* is an important component of Hispanic culture and culturally competent care with Mexican Americans. However, Hispanics have the lowest level of trust in healthcare providers compared with non-Hispanic Whites and Blacks (Jones, 2017). Developing trust for the Mexican American patient was described as a multifactorial component that ranges from having needs and relying on the nurse to connecting with the nurse, to its end point of feeling trust, *confianza*. It was also noted that for some patients when the nurse spoke Spanish in a social context or to explain their care, especially if they were LEP patients, this led to a feeling of comfort. Participants in this study also revealed that it was not important that the nurse be Hispanic.

"As a bilingual nurse, if you are the first language nurse to work with the patient when they access health services—be they in the hospital, home care, or primary care—sometimes you spend more time with them initially because the patient is so happy to have someone who speaks their own language" (Minority Nurse, 2018, p. 1). "You find out all this other stuff that the patient held back because of the language barrier or issues with interpreter services. Another advantage of being a bilingual nurse is that you can quality check video or phone interpretation" (Minority Nurse, 2018, p. 1)

When a LEP patient is hospitalized, it can be a scary situation especially with the inability to communicate their needs, questions or fears. When the barriers to using a certified interpreter arise and the Hispanic bilingual nurse is used to fill the communication gap, it may be of value for the patient as well as for the provider trying to assist the patient.

There is some conflicting information regarding policies in interpreting. Although the National Council on Interpreting in Health Care encourages interpreters to translate "messages accurately and completely, without adding, omitting, or substituting" information (Mueller et al., 2011), the California Healthcare Interpreting Association encourages the use of other interpretation alternatives, that interpreters clarify the meaning of terms and also provide simplified explanations of technical terms and expressions when appropriate (Mueller et al., 2011). The consensus between national and state agencies are lacking at this time. For the time being, certified interpreters must rely on their assigned agency or hospital for guidelines on the preference of interpretation style to be used. However, there is one factor that appears to be consistently important to patients, and that is trust.

Gaps in the Literature

The literature review identifies many issues involved with the use of certified interpreters. The data identified complex factors that may affect Hispanic bilingual nurses and communication at the bedside. These include time constraints, inconvenient methods to access certified interpreters, and a potential lack of trust from patients to disclose information to interpreters.

However, limited knowledge exists concerning the specific Hispanic bilingual nurses' experiences and perceptions. The HBNs perspective is relevant information to add to the existing body of knowledge. A need exists to understand perspectives and experiences of HBNs better as they translate at the bedside when there are certified medical interpreters available in the hospital setting. The purpose of this study was to gain knowledge about Hispanic bilingual nurses' perceptions and experiences translating

while providing nursing care for limited English proficient, Spanish-speaking patients in the acute care setting. The next section describes the methods used in the present study.

Methods

Research Design

A qualitative study using individual semi-structured interviews was conducted to understand better how Hispanic bilingual nurses perceive their experiences of translating for patients at the bedside. According to Merriam (2009), a basic qualitative study is the most common form of qualitative research. A basic qualitative study, as described by Merriam (2009), is a useful approach to understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences. Further, this approach can provide insight into their lived experiences. A qualitative design was found to be appropriate for the exploration of how Hispanic bilingual nurses perceive their lived experiences of providing translation services at the bedside by getting an idea of what meaning they attribute to their experiences (Merriam, 2009).

Setting/Sample

Participants were recruited from 1) a large academic medical center in the western part of the United States, 2) other acute care hospitals within northern California, and 3) referred to the primary investigator (PI) via snowball effect. Before recruitment, the Institutional Review Board (IRB) approved all procedures related to this study.

Procedures. A flyer was created and displayed on social media and in the breakroom of the investigator's place of employment (see Appendix A). Email invitations were also sent to those who expressed interest.

Sample. Inclusion criteria for the study are participants, above age 18, Registered Nurses; self-identify as being from Hispanic descent and speak Spanish fluently and currently employed in an acute care hospital in northern California. A sample of 12 bilingual Hispanic nurses was recruited for the study (see Table 1). All interviews were conducted in a private location from June 2018 through December 30, 2018.

Table 1

Hispanic Bilingual Nurse Participants

Participant	Gender	Background
Participant 1	Female	Hispanic
Participant 2	Female	Hispanic
Participant 3	Female	Hispanic
Participant 4	Female	Hispanic
Participant 5	Female	Hispanic
Participant 5	Female	Hispanic
Participant 6	Female	Hispanic
Participant 7	Female	Hispanic
Participant 8	Female	Hispanic
Participant 9	Female	Hispanic
Participant 10	Female	Hispanic
Participant 11	Female	Hispanic
Participant 12	Female	Hispanic

Data Collection/Procedures

Interviews consisted of semi-structured open-ended questions designed to elicit longer in-depth responses. Semi-structured interviews utilize an interview guide with broad questions (Polit & Beck, 2014). The interview questions were developed alongside an expert in qualitative research (see Appendix B). Each interview was audio-taped and then transcribed by a professional transcriptionist. Interviews lasted from 20 minutes to

45 minutes. The transcribed interviews were printed and read over along with the recorded audiotape to ensure transcription accuracy.

Data Analysis

After the audio-recorded tapes and transcriptions were reviewed by the Principal Investigator (PI) several times, the data was thematically and descriptively analyzed. Thematic analysis is a method used for analyzing, and reporting patterns within data (Braun & Clarke, 2006). This analysis was done by reading the written transcripts multiple times and identifying emerging themes derived from the interviews. Polit and Beck (2014) point out that themes identified through an inductive reasoning process can be used to construct a rich description of narration and identified themes. Themes were identified by reading, and re-reading, color-coding, and then retyped onto a separate document for organization. Once themes were identified, they were grouped into categories.

Protection of Human Subjects

Approval from the Institutional Review Board was obtained from the University of California–Davis. To protect the participants' confidentiality, the PI conducted one-on-one interviews in a private location selected by the participant. Participants were assured protection of their confidentiality and no identifying information was recorded. Audiotapes and notes were kept locked in a safe. Transcripts were saved in a password-protected laptop. No potential risks were identified. However, given the sensitivity of the research topic, there was a possibility that uncomfortable feelings could have been experienced related to their lived experience as a bilingual Hispanic nurse.

Results/Findings

A total of twelve participants were interviewed for this study from June 2018 through December 30, 2018. The data obtained from interviews resulted in four main themes: (a) motivations to translate or speak Spanish, (b) challenges to translate or speak Spanish, (c) experiences providing care for limited English proficiency Spanish-speaking patients, and (d) impact on workload.

Overall, the themes related to Hispanic bilingual nurses' experience at the bedside are multifaceted. Many of the participants felt that the ability to speak the language was an asset or a gift they were willing to share. They described positive experiences such as a sense of fulfillment, a sense of connection, and feeling helpful. However, there were challenges where some participants felt bullied into situations or obligated to translate. When participants set boundaries so that they could attend to their assigned patient workload, there was a sense of guilt. Some participants were reluctant to call it a burden but also described it as challenging to have another task added to their responsibilities.

Motivations to Speak Spanish or Provide Translation

Efficiency of care. The participants described many reasons that motivated them to interpret for patients. One of those reasons was efficiency. Part of that efficiency in care was building rapport. When patients open up, the nurses feel they can provide comfort and quality of care more efficiently. As Participant 11 shared:

> "I feel like it's more efficient. I speak Spanish, and they speak Spanish, so I feel it saves time."

Participant 2 stated:

> "Again, rapport… you build that trust with that patient, they get to know you, and as far as communication, it's just easier, you're not including a third party."

Empathy. Other motivating factors included empathy for having limited English proficiency, and building relationships with their patients. As Participant 6 shared:

> "I know how overwhelming the situation is to not know the language, to not know what's going on...I can relate to their situation...I try to help them as much as I can even if they're not my patients."

Additional factors discovered included being able "to help people that need help with interpretation" (Participant 4), to "give them a full understanding of what's going on in a language that they best understand" (Participant 9).

Participant 3 elaborated:

> "The ability for them to be knowledgeable about what's happening. Their ability to ask for what they need, and their comfort level. I think that being sick...is overwhelming in and of itself and just to have someone that understands your language and your culture and your tradition and the way that you have lived your life gives you a whole different experience."

Participant 5 shared:

> "I feel like they are able to have more of a comfort level with me...because it's also someone who understands not just their language, but [also] their culture."

Participant 3 explained:

> "There's a comfort level when you're ill, and you feel sick; you're afraid... to have someone speak to you in a language that you understand completely...and

then it also has its, you know, kind of joy for me also to feel that connection, a little bit of something above and beyond with these patients."

Retention of language. Nine out of the 12 participants revealed that Spanish was their first language and they see the value of retaining the skill of speaking their native language. Some participants also shared that they have personal experience with translating for their parents as children. Some participants expressed that Spanish was their primary language and that there was a level of enthusiasm when they had a Spanish-speaking patient.

"I kind of get a little excited when I can actually speak with them in my native language." (Participant 7)

This was further expressed by Participant 9:

"Well for me, it's really important for me to keep my second language; well it's my first actually. It was my primary language and it's very important for me to keep it."

Participant 12 confided:

"Because it's something really important and I feel like people who need translation services deserve it, and my parents needed translation services when I was little, and I was their translator. And I remember being their translator. And now I think that I'm a better person for it."

Participant 8 elaborated:

"It's always been a blessing. I grew up translating for my mom, and my mom still doesn't speak English. She's been in this country for almost 40 years. So I understand where the need is, and it's not a burden for me. And if I see somebody

who comes in who doesn't speak English, I will always go out of my way to translate for them because for me it's a blessing that I have, that I am bilingual and I try to give that to my children as well to make sure that they are bilingual. It's a gift to be able to communicate with other people of other countries."

Value of translation services for patients. The value of translation for many participants was described as a positive experience for their patients and for the nurse as well. While reflecting on the benefits of speaking Spanish, Participant 10 shared:

"I think primarily there is a sense of fulfillment, a sense that you're actually helping. And as nurses you have that, I think, innate feeling to help and to assist in any way. And if it's something as simple as translating that makes them understand and feel a sense of, you know, grasping better...then that's fulfilling."

Participant 1 spoke positively:

"So far it's been a good experience. I mean feeling helpful and being able to communicate with them and being able to help those that, you know, might need a little bit more help than other patients."

Participant 3 stated:

"I think it's made my nursing career more meaningful. I found a deeper sense of helping people that are like me… that like...you know, my grandmother.... and I know that every time I can comfort someone, or explain something, I feel like I'm almost reaching out to her. It's given me a bigger depth of satisfaction with my work and a bigger connection. And I feel like they give me as much connection back as I'm giving them."

Challenges of providing translations. Some challenges described by participants were being "pulled" from their primary assignments to translate, having an additional responsibility, the desire to want to help but the inability of doing so because of lack of time, lack of medical terminology, lack of protective protocols, and an interruption of workflow.

Impact on workload. All twelve nurses stated that serving as a translator for patients other than their own impacted their workload or the flow of their day. Some of the feelings associated with the workload impact were guilt, pressure, and anger. Participant 5 shared:

> "I won't say a burden, but it almost feels like it's one more thing that I need to do when I already have all these things to do. And it's an obligation, because there's nobody else...but again, then I feel like they're judging me, or saying, 'oh okay, she just doesn't want to help.' And you know it makes me feel like I'm being burdened, but then now they're going to have a certain view about me because I'm not helping them. And then if I forget, and they're like, 'oh, I'm sorry. I know I asked you but can you come now?' And then it just adds like another level of anxiety sometimes. Then I'm like, oh my God, I totally forgot...I need to hurry up and do this for my patient so then I can go translate. I always try my best to get out there as soon as I can, but nursing is about priorities. But it does put pressure on you knowing that, okay, now I need to finish this so I can go over there, and then come back, and figure that out."

Participant 7 recalled a situation that was difficult for them because of the pressure and guilt associated with translating:

"I was really conflicted because I knew that this [patient] needed someone to be there for them, someone that could actually talk with them and in their language, so I felt like I needed to be there and there was no one else that could go apparently. So I felt a lot of emotions at first. I felt a little angry because I have my own patient as well; you're taking time away from my time of taking care of this patient who also needs me. Because it took about 45 minutes both [times] for me to go translate. And my patient was also very sick. So I felt angry. And then that was the [time] when I said, I don't think I can do this again, and they were like, 'Well there's nobody else,' which is what they pretty much said both [times] I went."

The nurse participants described their experiences as difficult because of the ability to help with translation for Spanish-speaking patients yet the challenge of time constraints or of having their own patient load. Participant 5 shared:

"It really depends on the acuity of my patient. But I feel bad when I can't translate for them because I feel like, not that I'm letting them down, but I feel like they're going to be disappointed, like, 'Oh [she] never wants to help. She thinks she's busy with her assignment.'"

Participant 9 described the challenge of speaking the language when faced with time constraints during bedside report:

"...it happens every time that the five minutes may be coming in putting my name on the board, I'll be back in a little bit, let me check my other patients; that's not what happens. It's like all of a sudden they finally see somebody that speaks their language. And then all the questions...like they can ask all these questions that

> they nodded yes to the doctor they understood. But also they have the ability to communicate with somebody and I'm in there for an hour, you know, every time."

The challenges described by many participants included medical terminology and time constraints. Participant 10 stated:

> "I do speak Spanish but there are sometimes like medical terminology that I don't know exactly what precisely those exact words may be and I try and get."

Participant 9 elaborated:

> "They require more time from me especially when I'm translating for someone else."

Other challenges described were forgetting how to speak in Spanish as Participant 4 shared:

> "I think that one of the challenges is, especially if you don't use it quite often, you start forgetting and you want to go back and forth with speaking Spanglish."

Two of the participants described exceptional challenges that had not been mentioned by other participants. One of the challenges described was a manipulation of using the Spanish language to communicate. Participant 5 explained:

> "I've also experienced the other side where, then, I've built this relationship...and then they would get upset about certain things because I was there more; I was communicating with them more. But then if I didn't do something, this is also more of a manipulative type of [patient] that likes things a certain way...then if she didn't like something that was my fault."

Fear was another challenge that was described by Participant 12:

> "Honestly, not being covered by that protocol in the hospital, I think that's my biggest challenge is just hoping that I don't end up getting in trouble for something."

From the 12 participants, only two stated that they did not feel any challenges when speaking Spanish to patients.

Risk of poor translation for patients. The risk of poor translation recounted by Participant 3 was described as a disturbing situation:

> "I don't feel like they are explaining the services available or their options. I can come to mind of one lady in particular who was not aware that she had a kidney removed in a prior surgery. And when asked what other surgery she had, all she could tell me was that a doctor had fixed her at a different hospital. And digging into her chart further, were able to realize after an ultrasound was done that one of her kidneys was no longer there. And she wasn't even aware of what this meant for her. I feel like a lot of my patients think that what the doctor says is almost law. And they don't understand that they have the option to say, 'I'm not comfortable with this treatment. What does this treatment look like?' They are very willing to do whatever they're told to do which really does make it difficult sometimes when I feel like they don't understand the whole picture or what this is going to look like for them."

Participant 7 recalled a family member who had been frustrated with lack of listening and communication provided to him regarding his loved one. When the opportunity of finally being able to communicate with the Hispanic bilingual nurse came about, it was as if he had unleashed his frustrations.

> "When I was there, it was just like one thing after another. The [family member] was like, 'So why did this happen?' And he was like, 'Why did you guys just notice this?' So I feel like… I was like, okay, I'm done translating for this [family member] who is clearly very angry and I didn't know what the situation was because it wasn't my patient. This [family member] was very upset with the care that had been provided. And I don't know the full story because it's not my patient, so would you please call a translator? And they did, and they didn't call me anymore."

Given the nature of the complexity that involves translating for patients in need of understanding what is happening with their healthcare, it is vitally important to note that there is also a potential risk for the Hispanic bilingual nurse involved in helping during acute situations. Participant 8 shared her personal experience working for a facility that certified their bilingual nurses. The participant recounted the difficulty with facing allegations of a poor translation.

> "I was deposed; I went to a deposition for translating because they stated that I translated something for them that they didn't understand. And so there was a little bit of an issue, and at one point it settled out of court... that made me very cautious and so I said that I would never translate [at a facility that didn't certify me]. Essentially [I would be] giving my word that I am a fluent Spanish translator because nobody has evaluated my level of translating skills... And so I always [share] be very cautious what you translate because what you translate especially if it's tied into legality can have issues in the long run. And so you always want to make sure that you are also documenting exactly what you've told them,

especially if it's beyond like, oh, can I get you some water. If it's something more related to the plan of care, you want to make sure that you've documented everything you translated."

This study's participants identified both the positive and challenging aspects of interpreting for their Spanish-speaking patients in the hospital setting. Hispanic bilingual nurses are often called upon to provide translation services at the bedside. According to the participants, there is a mixture of feelings surrounding these services. It is welcomed, and many HBNs are honored and believe that it is a moral obligation. Challenges exist; however, with dedication and time, this can be improved upon.

Discussion

The barriers that exist to using certified interpreters in the hospital setting vary. The literature describes these barriers to be primarily of time constraints, challenges in accessing an interpreter, interpreting styles, and comfort levels of patients (Burbano O'Leary et al., 2003; Burkle et al., 2017; Jones, 2017). Limited documentation exists regarding Hispanic bilingual nurses' experiences other than a study of newly graduated nurses with the primary focus of their overall lived experience, not focused on solely translating at the bedside (Morales, 2013).

The lack of documented experiences and perceptions of HBNs translating at the bedside is what prompted the primary investigator's intrigue towards this study. There are barriers to using certified interpreters in the hospital setting. However, the impact that it may or may not have on HBNs should be noted. Understanding the impact that these barriers to utilizing certified interpreters have on HBNs may open opportunities for improvement in nurse satisfaction as well as patient satisfaction. Also, opportunities to

improve current practices and policies that best serve patients and bilingual nurses are topics to be further investigated.

The purpose of this study was to explore and understand what the Hispanic bilingual nurses' experiences are in translating at the bedside in the hospital setting when certified interpreters are available. The findings of this research study include the Hispanic bilingual registered nurses' experiences, the revelations about the struggle between the fulfillment, joy, stress, and workload impact that some HBNs may experience translating at the bedside. Currently, documented information regarding HBNs experience is lacking in the literature. All twelve participants disclosed that they were always willing to help, but when asked to help translate for a patient other than their own, a challenge exists because it takes them away from their primary patient responsibilities. There was a hesitancy to call it a burden because of its negative connotation, yet all participants concurred that it does impact their workload. On the other hand, most participants spoke about the comfort that it brings, not only for their patients but also for the nurse.

Hispanic bilingual nurses want to assist in translating and want to be given the platform to do so. Many times, they are placed in situations that "pull" them emotionally and physically because they want to share their gift of communicating yet they have to balance their primary obligations with their moral obligations. Spanish-speaking patients most often appreciate and yearn to have a healthcare provider who can effectively communicate and connect with them. However, the challenges are the disproportion that exists between Spanish-speaking patients and Hispanic bilingual nurses. Also, HBNs are not always given the opportunity to care for Spanish-speaking patients solely. This leaves

a gap of communication left open due to the already existing barriers in using the certified interpreters mandated by law. Some hospitals have already acknowledged this phenomenon by offering a certified bilingual certificate for those bilingual nurses to fill the gap in communication and also acknowledge the additional workload that it entails by offering a monetary stipend. Some participants disclosed they came from such facilities and did not express the same anguish described by others from institutions that did not offer the same acknowledgment.

Implications for Nursing Research

This current study will hopefully pave the way for more research regarding Hispanic bilingual nurses in healthcare settings. Understanding the Hispanic bilingual nurses' experiences provide important data for improving patient-centered care and establishing policies that best serve limited English proficiency patients and bilingual nurses. The data indicate that patients, as well as HBNs, share the joy and comfort associated with the shared language of Spanish.

Implications for Practice

This study further proves that policies need to be developed to assist in having better continuity of care for LEP patients as opposed to having HBNs separated from their primary assignments to translate if and when a certified interpreter is unavailable. Assignments can be designed with language concordance in mind. Based on the findings of this study, some participants felt they had no choice but to translate whenever a certified interpreter was not available. Some participants disclosed feeling pressured to hurry up and carry out tasks faster. This practice may be unsafe for all patients involved. The fact remains, limited English proficiency patients deserve equal access to

communication and thus far, that is achieved by utilizing a certified medical interpreter. If there is an option to offer nurses a bilingual certification, policies must be established to protect both the patient and the registered nurse.

Implications for Nursing Education

There would need to be education surrounding the bilingual certification process. A language service agency would provide the criteria that are required for proper competency in a specific language. Nursing education would be geared towards preparing for the examination, testing information, and next steps involved following successful examination and bilingual certification. Furthermore, educating nursing staff on what it means to be bilingually certified and proper usage of the certificate would need to be included.

Implications for Health Systems

Strategies for supporting bilingual nurses with interpretation. There are three main strategies that organizations can consider to support Hispanic bilingual nurses. First, acknowledgment for the time and effort that it entails to provide bedside care in Spanish or to interpret for their colleagues by offering HBNs a bilingual certification with a monetary component. Second, establishing protective policies for the HBNs would ensure that HBNs are not practicing unsafely and are not being taken advantage of. Lastly, formulate a method to pair Spanish-speaking patients with the certified bilingual nurse. This would help eliminate the additional responsibility for HBNs to assist patients that are not under their direct care.

These strategies to support the HBNs would be in conjunction with the certified medical interpreters and is not designed nor suggested they be replaced with certified

HBNs. In contrast, it would enhance services provided by the Interpreting Services Department. Certified medical interpreters would continue to provide interpreting services, a very specialized skill. However, bilingual certification would allow delivery of care in the preferred language of the patient.

Bilingual nurses have the opportunity provided by the organization to get a bilingual certification. For the bilingual nurse, this would offer a means of enabling language-concordant care when feasible. In doing so, this could not only assist the patient in communicating, but would enhance the patient experience, improving patient satisfaction, and also perhaps eliminating long wait times for communication between the patient and the healthcare provider. This would not eliminate the need for certified interpreters, but this would enhance services provided by the Interpreting Services Department. This research should not be used to decrease the use of Certified Medical Interpreters nor should it be used to decrease their services. The Joint Commission currently supports allowing bilingual practitioners to communicate directly to the patient in another language. However, it recommends "...that the organization has a process to make sure that communication with the patient in the non-English language is effective and meets the patient's needs" (Joint Commission, 2019).

Policies need to be set in place that would also protect the nurses from being taken away from their primary patient care. For example, once a Hispanic bilingual nurse becomes certified, this would enable the HBN to work directly with patients in the unit that speak Spanish. The HBN would be assigned to Spanish-speaking patients when feasibly safe. Thus, HBNs would not be traveling across a large unit to care for Spanish-speaking patients but would be assigned to one to three patients that are Spanish-speaking

and within a reasonable distance from one another. The charge nurse on the designated unit would have access to a list of certified nurses and would pair them accordingly. In this event, the HBNs would not be pulled to translate for other patients that are not under their direct care. For patients that require language services and do not have a certified bilingual nurse caring for them, a certified medical interpreter would be accessed and utilized. Also, the policy would state that HBNs are not to partake in the consent process for procedures and that certified medical interpreters would continue to be required for those services. The Health Sciences Research Commons further recommends policies to include assessment for language proficiency for bilingual clinicians in addition to explicit policies and plans related to the provision of language services for patients with limited English proficiency (Huang, Jones, Regenstein, & Ramos, 2009).

The pairing of the certified bilingual nurse and the limited English proficiency patients would support the medical interpretation services. The certified bilingual nurse, in essence, would be caring for the patient and would be deemed as competent to communicate in the designated language. Instances where meal preferences or questions about the daily routine could be fulfilled by the certified bilingual nurse and would not require the coordination of accessing the certified medical interpreter. It would be beneficial to the medical interpretation services because the certified medical interpreters could be utilized in more complex cases that require consent forms or updates on the plan of care, for goals of care meetings, family meetings or other complex, time-consuming scenarios that require a professional certified medical interpreter. This, in turn, could eliminate long wait periods by freeing up some time for certified medical interpreters and their services not being associated with a long wait time (Burbano O'Leary et al., 2003).

Limitations

Several limitations of this study are to be noted. One limitation is that this study's participants were solely female nurse participants; there are no male nurse participants. It is unclear if this is due in part to a dearth of male HBNs. As with all qualitative studies, the sample size is small which limits the ability to generalize. However, qualitative studies are not to generalize but to take a deeper dive into the participants' lived experiences. Other limitations include participants' years of practice or whether they currently work for an organization that certifies their bilingual nurses. Some participants did share that they are currently certified as being bilingual in their institution. However, this was not a question that was asked of any participants. In hindsight, a great question to have asked participants is what they view as a solution to this difficult position one is placed in with struggling between the joys and challenges of translating for LEP Spanish-speaking patients.

Future Research

Further studies to include a larger participant pool could be of benefit. Although efforts were made to include a larger number of participants, the small sample size does not represent all HBNs who provide translation services in the healthcare settings. Also, it would be interesting to compare and contrast Hispanic bilingual nurses that are employed in an environment where they have an option to become certified, versus HBNs that are not certified interpreters to compare their experiences translating at the bedside. Also, asking participants' insight about what they believe to be potential solutions or recommendations may be an intriguing line of inquiry. Future studies could

also consider quantitative studies to explore the HBNs further and perhaps the patients' perspective of having a Hispanic bilingual nurse caring for them as well.

Conclusion

In conclusion, there are legal mandates available to protect limited English proficiency patients. For a variety of reasons, they are not always utilized. Hispanic bilingual nurses are often called upon to fill the communication gap. The nurse participants in this study shared mostly positive experiences but noted some challenges involved as well. These challenges involve potential patient safety concerns, ethical dilemmas that cannot be negated, and HBNs yearning to embrace their culture and sense of community and family. In learning more about those challenges from the participants, it has become apparent that there are alternatives that could be explored further. The alternatives require coordination and acknowledgment that this is not a simple fix. However, alternatives could enhance the patient experience, improve patient outcomes, improve nurse satisfaction, and empower a patient population that is already so vulnerable. These efforts will support Hispanic bilingual nurses in providing the best care to their patients, facilitate trusting relationships, and contribute to positive patient outcomes. There is an existing population of Hispanic bilingual nurses that have a desire to help; however, the proper format needs to be provided. Perhaps future studies could help support an environment for change.

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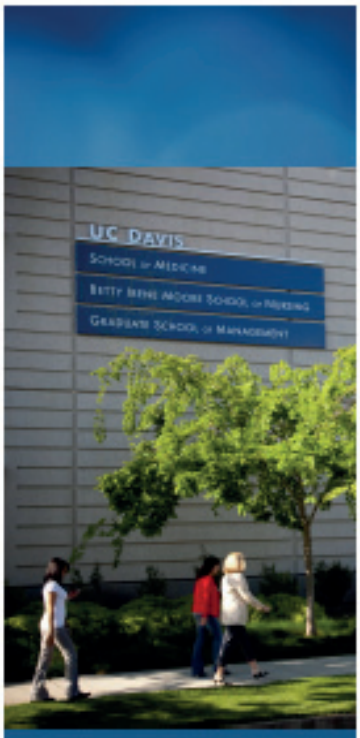
Appendices

Appendix A: Recruitment Flyer



UCDAVIS
BETTY IRENE MOORE SCHOOL of NURSING

Research Study

The purpose of this study is to gain knowledge about Hispanic Bilingual Nurses perceptions and experiences translating for Spanish speaking patients in the acute care setting.

Who is Eligible? Registered Nurses; self-identify as being from Hispanic descent and speak Spanish fluently and currently employed in an acute care hospital in Northern California.

This will be a one-to-one confidential interview that will last approximately one hour or however long participant chooses to share their experience.

You will receive a $10 gift card for your time and participation in this study.

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Appendix B: Interview Questions

Based on your personal experience(s) when caring for Limited English Proficiency (LEP) Spanish-speaking patients, please

- Describe past experiences providing care for your Spanish-speaking patients.
- Describe your motivations to speak Spanish with your patients.
- Describe challenges, if any, to speak Spanish with your patients.
- Describe benefits, if any, to speak Spanish with your patients.

Are there variations in the topics or procedures that you feel comfortable translating or not translating?

- Have you ever been asked to translate by a co-worker, physician or family member for a patient who was not under your direct care? If so, would you describe the situation? How did you feel about being asked to do this?
- Have you found that serving as a translator for patients other than your own impacts your workload or the flow of your day? If so, would you describe?
- Have your feelings or response to being asked to translate for other patients changed or evolved over time? If so, how?
- Has/have your experience(s) as being a Bilingual Registered Nurse influenced your nursing career?