Overcoming Language Barriers in the NICU

Infants of limited English proficient (LEP) families in the NICU are at risk for poor outcomes and potential medical errors due to language and cultural barriers. Clinician interpretation techniques may fail to consider LEP family cultures and expectations, which have led to disproportionate readmission rates, less time performing skin-to-skin, decreased breastmilk use rates, and patient dissatisfaction. Data have shown that even where professional medical interpreting services are available, they remain underutilized due to apparent lack of time, lack of training, and the normalization of the underuse of interpreters.

The goal of this tip sheet is to enable hospitals to:

1. Foster a trusting environment between clinicians and LEP families in order to improve infant outcomes.
2. Minimize medical error and miscommunication.
3. Better understand cultural differences of LEP families that may potentially affect care.

Potentially Better Practices (PBPs) for overcoming language barriers in the NICU:

1   Do not assume language proficiency based on the patient's name or characteristics. [1]

- More than 25% of families coming to HRIF clinics have a language other than English as their primary language spoken at home. We anticipate that there is an even higher percentage of LEP families in the general NICU population.
- Be aware that there are degrees of language proficiency and that the listed language proficiency may not be entirely accurate.
- Relying on unqualified interpreters, whether members of the patient's family or other hospital staff, can lead to miscommunication. Unqualified interpreters include; family, friends, and NICU staff who are not qualified bilingual staff. Section 1557 of the Patient Protection and Affordable Care Act emphasizes the importance of using a qualified medical interpreter versus an ad-hoc one and expressly prohibits the use of unqualified interpreters barring extreme circumstances. Unqualified interpreters include; family, friends, NICU staff who are not certified healthcare interpreters, etc. Studies have shown that using qualified in-person or remote (phone/video) services results in better communication than unqualified, ad hoc interpreters. [1][2][7][10]
- When using an interpreter, continue to address the patient's family directly and not the interpreter ("Can you tell me more?" is more appropriate than "Can you tell the patient's family to tell me more?).
- Body language and positioning of interpreters and other clinicians can affect patient perceptions of healthcare and comfort.
  - It may be helpful for the interpreter to stand beside/behind the patient/family member to be able to receive and interpret information from the entire medical team.
  - For video interpreters, ensure that the interpreter can see the patient/family member and vice versa. It is also recommended to brief the interpreter before beginning the conversation with the patient/family member (e.g. "I'm Nurse X and we're in the NICU. I'm about to discuss discharge planning and readiness with the patient's mother.").
- Avoid using online translation tools (Google translate, etc) as this is not a suitable substitute since accuracy may vary widely, and could potentially introduce risk and patient safety issues.

2 Understand that different cultures have different preferences for involvement with staff.

- Many families may be wary of inconveniencing health care providers or feel unable to ask for help when needed.[4][5][6]
- Some families may not be inclined to ask for interpreting services, additional support, or further clarification due to cultural stigmas, or practices.
- Be willing to breach the cultural divide, as many LEP patients come from varying backgrounds with different value systems that that may not be reflected in U.S. healthcare systems.
- Be cognizant of potential power dynamics between LEP families and healthcare providers.
  - Some families may feel left out from the decision making process due to lack of education, lack of understanding, etc.

4 Emphasize family centered care.

- Ensure that LEP families have access to social services such as post-discharge counseling programs and connections to local community organizations like WIC and breastfeeding support groups, in a variety of languages.
- Empower family decision making and vocalize empathy for family concerns.
  - It is important to communicate and vocalize empathy to the family even though this will require more time with the patient's family.

3 Remember to constantly check for family comprehension.[3][4]

- Assessing and addressing the patient/family health literacy and learning preferences will help providers improve and minimize barriers to effective communication. [8]
- Nodding, smiling, or making eye-contact may not equate to patient comprehension.
- Using techniques such as the "teach-back" method can be a helpful approach to confirm understanding. [9]
  - For example: "Just to make sure I've done a good job explaining the procedure/process, can you tell me what you understand in your own words?"
- Using a variety of different communication strategies when encountering LEP patients and families may be beneficial to improved communication.
  - Non-verbal communication strategies such as using mannikins, printed translated materials, parent buddy programs or peer support specialists (especially if they are language concordant), may aid comprehension in addition to using qualified interpreters.

5 Bias is prevalent in every team.

- It is important to work collectively to combat implicit bias to protect families, patients, and staff and to ensure respectful care.[2]
- Avoid jargon, acronyms, and speak in standard English. Speaking louder does not enhance clarity or comprehension.

[1] Improving Patient Safety Systems for Patients With Limited English Proficiency. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/health-literacy/professional-training/lepguide/index.html

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[5] Sigurdson K, Morton C, Mitchell B, Profit J. Correction: Disparities in NICU quality of care: a qualitative study of family and clinician accounts. J Perinatol. 2018;38(8):1123. doi:10.1038/s41372-018-0166-z. https://pubmed.ncbi.nlm.nih.gov/30042468/

[6] Merritt L. Communicating with Chinese American Families in the NICU Using the Giger and Davidhizar Transcultural Model. Neonatal Network Vol 32 Issue 5, DOI: 10.1891/0730-0832.32.5.335. https://connect.springerpub.com/content/sgrnn/32/5/335

[7] Jones J et al. Increasing Health Care Workers' Proficiency With Using Professional Medical Interpretation: A Workshop. MedEdPORTAL. 2020. https://www.mededportal.org/doi/full/10.15766/mep_2374-8265.11017

[8] Cornett, S., (Sept. 30, 2009) "Assessing and Addressing Health Literacy" OJIN: The Online Journal of Issues in NursingVol. 14, No. 3, Manuscript 2.

[9] Farris, Cindy PhD(C), MSN, MPH, CNE The Teach Back Method, Home Healthcare Now: June 2015 - Volume 33 - Issue 6 - p 344-345 doi: 10.1097/NHH.0000000000000244

[10] https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html