ABSTRACT
Language barriers impede access to healthcare, can compromise quality of care, and may increase the risk of adverse health outcomes among patients with limited English proficiency (LEP). Events reported to the Pennsylvania Patient Safety Authority from June 2004 through May 2010 were reviewed to determine what types of events most frequently affect patients with LEP. Falls, errors related to a surgical procedure, and medication errors composed the top three types of events reported for these patients during the time frame. Federal civil rights policy obligates healthcare providers to supply language services, and guidelines have been developed to help providers adhere to those requirements. Resources for language services, however, can be limited. Strategies that facilities can use to manage LEP patients include writing a clear plan, reviewing vital documents for languages most frequently spoken (e.g., informed consents), using interpreters, hiring and testing the language proficiency of bilingual staff, and educating staff on cultural awareness. (Pa Patient Saf Advis 2011 Mar;8[1]:26-33.)

INTRODUCTION
According to the 2000 U.S. census, nearly 18% of U.S. residents five years of age or older speak a primary language other than English at home. More than 21 million (8%) speak English less than “very well.” More recent data from the American Community Survey (2005-2009) reports that 8.6% of the population (24 million Americans) have limited English proficiency (LEP). Research documents that language barriers encountered in healthcare settings can compromise the quality of care for LEP patients or patients who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. A study by Wilson et al. showed that language barriers are associated with decreased access to primary and preventive care, impair patient comprehension, decrease patient adherence, and diminish patient satisfaction. A systematic review revealed that the use of trained medical interpreters and professional medical interpreter services and bilingual providers can improve communication, satisfaction, and adherence among LEP patients.

Many patients and providers who need medical interpreters have no access to them. For example, a study on the effectiveness of interpreters found that no interpreter was used in 46% of emergency department [ED] cases involving LEP patients. When a language barrier exists without a qualified medical interpreter, the situation can be dangerous. This is particularly true if young children serve as ad hoc interpreters. They are unlikely to have full command of two languages (their first language and English) or medical terminology and may avoid discussing sensitive issues.

Compared with English-proficient patients, LEP patients report less satisfaction with medical encounters, have different rates of diagnostic testing, and receive less explanation and follow-up. Although professional interpretation has been associated with improvements in patient satisfaction, communication, and healthcare access, these services are often largely underutilized. Reliance on untrained ad hoc interpreters, perceived time and labor associated with obtaining and working with an interpreter, and costs of implementing professional interpreter services serve as barriers to implementation and utilization.

Pennsylvania Patient Safety Authority analysts reviewed 232 events associated with language barriers and LEP reported to the Authority from June 2004 through May 2010. Analysis of these events and review of the relevant literature identify LEP as an issue that can affect patient safety in all settings. This article reviews LEP-associated events reported to the Authority, reviews the laws that govern and protect patients with LEP, and discusses ways that facilities can enhance the quality of care for LEP patients.

AUTHORITY REPORTS
Of the 232 event reports, 114 (49%) involved patient falls, 62 (27%) involved errors or complications related to a surgical procedure, and 14 (6%) involved medication errors or adverse drug reactions. (See Table 1.) One-hundred nine reports (47%) were for LEP patients over the age of 65. (See Table 2.) Of the 232 reports, 128 (55%) reports specifically mentioned the primary language spoken, whereas the remaining reports (104) did not. Where the language was specifically documented, Spanish was most frequently mentioned. (See Table 3.) Seventy-eight reports (34%) referenced the use of an interpreter. The locations of the reports within the facilities included the medical/surgical units, ED, operating room, intensive care unit (ICU) (all types), diagnostic imaging, cardiac floors (non-ICU), and obstetrics/labor and delivery. (See Table 4.)
The following highlights some of the issues from events reported to the Authority. The greatest number of reported events were those resulting in patient falls. In many cases, this was due to the patient not understanding or following instructions. In addition to the language barrier, in many cases patients had suffered a stroke or had some other neurological deficit that further compounded the communication barrier.

Staff nurse found patient sitting on floor and assisted to chair. Via interpreter, patient stated he was trying to stand by himself and slid to floor. Patient debilitated, deconditioned, and does not speak English. No harm noted.

Patient found on floor at foot of bed lying on his right side. . . . He was Spanish speaking, and through an interpreter, the patient was unable to relate what happened. He has a seizure history. . . . He was evaluated by a physician and there were no noted injuries.

The second highest number of events consisted of errors or complications related to a surgical procedure. Several reports identified issues with obtaining consent before the procedures. In many cases, interpreters needed to be located before the procedure could proceed as scheduled.

A patient in the holding area was waiting for surgery. When patient arrived in operating room [OR], nurse informed staff that patient only speaks Spanish. Nurse to get translator for OR consent that is in English. The physician was notified.

The patient, who speaks Chinese only, was diagnosed with a brain lesion. The family and patient were not informed of the diagnosis. The morning of the procedure, the patient’s head was shaved and markings placed for a follow up . . . The surgeon’s assistant admitted to shaving the head of the patient without informing the patient. He claimed that he spoke Chinese so it was pointless to talk to him. I informed him that a translator phone was available and he admitted to not making an effort at all. He went on to admit that he would have informed an English-speaking patient, but treated them differently because he spoke a different language. Neurosurgery did not inform the family of their plan either and when they later called for consent, the assistant attempted to obtain consent from the patient’s son, who speaks limited English, and still did not speak with the patient. [The patient was] awake, alert, and following commands.

Report was given that returning patient had heavy vaginal bleeding and clotting [postprocedure]. Doctor was at the patient’s bedside for two hours and deemed the patient stable to come to same day procedure unit [SPU]. When the patient arrived she had moderate vaginal bleeding, with orders to get patient up and walk her to see if she bleeds worse. It was also verbally passed along that if blood clots would be noted in the vaginal meatus, that they should be gently removed and the size called to doctor. I expressed my concern for the patient and felt that a 23-hour stay in an appropriate level unit would be better for the patient. The patient was eventually sent back to the OR for excessive bleeding. My other concern is that a 10-year-old child was used for a translator in this case and expected to translate what she did not understand. SPU solicited a Farsi translator from the [pediatric intensive care unit].

Anesthesia consent obtained in English; operative consent obtained in Spanish.

Non-English speaking Haitian patient arrived in ED with possible ruptured abdominal aortic aneurysm [AAA]. Surgeon and other physician spoke with patient through interpreter. Patient rushed to OR where it was noted that no consent had been signed. Notes were written in progress note by surgeon and anesthesiologist.

Table 1. Pennsylvania Patient Safety Authority Reports of Limited English Proficiency by Event Type, June 2004 through May 2010

<table>
<thead>
<tr>
<th>EVENT TYPE</th>
<th>NUMBER OF REPORTS</th>
<th>PERCENTAGE OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>114</td>
<td>49%</td>
</tr>
<tr>
<td>Complications related to a surgical procedure</td>
<td>62</td>
<td>27%</td>
</tr>
<tr>
<td>Medication errors and adverse drug reactions</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>42</td>
<td>18%</td>
</tr>
</tbody>
</table>

Table 2. Pennsylvania Patient Safety Authority Reports of Limited English Proficiency by Patient Age, June 2004 through May 2010

<table>
<thead>
<tr>
<th>AGE</th>
<th>NUMBER OF REPORTS</th>
<th>PERCENTAGE OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 21 years of age</td>
<td>19</td>
<td>8%</td>
</tr>
<tr>
<td>21 to 64 years of age</td>
<td>104</td>
<td>45%</td>
</tr>
<tr>
<td>65 years of age or older</td>
<td>109</td>
<td>47%</td>
</tr>
</tbody>
</table>
Due to emergent status, consents were waived. Circumcision consent obtained without interpreter; the mother (Italian speaking) expressed in the delivery room that she didn’t want her baby circumcised. Procedure was tolerated well with no complications.

The third highest number of events, excluding events reported as “other,” were reported either as medication errors or adverse drug reactions.

Patient was given four caps of Colace in her self med pack. Instruction sheet states “Take one gelcap by mouth in the morning and again in the evening as needed to have a BM”. Patient took all 4 gelcaps within 12 hours. Patient received instruction on self medication and signed record acknowledging instruction and understanding of form. English is patient’s second language and form not available in Spanish. No harm to patient occurred.

CHALLENGES FACING LEP PATIENTS ACCESSING CARE

For LEP patients, obtaining healthcare services can be frustrating and difficult and may have potentially dangerous consequences. Language barriers contribute to inadequate patient evaluation and diagnosis, lack of appropriate and/or timely treatment, and other medical errors that compromise the safety of LEP patients and result in increased medical costs. LEP patients face barriers in scheduling appointments, understanding medical forms, communicating symptoms and ailments, and comprehending diagnoses and treatment.

A 2003 study published by Flores et al. reported that errors in medical interpretation are common, averaging 31 communication errors per clinical encounter between a provider and a LEP patient. The most common error occurred when an interpreter assisting in a pediatric visit omitted information either given by the LEP parent or by the healthcare provider. The study authors recommended that given the frequency of errors (including those that untrained interpreters made) and the potential negative clinical consequences, the best solution to these problems would be to provide third-party reimbursement for trained medical interpreters.

As further evidence, six Joint Commission hospitals set out to examine differences in the characteristics of adverse events between English-proficient patients and LEP patients in U.S. hospitals. Approximately 49.1% of LEP patients’ adverse events involved some physical harm, whereas only 29.5% of adverse events for English-proficient patients resulted in physical harm. Of those adverse events resulting in physical harm, 46.8% of LEP patients’ adverse events had a level of harm ranging from moderate temporary harm to death, compared with 24.4% of English-proficient patient adverse events. The adverse events that occurred among LEP patients were also more likely to be the result of communication errors (52.4%) than adverse events for English-proficient patients (35.9%). The study concluded that language barriers appear to compromise patient safety.
FEDERAL LAWS PROTECTING LEP PATIENTS

Protection of LEP patients was first recognized in Title VI of the Civil Rights Act of 1964. In 2000, President Clinton issued Executive Order 13166 requiring all federal agencies to work with recipients of federal financial assistance in order to provide “meaningful access” to their LEP applicants and beneficiaries. These laws apply to hospitals and medical clinics, nursing homes, home health agencies, managed care organizations, universities with health or social service research programs, individual physicians, and other healthcare providers. All providers receiving federal money (such as Medicare or Medicaid) need to have policies in place that conform to the federal LEP guidelines. If a healthcare provider is treating a LEP patient, these federal guidelines provide that the LEP patient is entitled to receive language assistance in the form of oral interpretation or written translation for medical treatment. Healthcare providers who are recipients of federal financial assistance are required to “take reasonable steps to ensure meaningful access” to their services by LEP patients.

The U.S. Department of Health and Human Services (HHS) published a set of LEP policy guidelines to assist providers in compliance with federal mandates. Many healthcare providers (including representatives of the American Medical Association) challenged the executive order as well as the guidelines established because it forced them to pay for medical interpreters for LEP patients with nominal or no reimbursement. HHS changed its guidelines in 2003 to bring them into line with the LEP guidelines released that year by the Department of Justice. These revised guidelines put in greater flexibility to further encourage voluntary compliance. While healthcare providers still have a responsibility to provide “meaningful access to LEP persons,” under the 2003 revised guidelines, HHS recognized the need for providers to conduct individualized assessments of their ability to provide this access. To conduct this individualized assessment, the revised HHS guidelines provide a four-factor balancing test. The four-factor test addresses:

1. the number or proportions of LEP persons eligible to be served or likely encountered,
2. the frequency with which LEP individuals come into contact with the service,
3. the nature and importance of the service to people’s lives, and
4. the resources available to the federal funding recipient and costs.

Comprehensive services for LEP patients may require both oral interpretation and written translation. The Healthcare Insurance Portability and Accountability Act of 1996 does not require that healthcare providers obtain an LEP patient’s authorization to disclose protected health information to an interpreter, so long as certain conditions are met.

Language services to LEP patients may be provided in one or both of two ways: (1) oral interpretation, either in person or via a telephone or video interpretation service; and (2) written translation. Physicians have flexibility in determining the appropriate mix of the language services they provide, applying the aforementioned four-factor analysis.

Physicians are required to expressly advise a LEP person who presents for services that he or she has the option of having an interpreter provided free of charge. The facility should not require a LEP person to use a family member or friend as an interpreter.

(For legislation specific to Pennsylvania, see “Pennsylvania Law Protecting LEP Patients.”)

LEP Patients’ Understanding of Vital Documents

Documents that require written translation are those that are vital to the meaningful access to services by the LEP groups that the facility may frequently encounter. In accordance with HHS guidelines, facilities are asked to determine which documents are vital by applying the four-factor analysis. Vital documents that require written translation include the following:

- Consent and complaint forms
- Intake forms with potential for important health consequences
- Discharge instructions, prescriptions, and research protocols
- Notices of eligibility criteria or rights
- Notices advising LEP persons of free language assistance

Fully informed consent to medical interventions is critical not only to ensure meaningful patient participation in decision making, but also to act as a safeguard against potential adverse outcomes or medical errors. Asking patients to recount what they consented to is one strategy to ensure that they understand information about the risks, benefits, alternatives, and reasons for the medical treatment they receive.

Safe harbor provisions apply to the translation of written documents only. The following actions are considered strong evidence of compliance with written translation obligations:

- Written translations of vital documents are provided for each eligible LEP language group that constitutes either 5% or 1,000, whichever is less, of the population eligible to be served or likely to be affected or encountered. Oral translation of other nonvital documents is permitted.

- If there are fewer than 50 people in a language group that reaches the 5% trigger as an alternative to translating vital written materials, the facility may provide written notice in the primary language to the LEP patient about his or her right to receive
competent oral interpretation of the written materials without cost. The National Quality Forum has established national standards (i.e., safe practices 5 and 10) for ensuring adequate comprehension during the informed consent process. These standards address the needs of patients who face communication challenges in the medical system, such as LEP and low health literacy groups.

Informed consent laws vary from state to state, either by statute or by common law, but the principles as they apply to physicians are generally the same: without first obtaining consent from a patient upon whom the provider intends to perform an invasive procedure, the provider may face liability.

When a provider is treating a LEP patient, clear communication is important to determining whether consent is valid. Healthcare providers treating LEP patients are vulnerable to communication mishaps that may result in negating a patient’s consent. For example, consent may be void when the LEP patient misunderstands the healthcare provider’s proposed treatment due to an interpreter error when the interpreter is not well versed in medical terminology. Another scenario of potential invalid consent is when the diagnosis of the healthcare provider is mistaken or misinformed due to a LEP patient’s reluctance to adequately describe symptoms in front of the patient’s family member or child who is interpreting.

STRATEGIES TO ENHANCE QUALITY OF CARE FOR LEP PATIENTS

It is important for patients with language barriers to have ready access to competent language services. Providers need to collect reliable language and English proficiency data at the patient point of entry and document the language services provided during the patient-provider encounter.

If a LEP person voluntarily chooses to provide his or her own interpreter, providers are asked to document in the medical record that the person declined the offer of free language services. The name of the interpreter designated by the LEP person, the interpreter’s relationship to the LEP person, and the time or portions of the patient encounter that the interpreter’s services were used should also be documented.

DEVELOP A WRITTEN PLAN

HHS identifies the following five steps as being “typically part of effective implementation plans” for providing language assistance:

1. Identify LEP individuals who need language assistance. A set of language identification cards, “I speak cards,” are available from the federal government at http://www.lep.gov. Facilities are also encouraged to post notices in all points of first contact in commonly encountered languages, notifying LEP patients that language assistance is available. This information should be entered into the patient’s chart or electronic medical record and should be accessible both to scheduling staff and clinical staff.

2. Identify the language assistance measures that staff and patients will use. Include information on the types of available services and how staff can obtain them; how to respond to oral, written, and in-person contacts from LEP persons; and how to ensure competency of interpreters and translators.

3. Train staff regarding LEP policies and procedures. Management staff must be knowledgeable of the plan so that they can reinforce its importance to other staff and ensure its implementation. All staff that have contact with the public should be trained to work effectively with in-person and remote interpreters.

4. Notify LEP patients of the language assistance services that are provided. The notice should state what services are available and that they are free of charge, and it should be written in a language that the identified LEP groups will understand. Methods of providing notice to LEP patients include posting signs in intake areas, working with community-based organizations, using a telephone voice menu in the most common languages, and publishing notices in local newspapers. The Social Security

PENNSYLVANIA LAW PROTECTING LEP PATIENTS

Pennsylvania Title VI of the Civil Rights Act of 1964 provides that doctors and agencies getting federal money make language services available to people who do not speak or understand English well enough to access services. Medical assistance physicians must give free access to an interpreter to all people who need an interpreter in order to access medical care. The Office of Medical Assistance Programs expects all medical assistance physicians to comply. In Pennsylvania, information for the Bureau of Fee-for-Service Programs is as follows:

Telephone: 866-872-8969
TTY: 866-872-8970
E-mail: MA-Interpreter@state.pa.us
Fax: (717) 772-6179 (Attention MA-Interpreter)

Administration has made sample notice signs available that may be accessed at http://www.lep.gov.

5. Monitor and update the LEP plan as necessary. This includes determining on an ongoing basis whether additional documents or services need to be made accessible and whether changes in demographics require changes in the language assistance services that the facility provides.

Use Trained Interpreters

In their review of the literature and studies, Ku and Flores found that LEP patients who are provided with interpreters make more outpatient visits, receive and fill more prescriptions, and have higher satisfaction with care. Use of professional interpreters, rather than untrained interpreters, is associated with improved clinical care, and professional interpreters appear to raise the quality of clinical care for LEP patients to that of patients without language barriers. In a systematic review of the literature by Karliner et al., 28 articles reviewed reported positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes, and satisfaction with care.

In addition to the potential miscommunications that may arise with ad hoc or untrained interpreters, LEP patients may face difficulty in asking an ad hoc interpreter to relay symptoms that are embarrassing or that are stigmatized within their culture. Even healthcare providers’ information may suffer with an ad hoc interpreter in the room. For instance, a provider may be reluctant to ask a LEP patient’s child to relay information about an embarrassing side effect of a particular prescription. Other difficulties arise if the ad hoc interpreter is a family member and also the source of the injury suffered by the LEP patient, such as in a spousal or child abuse situation.

Competence to interpret requires more than self-identification as bilingual. Competence to interpret requires demonstrated proficiency in and ability to convert the meaning of a message accurately in both English and the other language and to identify and use appropriate modes of interpreting. A competent interpreter also has knowledge in both languages of terms or concepts particular to a program or service (e.g., medical terms) and is able to understand and comply with confidentiality and impartiality rules as required. Formal certification is helpful but not required.

To examine the accuracy of medical interpretations provided by nurses untrained in medical interpreting, Elderkin-Thompson et al. conducted a qualitative, cross-sectional study at a multi-ethnic, university-affiliated primary care clinic in southern California. The study found that approximately one-half of the encounters had serious miscommunication problems that affected either the physician’s understanding of the symptoms or the credibility of the patient’s concerns. Interpretations that contained errors that led to misunderstandings occurred in the presence of one or more of the following processes:

- Physicians resisted reconceptualizing the problem when contradictory information was mentioned.
- Nurses provided information congruent with clinical expectations but not congruent with patients’ comments.
- Nurses slanted the interpretations, reflecting unfavorably on patients and undermining patients’ credibility.
- Patients explained the symptoms using a cultural metaphor that was not compatible with Western clinical nosology.

The study concluded that errors occur frequently in interpretations provided by untrained nurse-interpreters during cross-language encounters, so complaints of many non-English-speaking patients may be misunderstood by their physicians.

LEP patients who need but do not get an interpreter have the lowest satisfaction with interpersonal aspects of care of any group of patients. If such patients use untrained interpreters, they are much less likely to be satisfied with their medical office visit than LEP patients with bilingual providers or English-proficient patients with monolingual English providers.

Hire Bilingual Staff

Hiring bilingual staff can have multiple benefits, from having nonfamily member interpreters available if necessary, to increasing diversity in the workplace, both of which may serve to make LEP patients feel more comfortable. Some employers pay an increased salary to bilingual staff who serve in a dual role as both a staff person and a trained medical interpreter. There also may be local classes that interpreter staff can attend to learn basic medical terminology, a cost-cutting measure for the provider in the long run. Dual-role interpreters, as with all interpreters, should be trained to interpret. This involves knowledge of the interpreter role, ethics, and protocols; techniques to achieve accurate and complete interpretations; and an understanding of how culture affects communication. The National Council on Interpreting in Health Care will publish national standards for healthcare interpreter training programs in 2011.

Educate Staff in Cultural Competency

Finally, cultural competency courses are a recommended way to ensure staff understand the difficulties facing LEP patients and to foster communication between healthcare providers and their patients. Studies have shown that when a provider makes cultural competency a core institutional value, it improves the quality of care for all patients.
CONCLUSION

For many LEP patients, the inability to communicate in English is the primary barrier to accessing health information and services. Health information for LEP patients’ needs to be communicated plainly in their primary language, using words and examples that make the information understandable.29

Not providing adequate services for LEP patients means the following:

— The facility may be violating the patients’ civil rights under Title VI of the Civil Rights Act of 1964.30
— LEP patients are less likely to receive preventive care or early treatment for chronic diseases, which often results in greater healthcare costs.30
— Chances of misunderstanding and miscommunication between patient and doctor increase.30
— Patient-doctor communication is less reliable, as LEP patients may not be as forthright about sensitive medical issues.30
— Healthcare providers may be unable to obtain truly informed consent from a patient, increasing the risk of medical malpractice.30
— The facility faces loss of accreditation through the Joint Commission, which has new communication standards as of January 2011 that specifically require the availability of interpreters and translated vital documents.31

NOTES


Editor’s Note
Reviewer Dr. Glenn Flores notes that the aforementioned 2003 LEP policy guidelines from the U.S. Department of Health and Human Services should be viewed with caution. He contends that many experts in the field believe that the 2003 guidelines, instead of creating a greater flexibility and compliance, confuse the matter even further. For example, the term “voluntary compliance” sends the message that it is acceptable not to provide language services; however, compliance is not really voluntary in that failure to do so is a violation of Title VI and may lead to a lawsuit. Flores further contends that most advocates disagree with these guidelines because they provide a loophole that essentially allows providers to not provide language services if they believe that cost is a factor. Finally, these guidelines inappropriately allow the patient to choose their interpreter (e.g., a family member who has not had formal training), which could be dangerous.
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THE PENNSYLVANIA PATIENT SAFETY AUTHORITY AND ITS CONTRACTORS

The Pennsylvania Patient Safety Authority is an independent state agency created by Act 13 of 2002, the Medical Care Availability and Reduction of Error (“Mcare”) Act. Consistent with Act 13, ECRI Institute, as contractor for the Authority, is issuing this publication to advise medical facilities of immediate changes that can be instituted to reduce Serious Events and Incidents. For more information about the Pennsylvania Patient Safety Authority, see the Authority’s website at http://www.patientsafetyauthority.org.

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