Language Barriers and their impact of Provision of Care to patients with limited English Proficiency: Nurses Perspectives; Roger Watson

ABSTRACT

Aim: The aim of this study was to explore nurses' perspectives of language barriers and their impact on the provision of care to patients with limited English proficiency from diverse linguistic background.

Design and Methods: A qualitative descriptive approach was used. Using individual interviews and focus group discussions, data were collected from 59 nurses working in tertiary care hospitals in England. A thematic analysis was used to analyse the data.

Findings: Three themes: 'multi-ethnicities and language barriers'; 'the impact of language barriers'; and 'communicating via interpreters', were identified. Communication was identified as the most important aspect of care provision and an essential component of a nurse's professional role regardless of the clinical area or speciality. Language barriers were identified as the biggest obstacles in providing adequate, appropriate, effective and timely care to patients with limited English proficiency. Use of professional interpreters was considered useful; however, the limitations associated with use of interpretation service, including arrangement difficulties, availability and accessibility of interpreters, convenience, confidentiality and privacy related issues and impact on the patient's comfort were mentioned.

Conclusion: Language barriers, in any country or setting, can negatively affect nurses' ability to communicate effectively with their patients and thereby have a negative impact on the provision of appropriate, timely, safe and effective care to meet patient's needs.

Clinical Relevance: An understanding of language barriers can help nurses find appropriate strategies to overcome such barriers and, consequently, enhance the provision of effective care to patients affected by language barriers in any clinical setting in any health care system. The

findings of the study has international relevance as language barriers affect health care provision in any country or setting.

Keywords: communication issues; interpreters; language barriers; limited English proficiency

What does this paper contribute to the wider global clinical community?

- Increased migration within and between countries has increased the prevalence of language barriers.
- Language barriers hinder effective communication between patient and nurses in any country and health care system
- Eliminating language barriers is a crucial step in providing culturally competent and patient-centred care.
- Use of professional interpreters may help improve communication, but is not free from limitation
- Nurses should be involved in the development of language and interpretation policies in the organisation

INTRODUCTION

Language is central to communication and it helps the speaker and the listener to understand each other's needs. Use of language also relates to individuals' identity. Globalization and migration within and between countries has increased the likelihood of experiencing language barriers for health care professionals (HCPs) as well as health care recipients. Taking example of English language, evidence suggests that even bilingual people who speak English fluently, in situations of stress, illness and tiredness may feel more comfortable communicating in their primary language (Robertsa *et al.* 2007). Language barriers may contribute to health inequalities that people from minority ethnic communities, in any country, experience due to various factors, such as gender, socioeconomic status, education, sexual orientation or disability. These may worsen the situation for such marginalized groups by negatively affecting their ability to communicate effectively. Although, HCPs such as nurses are responsible to provide care to patients regardless of their culture, religion, linguistic ability and ethnic background, language barriers hamper their ability to provide culturally competent and patient centred care (Bischoff & Denhaerynck 2010, Gerrish 2001, Hull 2015, Richardson *et al.* 2006) to their patients. The issue of language barriers is not new, however, has never been given appropriate attention globally as limited evidence is available with regards to impact of language barriers in non-English speaking countries. While language barriers relate to any language and affect the provision of care in any country part of the world, we will focus on English language as the study presented here was conducted in the United Kingdom (UK). The issue, however, is relevant internationally.

The National Health Service (NHS), in the UK, aims to offer high quality, patient centred care to the diverse population, it serves (Department of Health 2012). The diversity of the population it serves is evident from the results of the 2011 census, which show that 16% of the population

in England and Wales belong to minority ethnic communities. Approximately 8% (4,153,266) people (aged > 3 years) of this group identify themselves as non-English/non-Welsh speakers (Office of National Statistics 2013). As shown in Figure 1, among these, approximately 59% find it difficult to or cannot communicate in English at all (Office of National Statistics 2013). The results of the 2011 census also indicate that 785,000 residents aged 16 and over speak English less than 'very well'. These individuals are known to have limited English proficiency (LEP) which means they cannot speak, read, write or understand the English language at a level that permits effective interaction with HCPs (Karliner *et al.* 2007). Such language barriers may lead to many problems for the patients as well the HCPs who may find it difficult to understand and assess their patients' needs (Harmsen *et al.* 2008, Hudelson & Vilpert 2009). Therefore, they are unable to provide safe and effective care (Gerrish 2001, Richardson *et al.* 2006).

Evidence suggests that language barriers are negatively associated with treatment compliance, follow-up for chronic illnesses, understanding of diagnosis and treatment (Richardson *et al.* 2006, Wilson *et al.* 2005), ability to find appropriate health information (Gerrish 2001, Pippins *et al.* 2007) and medical complications (Jacobs *et al.* 2007, Karliner *et al.* 2007). For instance, a study from the USA reported that patients affected by language barriers are less likely to have blood pressure and cholesterol screening (Jurkowski & Johnson 2005). Another study reported that Latinas with LEP, are less likely to be offered various screening tests such as Pap Smear, mammogram, faecal occult blood test, and sigmoidoscopy (Goel *et al.* 2003). Evidence also suggests that language barriers can jeopardize patient safety by increasing the risk of adverse events including medication errors (Richardson *et al.* 2006, Wasserman *et al.* 2014). This qualitative study aims to present nurses' perspectives about language barriers and its impact on patients and nurses.

Background

While the risk of miscommunication or misunderstanding cannot be eliminated, language barriers do not arise when HCPs such as nurses and patients speak the same language. Ensuring such language concordance (when the patient and the provider speak the same language), however, is not always possible. Use of professional (may or may not be medically trained) interpreters is one way of minimizing the impact of language barriers (Flores 2005), though, risk of communication errors and difficulties in establishing rapport limit the effectiveness of these services (Cioffi 2003, Richardson *et al.* 2006). Communication via interpreter—regardless of their interpreting skill—can never be as satisfying as direct communication (Eamranond *et al.* 2011) and may not minimize patient safety risks (van Rosse *et al.* 2015). In addition, use of interpreters and translators can be prohibitively expensive. For instance, a study reported that NHS Trusts (Trusts are the units of organization of the NHS) spent £23.3 million on translation services in 2011 (Gan 2012). The authors could not provide a breakdown of the cost spent on interpretation services, but suggested that the interpretation cost is increasing as the cost of written translation is decreasing (Gan 2012). This is also evident by the fact that the: "Birmingham Integrated Language and Communication Support Service provided interpreters for 30,000 consultations at a cost of over £1,000,000 in 2007/8…" (Gill *et al.* 2011).

Much research has been conducted to explore the effectiveness of language concordant communication between patients and HCPs (Eamranond *et al.* 2009, Fernandez *et al.* 2004, Khan *et al.* 2010, Raynor 1992, Wilson *et al.* 2005) and effectiveness of interpreter mediated communication (Flores 2005, Flores *et al.* 2012, Leanza *et al.* 2010). Some researchers have also explored HCPs perceptions of language barriers and their impact on the provision of care (Fatahi *et al.* 2010, Tay *et al.* 2012, Taylor *et al.* 2013). However, literature about nurses' experiences and perspectives of language barriers they encounter while providing care to LEP patients from diverse cultural backgrounds, the impact of language barriers on provision of

care and effectiveness of language concordant care is scant. In addition, nurses' experiences of using and working with interpreters remain under explored. To fill this gap, this paper aims to present findings related to one aspect of the study that explored:

- Nurses' perspectives about language barriers they encounter when providing care to LEP patients from diverse linguistic background
- Nurses' perspectives about impact of language barriers on provision of care to LEP patients.

METHODS

Design

The study was conducted in England, UK using a qualitative descriptive approach. It is a subjective but systematic method that helps explore a social issue and paint a holistic picture of participants' experiences and perspectives about a phenomenon of interest (Creswell 2009). The study was reviewed and approved by the University of Sheffield Research Ethics Committee (Reference Number 002133). Potential participants were provided with an information sheet explaining the study's aims, objectives and procedures. Informed consent was obtained from each participant prior to interview. Confidentiality and anonymity of participants was ensured, for instance, by using pseudonyms during data analysis and reporting of findings.

Participants

Using purposive and snowball sampling, 59 registered nurses including 32 female and 27 male, working in various acute care NHS hospitals were selected. The majority of the participants were registered adult nurses (n=57), with a degree in nursing (n=30) or Diploma in Nursing (n=29). One participant was also a Registered Mental Health Nurse and another was a health visitor. Professional work experience of the participants ranged from 2-23 years in various

settings including medical, surgical, intensive care, cardiology, outpatient departments and post-operative recovery units.

Data Collection

Data for the study were collected through 26 individual interviews and three focus group discussions (FGDs). A semi-structured interview guide informed by the study's aims, objectives, and a review of the available literature was used. Each participant contributed to only one type of data collection. Prior to actual data collection, two pilot interviews with non-research participants were conducted to determine the length, suitability, and appropriateness of the language of the interview questions. As a result of this exercise, a few probes related to participants' perceptions about language barriers were identified and added to the interview guide. Data collected from pilot interviews were not used in the data analysis.

Each individual interview lasted 50-75 minutes, whereas each FGD lasted 75-90 minutes. The individual interviews were conducted at a time and place convenient to the participant, while aiming for an environment with minimal disruptions. Depending on the participant's preference, face-to-face and telephone interviews were conducted. Given the nature of the topic, face-to-face or telephone interviews were considered equally useful. Preference was given to face-to-face interviews where possible, though the option of a Skype or telephone interview was welcomed by many participants. Parallel to this, three FGDs - each attended by 9-13 participants - were also conducted (Table 1). Data collection stopped once saturation was achieved. With participant's permission, every interview and FGD were digitally recorded. Details of the setting, participant's non-verbal behaviour, and any interruptions during the interview were noted. A reflexive diary was kept throughout data collection and analysis to help the researcher keep notes of the occurring and personal thoughts and reflection during data collection and analysis process.

Data Analysis

All interviews and FGDs were transcribed verbatim by independent transcribers. Data were analysed using a thematic analysis approach (Spencer *et al.* 2003). Each transcript was read and re-read to identify emerging themes. First, every line and sentence were given a code. The initial code list was developed for six interviews. Similar codes were then clustered into sub-themes and themes. The process was then applied to rest of the interview and FGD transcripts. The data in each interview transcript were compared and contrasted with data from other interview transcripts and FGD transcripts.

Following preliminary analysis and identification of themes, a finding consolidation and verification workshop involving 23 professionals, including nurses, managers, human resource representatives and other people responsible for equality and diversity related issues in various NHS organizations was held. Using interactive activities, the workshop participants explored the relevance of findings to practice, ways to improve practices and strategies to overcome language barriers. Participants' views facilitated consolidation of findings and development of recommendations.

Rigour

The trustworthiness encompassing credibility, transferability, dependability, and confirmability, is an important criterion to determine the rigour of a qualitative study (Denzin & Lincoln 1998). To ensure rigour, strategies such as member checking (checking interpretation of the emerging findings from previous interviews with new participant), triangulation (comparing and contrasting data from individual interviews, FGD and literature), and peer debriefing (discussing emerging findings with colleagues, research team, and in the findings consolidation workshop) (Lincoln & Guba 1985) were used. In addition, appropriate information about the context in which study was conducted, findings and context of findings is described to enhance transferability of the findings to other contexts and settings.

FINDINGS

Participants of the study provided care to a diverse patient population in terms of age, gender, ethnicity and health care needs. While describing groups they provide care to, a participant stated:

'M*ost of them are English; some of them are from Somalia, West Indies, Africa, Sudan, Pakistan, Arab countries, China, and from Taiwan'* (Joshua).

Another participant, Daniel mentioned:

'*I live in the Northwest part of England, where people from India, Bangladesh, Pakistan, Sri Lanka, and the EU [European Union] are settled and obliviously a majority of patients who come for treatment in hospital are English'*.

Anna, working in a different part of the country stated:

'*We get patients from diverse of ethnic backgrounds admitted to the ward… mostly White; they could be British, Irish, White, sometimes white from Europe. We come across many Pakistani, Bangladeshi, Indian, East, and South Asian patients*'.

Depending on the participants' area or speciality of the work (medical, surgical, intensive care, cardiology, outpatient department, and post-operative recovery units), health care problems that their patients presented with varied. A thematic analysis of the data resulted in the identification of three themes: 'multi-ethnicities and language barriers', 'the impact of language barriers', 'communicating via interpreters'. Together, these themes explicate participant's views about the language barriers that they encounter in clinical practice and the impact of language barriers on provision of care to LEP patients.

Multi-ethnicities and language barriers

This theme relates to communication issues that participants face when working with a diverse group of people with varied linguistic abilities and diverse health needs. Communication was identified as the most important aspect of care provision and an essential component of a

nurse's professional role, regardless of the clinical area or speciality a nurse was working in. Joshua, mentioned:

'C*ommunication is the biggest part of our role. Isn't it? And if you cannot communicate with your patient, it just creates lots of issues and affects patients' experience of receiving care from caregivers like nurses'.*

The language barriers were identified as the biggest obstacles in providing adequate, appropriate, effective and timely care to many LEP patients as one participant highlighted:

'*… those people who have not learned to speak English here or back in their country of origin, ... face many barriers … We have to deal with language barriers in every other shift* (Noreen).

Some participants mentioned language barriers as a particular issue for the older BME population, who may have been living in this country for decades, but could not develop an ability to speak English. Ruby, while talking about this stated:

'm*ost of the Asian patient who are 60 years and over cannot speak English very well, because they came to the UK either in an old age or they did not learn English at all'.*

Annie added

'*if there are young patients, they obviously do not have a language issue, but… elderly! They don't speak English very well or they can just speak a few basic words like 'thank you' and all that. Then it becomes difficult to communicate and provide care'.*

However, some participants considered that language barriers might also affect relatively younger patients who may have immigrated to the country recently for various reasons. Maya described this as:

'*we also face language barriers when providing care to younger patients for instance, Asian women or men who may have come to the country after marriage. Their English language skills are poor too'.*

Language barriers do not only affect Asians or people coming from non-western countries, but migrants from European countries were also identified as those with LEP as Elsa mentioned: '*these days, as a result of active migration from various EU [European Union] countries, we provide care to many European patients with limited English speaking ability*'.

Impact of language barriers

Participants recognised that language barriers could cause many issues such as missed appointments and/or difficulties in arranging appointments as Alicia said: '*There are lots of different people who come to us, they cannot really speak English as it's not their first language. When we are booking, it is quite hard to book them because it is harder to communicate with them*'.

Participants felt that LEP patients might not comprehend the reason for their appointment, even when the information is sent to them via a letter. They considered that ability to speak English is related to the ability to read English and a person who cannot speak English is not likely to be able to read information written in English. For instance, Daniel mentioned: '*I have been in situations where patients have not understood the reason for the appointment or procedure. They may have received an appointment through the post as a self-explanatory information leaflet, which I myself realise, is not very helpful. Papers don't speak for themselves you know*'.

When these hurdles are overcome and the patient gets through the procedure, participants thought language barriers make it difficult for LEP patients to understand instructions during care procedures, comprehend treatment regimen and side effects of medication. Soha, while sharing one such example, stated: '*… I have seen on some occasions that people don't inhale through mouth because they don't understand the instruction and what it means*'.

Communicating via interpreters

This theme describes the participants' perspectives on working with interpreters. Participants acknowledged the usefulness of interpretation services in dealing with language barriers and the provision of safe care to LEP patients. However, the majority of the participants recognized limitations associated with use of interpretation services. These include arrangement difficulties, availability and accessibility of interpreter services, convenience, confidentiality and privacy related issues and impact on the patient's comfort. Noreen highlighting this stated: '*availability of interpretation service is time-bound and we have to book the interpreter for an hour… also it is not convenient because they can only be arranged at the certain times of the day'*.

Ellie, another participant explained the difficulties of the arrangement and its impact by saying: 'i*t's difficult to arrange an interpreter even through a telephone during the night or out of hours and this often makes it very difficult to communicate with the patient and we have to find other ways of doing so'.*

When asked about other ways of communication, participants mentioned the use of *ad hoc* interpreters such as identifying and requesting a nurse or other staff member with an ability to speak the language of the patient. However, such arrangement was not always possible. Participants mentioned that the inability to arrange interpreters could result in cancellation of appointments, or cause unnecessary delay in service provision resulting in increasing length of stay of the patient in hospital in some situations as Anna mentioned:

'*I remember a situation when we couldn't discharge a patient on the day because of the unavailability of an interpreter who could explain the discharge process and home care instructions. So the patient had to stay in hospital for another day'*.

Participants mentioned that the situation requiring communication with a patient could also be very complex. Most organizations prefer to use telephone interpretation services; however,

there were various issues associated with it. For instance, it requires extra time by a clinician as well as a patient as Danny stated:

‘*communicating through an interpreter can take very long. It’s even more complicated when the patient is not fully conscious, how can you ask a semi-conscious patient to talk to an interpreter on the phone?’*

It is difficult for many patients, such as those with cognitive impairment or hearing difficulties to comprehend information given on the phone. Maya, while explaining this further stated:

‘w*e booked, twice, a telephonic interpreter for an elderly Bengali patient and still she was not getting what the doctor wanted to tell her. At the end, we had to book a face-to-face interpreter the next day and this meant waiting for longer and more expenses’*.

Other situations where using an interpretation service was difficult, as identified by participants, include when a patient was undergoing an invasive procedure, or was unable to concentrate and comprehend information due to anxiety or pain. Roy mentioned that:

‘I*n my experience, it’s much easier to explain the process [to the patient] in their own language especially during procedures. Poor patient may already be anxious and scared of the procedure he/she is going through and communicating through interpreter adds to stress, but I know it’s not always possible’*.

Use of interpreters can be even more challenging when a patient is under the influence of anaesthesia, as it requires extra efforts of the patient as well as a nurse or any other HCP.

‘*Well, it’s complicated, in my area, which is post-operative recovery; it’s not practical or useful to talk to a patient who is coming out of the effects of anaesthesia, via an interpreter. It just doesn’t work’* (Danny).

Participants thought that interpreters do not always understand the medical terminology and this result in misinterpretation resulting in miscommunication of the information, which is neither cost effective nor efficient as Fakher explained: ‘o*n one occasion, we had a Polish*

patient who came with an interpreter. She was booked for cystoscopy but her interpreter told her that she was going for gastroscopy. The patient thought that we would be putting the camera from her mouth to stomach. But of course, this was not the case. So I think… they (interpreter) should have some training, especially for some specific procedures, but I don't know how they do it'. This issue was highlighted by many participants during the study.

DISCUSSION

The present study was conducted to explore nurses' perspectives about language barriers they encounter when providing care to LEP patients in acute care hospitals in England. The study also explored the impact of such barriers on provision of effective care to patients. While the study is conducted in the UK, the findings of the study are relevant internationally to all health care systems and countries. This is because populations, societies and communities are not homogenous and a range of languages are spoken in each and every country and it is not always possible to provide language concordant care to everyone and thus the impact of language barriers becomes a reality. The issue of language barriers and its impact on care provision has been explored in mainly English speaking and western countries and not much is known about non-English speaking countries.

The findings of the present study highlight nurses' concern in relation to the provision of quality care to patients from linguistically diverse background. Findings suggest language barriers are not specific to one particular group in the population, therefore, meeting the language needs of every patient may be difficult. Patients from Asian, non-western and European countries make the larger proportion of ME population in the UK and may have limited ability to speak English. Consistent with previous research, the findings of the study suggested that nurses tried to deal with the issue as best as they could (Taylor *et al.* 2013). Nurses aim to deliver effective, safe and quality care and therefore, would try and find ways to

manage language barriers by finding ways of communicating with patients. Most of the research related to language barriers in health care has been conducted in the US (Eamranond *et al.* 2009, Eamranond *et al.* 2011, Elderkin-Thompson *et al.* 2001, Fernandez *et al.* 2004, Pippins *et al.* 2007). However, some research has also been conducted to explore HCPs perceptions about language barriers and their impact on the provision of care in Singapore (Tay *et al.* 2012), Sweden (Fatahi *et al.* 2010) and England (Taylor *et al.* 2013). There is not much research available on the perspectives of nurses about the language barriers that they may face when providing care to patients with LEP and the present study fill that gap. The findings of this study are interesting and novel as all nurse participants themselves came from diverse ethnic and linguistic background and most of them spoke at least one additional language other than English.

The findings highlight many issues that arise due to language barriers and examples include difficulties in arranging appointments, missed appointments, explanation of the treatment regimen and invasive procedures to patients. These findings are consistent with previous research that explored the influence of language barriers on care provision to patients (Bischoff & Denhaerynck 2010, McCarthy *et al.* 2013, Savio & George 2013, Tay *et al.* 2012). In the absence of HCPs, who can communicate with patients in the same language, use of interpreters can be very effective (Flores 2005, Flores *et al.* 2012, Leanza *et al.* 2010), though not ideal. Consistent with previous research, the findings of this study suggest that using interpreters to provide language concordant care is not free from limitations, as the interpreters are not always aware of medical terminology and may find it difficult to explain it to a patient (Bischoff & Denhaerynck 2010, Bischoff & Hudelson 2010, Green *et al.* 2005). Some may argue that use of medically trained interpreter may be more useful, it is important to mention that interpretation as a field of practice and there is a limited supply of medically trained interpreters. In addition, such provision may only be possible in developed and wealthy

countries such as USA, UK, Australia and Canada and not in developing or under developed world. In addition, arranging an interpreter can be time consuming and expensive. This finding contradicts previous research which suggests that use of interpreters can reduce the cost of care (Carter-Pokras *et al.* 2004, Jacobs *et al.* 2007).

Additionally, findings suggest that communication through interpreters is not always feasible, especially when a patient is under stress, experiencing pain or is under the influence of medication or anaesthesia. In such situations, bilingual nurses or other health care professionals who can speak the language of the patient can be very useful. This is an interesting finding that contradicts previous research (Elderkin-Thompson *et al.* 2001, Hudelson *et al.* 2013, Ngo-Metzger *et al.* 2007). This may be due to the fact that the majority of previous studies have been conducted in outpatient departments (Hudelson *et al.* 2013), primary care settings (Elderkin-Thompson *et al.* 2001, Ngo-Metzger *et al.* 2007) or community based health centres (Green *et al.* 2005) where situations in which communication takes places is very different. For instance, in such settings, factors such as extreme pain or lack of consciousness are unlikely to be issues and patients are alert and conscious. Another important aspect highlighted by the current study is that interpreters are arranged for a specific duration and specific conversations. Such arrangement may help practitioners who require short interactions with the patient to explain a diagnosis or discuss prognosis of the condition; however, nurses provide care to patients throughout their stay—ranging from few hours to days—in hospital. Therefore, nurses need to be able to communicate effectively with patients to understand their needs and to provide effective care.

The study highlighted the impact of language barriers and the importance of provision of language concordant care to patients. As mentioned previously, this paper only aims to present findings related to the nurses' perspectives of language barriers they encounter when providing care to patients with LEP. The project also explored factors affecting the provision of language

concordant care and findings related to that aspect are presented in another paper (Author, 2016). More research is needed to explore the impact of language barriers and provision of language concordant care in various clinical settings and health care systems in different countries. In particular, the relevance of the issue with nurses providing care to patients in specialized areas such as intensive care units (ICU), recovery rooms, and operating theatres needs to be investigated. Nurses and patients' perspectives about how these barriers may be addressed to improve communication can be explored. In addition, nurses and patients' perspectives about the effectiveness of various forms of interpreting services (telephone, face to face, *ad hoc* interpreters, use of family members as interpreters) need to be explored. Such research may help identify gaps in existing practices and find ways to improve practices and enhance patient experiences.

The findings of the study should be interpreted cautiously in the light of several limitations. The findings may help develop an instrument that can be used to explore nurses' perspectives about language barriers, the impact of language barriers and challenges associated with the use of interpreters in various settings. Nevertheless, the study explored the issue of language barriers affecting practices of nurses in an English-speaking country, the findings of the study are relevant to the wider nursing community, regardless of the geographical location as language barriers can affect any clinical setting where nurses and patient do not use the same language to communicate.

Conclusion

Nurses are responsible for providing patient-centred care to their patients regardless of their personal characteristics including language skills. This requires effective communication between nurses and patients. However, language barriers negatively impact the nurses' ability effectively assess patient's care needs and consequently hampers their ability to meet those needs. Providing language concordant care can enhance the health care experience of patients

with LEP; however, it is not always easy. In such situations, bilingual nurses can play a very useful role by using their language skills to provide language concordant care to LEP patients. With the advancement of technologies, possibilities of managing language barriers have improved and there is a need to explore how this technology (e.g. Google Translate®) can be used to reduce language barriers affecting the quality of care provided to LEP patients. Nurses need to be proactive in identifying ways to provide effective care to their patients; therefore, they need to be involved in policy making. Nurses should be encouraged to provide feedback about the usefulness or lack of usefulness of prevalent language and interpretation services in their organisations and health care systems.

Relevance to Clinical Practice

The findings of this study are highly relevant to clinical practice, internationally, as it provides important insight about an issue affecting life of many patients with limited ability to speak the mainstream language of the country. With the globalization and increased migration, the possibilities of experiencing language barriers have increased for nurses as well as patients. Nurses cannot learn every language to meet the needs of every patient they serve; however, an understanding of language barrier and its impact can help nurses find way to overcome challenges and provide effective care to their patients.

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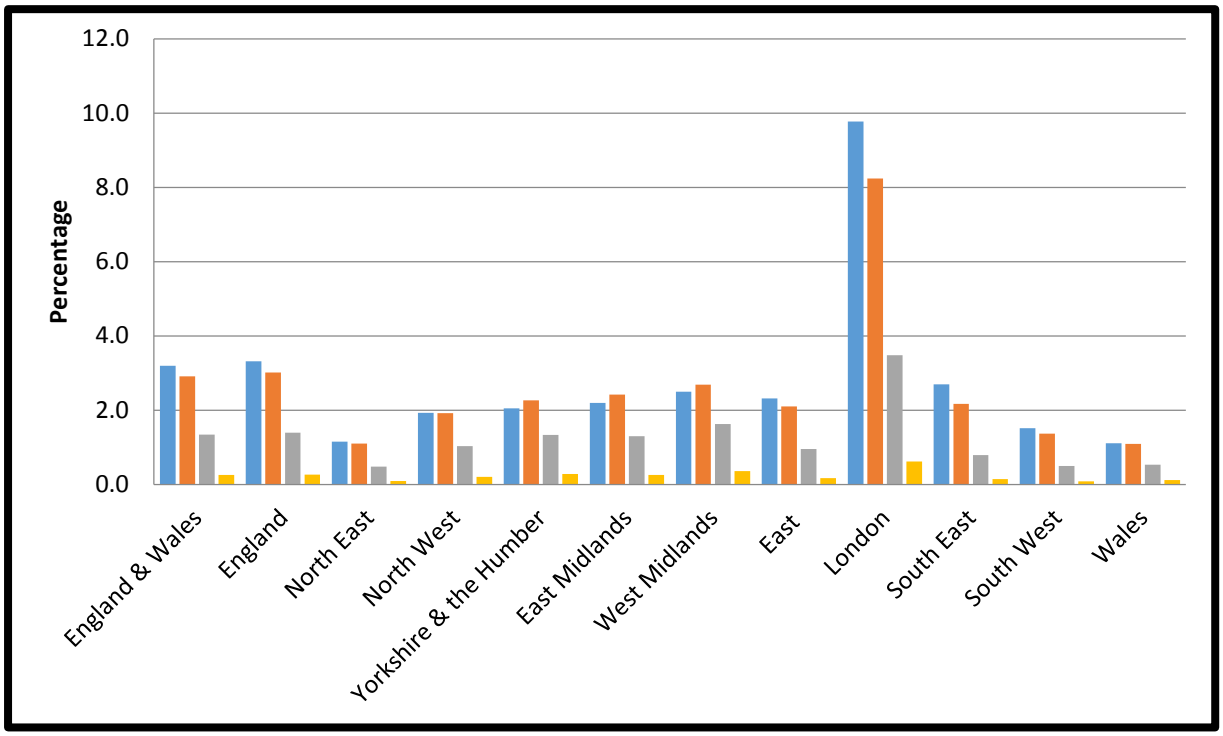
Table 1: Details of focus group discussions

Focus	Focus Group 1	Focus group 2	Focus Group 3
Number of participants	13	11	9
Age of participants	28-40	30-52	25-45
Gender: Male	9	08	0
Female	3	01	10

Figure 1. Language proficiency in English by region in England and Wales, 2011



Source: Census 2011, Office for National Statistics