Ethnic inequalities in patient safety in Dutch hospital care
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Chapter 7

Safety risks during hospitalisation and signaling, reporting and bridging of language barriers in Dutch hospital care. A mixed methods study.

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In revision
ABSTRACT

Introduction

A language barrier has shown to be a threat for quality of hospital care. International studies showed a lack of adequate signaling, reporting, and bridging of a language barrier. However, studies on the link between language proficiency and patient safety are scarce, especially in Europe. The study answers the following research questions:

1. At which moments during hospitalisation do language barriers constitute a risk for patient safety?
2. How are language barriers signaled and reported in hospital care?
3. How are language barriers bridged in hospital care? What is the policy and what happens in practice?

Methods

We combined quantitative and qualitative methods in a sample of 576 ethnic minority patients who were hospitalised on 30 wards within four urban hospitals. The nursing and medical records of 17 hospital admissions of patients with language barriers were qualitatively analysed, and complemented by 12 in-depth interviews with care providers and patients and/or their relatives to identify patient safety risks during hospitalisation. To answer the 2nd and 3rd research questions, all 576 medical records were screened for language barrier reports. The results were compared to patients’ self-reported Dutch language proficiency. The policies of wards to bridge language barriers were compared with the reported use of interpreters in the medical records.

Results

Situations in hospital care where a language barrier threatened patient safety included daily nursing tasks (i.e. medication administration, pain management, fluid balance management) and patient-physician interaction concerning diagnosis, risk communication and acute situations. In 30% of the patients who reported a low Dutch proficiency, a language barrier was not documented in the patient record. Relatives of patients were often used as interpreter and professional interpreters were hardly used.

Discussion

The present study showed a wide variety of risky situations in hospital care for patients with language barriers. These risks can be reduced by adequately bridging the language barrier which, in the first place, asks for adequate signaling and reporting of a language barrier. This is currently not sufficiently done in most Dutch hospitals. Moreover, new solutions to bridge language barriers are needed for situations, such as routine safety checks performed by nurses, in which a professional or even informal interpreter is not feasible.
INTRODUCTION

A language barrier, which is a communication barrier resulting from speaking different languages, has shown to be a threat for quality of hospital care. [1] Patient safety is a prerequisite for good quality of care. Safe hospital care is care without harm for patients caused by not following professional standards or by inadequate healthcare management resulting in adverse events (AEs) such as misdiagnosis or adverse drug reactions. Patient safety risks are situations that potentially lead to AEs. Several studies described the link between a language barrier and patient safety [2,3] and Divi and colleagues showed that US patients with low English proficiency experienced more AEs than patients with adequate English proficiency. [4] Other studies showed AEs associated with language barriers in specific domains in hospital care. For example, Wasserman and colleagues found that medication errors represented a larger share of AEs for those patients who had a language barrier compared to those who did not. [5]

Several international studies showed a lack of adequate signaling, reporting, and bridging of a language barrier [1]. International guidelines, such as the Joint Commission International, give directions to overcome language barriers in their “Standards for hospitals”. [6] They state that 1. patient education, follow-up instructions, and informed consent must be given in a language the patient can understand, 2. the hospital should seek to reduce language barriers, and 3. the patient’s language must be assessed and noted in the patient record. The main accreditation system for quality of hospital care in the Netherlands does not contain standards explicitly related to language barriers. [7]

Professional interpreters are considered the most optimal bridge for a language barrier in health care. [1] Internationally, underuse of interpreters in healthcare was reported. [8, 9] A Dutch study convincingly showed underuse of professional interpretation services in general practice and another study using professional interpretation service data also suggests underuse in hospital care. [10,11] However, evidence on underuse of professional interpreters in Dutch hospital care is lacking.

A Dutch record review cohort study among 1339 hospitalised patients assessing ethnic inequalities in AEs in Dutch hospital care enabled us to investigate how language barriers were reported and bridged in Dutch hospital care, and to identify patient safety risks related to language barriers during hospitalisation. [12] Since nurses and physicians have different tasks and play different roles in the care process, we analysed patient safety risks during nursing care and during physician care separately. The following research questions were answered in this study:

1. At which moments during hospitalisation do language barriers constitute a risk for patient safety?
2. How are language barriers signaled and reported in hospital care?
3. How are language barriers bridged in hospital care? What is the policy and what happens in practice?
METHODS

This study was embedded in a cohort study in four Dutch urban hospitals among 1339 hospitalised patients of whom 576 patients with an ethnic minority background, hereafter called ‘the umbrella study’. [12] Patients were included in the cohort during their hospital admission, and signed a consent form to review their medical record. Details on patient inclusion can be found in another publication.[12] Data collection took place between December 2010 and February 2013 and is visualized in Figure 1. [figure 1]

Data collection

Record review

The records of all 576 patients were screened for the umbrella study by one of the seven independent, trained nurses who were not working in the hospital where the study took place [12]. For the present analysis the following additional data were extracted from the records: “Did the record give any impression of the Dutch language proficiency of the patient?” with response options: “No”, “Yes, adequate Dutch language proficiency noted in record”, “Yes, intermediate or poor Dutch proficiency noted in record”, “Yes, ‘no Dutch proficiency’ noted in record”, or “other”. The finding place of the language proficiency information was also recorded. When information about inadequate Dutch proficiency was found, nurses recorded whether the record obtained information about the (other) language patients spoke (E.g. Turkish, Arabic). Additionally, the 576 records were screened for bridging of a language barrier. Of all records where a language barrier was reported in the record, nurses answered the question “Which solutions were used?” by choosing one or more of the following answers: “an interpreter was used”, “a family member/relative of the patient was involved”, and “other”. When nurses chose “an interpreter”, we asked whether this was an interpreter via telephone or live. The nurses were blinded for the self-assessed language proficiency by the patient.

Patient questionnaire

Data on self-reported Dutch proficiency were, for the same 576 patients, collected by a patient questionnaire, containing items on the patient’s ability to understand, speak, write, and read the Dutch language, respectively, each on a 4-point scale (“not at all”, “a little”, “sufficiently” and “adequate”). Language proficiency was assessed during hospital admission at inclusion in the cohort umbrella study, and filled out by the patient himself, or with help of a researcher and/or help from relatives of patients. Questionnaires were available in Dutch, English, and Turkish. Also, Arabic, Berber, and Turkish speaking research assistants were available. [12] Self-assessment of language proficiency has been shown to be a valid method internationally and nationally. [13,14]
Qualitative data: Interviews and document analysis

We sampled 17 admissions of patients with low Dutch proficiency. We aimed at a heterogeneous sample (i.e. different hospitals, different wards, and patients with different ethnic backgrounds). We searched for language barrier related text passages in the nursing and medical records of these admissions. Where record reviewers only screened whether a language barrier (bridge) was reported or not, this qualitative approach aimed at finding patient safety risks by in-depth analysis of the language barrier related text passages. These data were complemented by seven interviews with care providers (2 nurses, 5 physicians) and five interviews with patients and/or relatives. Interviews were semi-structured and addressed the following topics: 1. The impact of a language barrier on daily practice in hospital care, 2. How the language barrier was bridged, 3. The impact of a language barrier on quality of care. Interviews were taped and transcribed verbatim, and took between 30 minutes and 2 hours. All interviews were carried out by the first author. We stopped sampling cases and planning interviews after we had obtained data saturation, i.e. no new patient safety risks emerged from the data.

Policy data

The heads of all participating wards (N=30) were asked to provide information on their policy of bridging language barriers. The hospitals’ policies regarding bridging of language barriers were verified through publicly available channels (e.g. from the communication department).

Data analysis

Research question 1. Qualitative data – Interviews and document analysis

To answer the first research question, “At which moments during hospitalisation do language barriers constitute a risk for patient safety?”, qualitative data were grouped into the main codes ‘language barrier related patient safety risks in daily nursing care’ and ‘language barrier related patient safety risks in daily physician care’ which were later on divided into specific sub-codes like ‘pain assessment’, ‘risk communication’ etc. All data were analysed by the first author and three transcripts of interviews and a random selection of record text passages were independently read by another researcher (JS) to check whether the same themes were derived from the data. The “Consolidated criteria for reporting qualitative research” (COREQ) were used as a reporting framework.[15]

Research question 2. Quantitative data- Record review reports and self-assessed language proficiency

To answer the second research question regarding reporting language barriers, we used quantitative data. Data were analysed using SPSS 20. Patient questionnaire data and record review data about language proficiency were linked with the unique patient code and correct linkage was checked with variables age and sex. From the patient questionnaires self-assessed language proficiency sumscores were calculated. Cut-off points were determined based on the distribution of the sumscores, and grouped into ‘low or no Dutch proficiency’
(scores 4-8), 'moderate Dutch proficiency' (9-14) and 'adequate Dutch proficiency' (15 & 16). We categorized record review results regarding reporting of a language barrier in adequate, moderate and low language proficiency. We visually compared language proficiency based on record review data with patient data using crosstabs.

**Research question 3. Record review data and policy data**

To answer our third research question “How are language barriers bridged in hospital care? What is the policy and what happens in practice?”, we used two sources of data. First, all answers of head nurses about policies regarding use of interpreters and other ways to bridge language barriers were put together in one document and categorized. Next the frequency of use of professional and informal interpreters noted in the medical records was assessed.
Safety risks during hospitalisation

Chapter 7

Figure 1. Data collection

30 wards/4 hospitals

Open-ended question to nursing head of each ward:
“What is ward policy for bridging language barriers”?

576 patients with ethnic minority background

All patients

Sub-sample

DURING HOSPITALISATION

1. Survey-question: patients ranked their proficiency in understanding, speaking, reading, and writing the Dutch language (classified as not at all, a little, moderately, adequate)

AFTER DISCHARGE

2. Record review:
   a. Language barrier reported in record?
   b. If yes: Where? Specific language reported?
   c. If yes: Bridging of language barrier reported?
   d. If yes: How was language barrier bridged?
   e. Open text field for comments on language barrier

All patients

Sub-sample

17 admissions of patients with inadequate Dutch proficiency.

1. Thorough document analysis of patient record (patient safety risks, ways of reporting language barrier)
2. Interviews with care providers (N=7)
3. Interviews with patients and/or relatives (N=5)

Figure 1. Data collection
RESULTS

1. Moments during hospitalisation where language barriers are a risk for patient safety

In our results we distinguished nursing and physician tasks.

Nursing tasks

The first patient safety risk we identified in daily nursing practice was the ‘drop-out’ of protocollised name- and/or date of birth checks during critical care moments like medication administration as illustrated by a nurse in excerpt 1.

Q1 [Interview with nurse1: “It is protocollised to verify the date of birth during medication rounds, when taking blood, or administration of intravenous medication...those are important things”  
FvR: “So all doublechecks...”  
N1: “All doublechecks are cancelled, at that moment.”]

A second daily nursing task where we identified patient safety risks was the fluid balance assessment. When the fluid-balance cannot adequately be measured, patient safety risks arise. Adverse outcomes like renal- or heart failure or dehydration can be a result of incorrect fluid balance management. Excerpts 2 and 3 show how language barriers affected both the management and the measurement of a patient’s fluid balance.

Q2 [Note from record 5: “Patient X does not understand that he must use an urinal, so he uses the bathroom, whereupon we cannot adequately report his fluid balance”]

Q3 [Interview with nurse1: “Sometimes she did not drink at all anymore, and other moments she drunk too much”]

Pain management was a third daily nursing task where patient safety risks were identified.. When a patient has had surgery and in some other medical situations, nurses assess pain three times a day, usually using a visual analogue scale. When a language barrier is present it is harder to explain the pain measurement tool to a patient. Inadequate pain measurement can be risky, and both under- and over-assessment of pain can occur leading to unnecessary suffering or overuse of pain medication. The examples in excerpts 4 and 5 illustrate the struggle with adequate pain assessment.

Q4 [Note in nursing record: Patient suffered from pain, reported 10 on the visual analogue scale. I explained to patient that 10 is really high. It came across like an 8 to me.”]

Q5 [Note in patient record 7: Patient appears painfull, but he does not report this]

The care around discharge and the follow up after discharge were also found to be prone to patient safety risk. When care around and after discharge is continued in the right way,
readmissions will be avoided. The example below describes a risky situation. The hospital guideline stated that every discharged patient was called by a nurse a few days afterwards. A standardized form in the patient record was filled out after this phone call. A green ‘check’ in the box showed that the patient was reached and the phone call had taken place. During qualitative analysis the researcher found out that a language barrier had been present and no additional actions were initiated by the care provider. The ‘aftercare phonecall’ was registered as ‘successful’.

**Q6: [Aftercare form in patient record 17:]
Date: x-x-2012
Diagnosis: Diabetes Mellitus
Time spent: 1 minute
Patient reached: Check, with text field filled out as follows: “Patient does not understand me on the phone”
All other questions (How does the patient feel, how is the pain going, etc.) were not filled out.

In the next example, excerpt 7, a nurse wrote down in the record that she felt that her patient did not understand that he was going to a rehabilitation center before he was discharged to home. Consultation of a professional interpreter was not considered. The nurse ordered a colleague to let relatives explain the situation.

**Q7: [Note in patient record8: Patient does not seem to understand that he goes to a rehabilitation center before he may go home. In case relatives visit patient tomorrow, please let them explain to patient]

The fifth and last nursing care situation we identified as a potential risk for patient safety, were actions including risk communication. For example the situation described in Excerpt 8.

**Q8 [Interview with nurse1: I cannot explain to the patient that she should not get out of bed]

Other examples that we found across records and interviews included: patients who leave their bed before they are advised to, are at increased risk of falls and a patient who did not understand instructions to lie on his side because of a pressure ulcer, needed surgery because his ulcer aggravated.

**Physician tasks**
The first physician task where we identified patient safety risks is the diagnosis. A language barrier can lead to a delay in diagnosis or misdiagnosis. The example in excerpt 9 shows how a language barrier can impede an adequate and timely diagnosis.
Q9 [Note from patient record 7: “Clinical picture hard to interpret because of language barrier”...“his both legs, without neurological paralysis, not specific for ‘radicular’, but diagnosis cannot be excluded because of language barrier”]

Acute situations constituted a second domain where we identified patient safety risks related to language barriers. An interview with a physician revealed a typical example. A patient had to lie down without any movements because he had a dangerous bleeding, and the physician was not able to make this explicitly clear to the patient. If the physician had not found someone in the corridor who spoke the same language as the patient, the patient could have died because instructions were not understood.

The third and last domain is equal to the last risk we described in daily nursing care and regards risk communication. Risk communication takes place in care situations such as surgery, including the informed consent procedure. Q10 illustrates the struggles of a physician during risk communication with patients with inadequate Dutch proficiency.

Q10 [Interview with physician10: “For someone who speaks Dutch it’s easier to say “No, I don’t want that”, than for someone not mastering Dutch [...] Than there is a tendency to foist. I think the rationale behind that is ok, but people [care providers] are not aware that they take a risk by doing so.[...]that leads to a tendency to trivialise. We have good intentions with the patient, and we want them to make a well-considered decision. I was steering this patient more than I would do with a Dutch speaking patient”]

2. Signalling and reporting a language barrier

For six records, record reviewers did not complete the questions on language barriers and thus data were missing. Analysis was carried out with the remaining 570 records with complete data. In 199 records the language proficiency of the patient was not recorded, while 62 of these 199 patients had self-reported inadequate Dutch proficiency. In the remaining 364 records where language proficiency information was found, often there was a discrepancy between self-reported and care provider-reported language proficiency. Overall, health care providers judged language proficiency more positive than the patients themselves. For example: In 24 of 189 records where a recording of adequate Dutch proficiency was found, self-reported Dutch proficiency was low. (Table 1)

In one of four hospitals included in this study, language was explicitly listed in the anamnesis form. Also, in case of inadequate Dutch proficiency, the preferred language was adequately filled out for each patient. In the three other hospitals, language proficiency was sometimes explicitly written down, but not at a specific, standardized place in the patient record. However, the presence of language barriers was often implicitly noticeable from the record. Also, in case of a language barrier, the preferred language was sometimes explicitly, but often implicitly noticeable from the record. See the six examples below.

1. Patient record: “Language barrier: ++”, the record review nurse assumed that this meant that a language barrier was present. The language spoken by the patient remained unclear.
2. Patient record: “Patient says ‘yes’ to everything, but I doubt whether he understands everything”. In this case a potential language barrier was reported in the daily nursing charts. The language spoken by the patient remained unclear.

3. Text field filled out by review nurse: “The reason for communication problems was not easily discovered. It seems that language plays a role”

4. Text field filled out by review nurse: “Because of a text passage in the patient record about the wish to watch a certain Dutch TV programme, I assumed that the patient spoke Dutch”

5. Text field filled out by review nurse: “From the discharge letter communication problems appeared, but this was not found in the nursing record”

6. Text field filled out by review nurse: “Patient was born in Morocco so probably the preferred language is Berber or Arabic”

### Table 1. Self-reported Dutch proficiency versus Dutch proficiency reported in patient record

<table>
<thead>
<tr>
<th>Record review</th>
<th>Self-reported Dutch proficiency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adequate Dutch proficiency</td>
<td>Moderate Dutch proficiency</td>
</tr>
<tr>
<td>Nothing reported</td>
<td>82</td>
<td>55</td>
</tr>
<tr>
<td>Adequate Dutch proficiency reported</td>
<td>107</td>
<td>58</td>
</tr>
<tr>
<td>Moderate Dutch proficiency reported</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Low/no Dutch proficiency reported</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>215</td>
<td>136</td>
</tr>
</tbody>
</table>
Research question 3: How are language barriers bridged in Dutch hospital care?

Ward policy

We had data available on ward policies from 24 of 30 ward managers (80%). Responses were diverse, and there was no similarity between ward policies within hospitals. From the responses of 24 ward managers we distilled five ways of language barrier bridging:

- No help of a third person or technical aid but communication with signs, “with hand and feet”
- Technical help like a smartphone with “google translate”, or books in different languages with common sentences like “I have pain” etc.
- Relatives of patients serving as interpreters
- Searching for hospital personnel speaking the same language as the patient to interpret
- Professional interpretation by telephone.

Nearly all wards indicated that relatives of patients were used to interpret. Five wards stated that their policy was the use of professional interpreters, and another five wards stated that they used one of the first four options during ‘daily care’ and professional interpretation services in critical cases like bad news. Some wards explicitly named telephonic interpreter services, others just indicated ‘interpreter’ and made no distinction between face-to-face and telephonic interpreters.

A few examples:

1. “Basically, we call an interpreter service. They currently interpret for a Romanian patient who is admitted. Sometimes, [bilingual] colleagues help us by making a paper with translated sentences like ‘I have pain’”

2. “We contact family members of the patient who master the Dutch language”

3. “In daily practice we communicate with ‘hand and feet’. When we have to explain things, we use colleagues who speak the same language as the patient, or family of the patient. Additionally, for important conversations or when we doubt the families’ interpreting abilities, we use telephone interpreters.”

Hospital policies

Three out of four hospitals have an explicit policy document which stated that the use of a professional interpreter is encouraged, and paid for by the hospital. In one of those three hospitals, the policy document was circulated to the hospital staff after data collection for the present study. This document also contained information such as “how to consult an interpreter?”. However, none of the heads of wards referred to the hospital policy in their response.
Practice

In 126 of all 576 records, involvement of relatives/family in communication was reported. In three records, the use of a professional interpreter by telephone was noted, and in 11 cases, a ‘live’ interpreter was mentioned. Record reviewers were not sure whether these interpreters were professionals or not.

In our qualitative analysis we found that care providers left the responsibility for bridging the language barrier to the patient and/or his relatives. Also the example below shows that care providers think that bridging of a language barrier is the patient’s own responsibility.

Q11 Note copied from patient record: “\textit{Diagnosis}: Unclear why patient came to ER. PE and additional examination revealed no clues for cardiac ischemia. \textit{Treatment}: None. Patient should drink sufficiently and bring an interpreter next time.

Another example is Excerpt 7, which was shown before, in which the patient that did not seem to understand that he was going to a rehabilitation home. The nurse wrote down ‘in case that relatives come...’), but there is no alternative written down for the case when no relatives came to visit the patient.

Q7: [Note in patient record8: Patient does not seem to understand that he goes to a rehabilitation center before he may go home. In case relatives visit patient tomorrow, please let them explain to patient]
DISCUSSION

We found a wide variety of patient safety risks related to language barriers during the hospitalisation of patients with low Dutch language proficiency. Both in nursing and physician care several high-risk situations were found. We found that language barriers were often not adequately reported in patient records. Our results suggest underuse of professional interpretation services. However, interpretation services cannot always be regarded a practical solution for problems, for instance during routine patient safety checks.

Patient safety risks

We identified potential patient safety risks for patients with inadequate language proficiency, like the drop-out of certain safety checks, difficulties with fluid balance management, and risks during acute situations. Some of these risks were also noted in a US Guideline aiming to improve patient safety systems for patients with limited English proficiency where the following high risk scenarios were mentioned: medication reconciliation, patient discharge, informed consent, emergency department care, and surgical care.[16] The patient safety risks we found in daily nursing care (i.e. protocollised date of birth checks during medication administration, fluid balance management) were not reported earlier, and might be the hardest to prevent because a professional interpreter is not feasible, on which we come back later. Another study in the Netherlands also found that a language barrier is a problem during daily nursing tasks [17], but a relation with patient safety risks was not assessed.

Signalling and reporting language barriers

For hospitals which are accredited by the JCI, reporting of language barriers is common practise.[6] However, most Dutch hospitals are accredited by ‘NIAZ’, a Dutch quality institute, which has no explicit standards on reporting language barriers.[7] Apart from the factual reporting, the right judgment of a language barrier is another problem. In our results, the care providers’ assessment was often more optimistic than the patient assessment, which points to an overestimation of patients’ language proficiency and thus an underestimation of the actual language barrier.

Bridging language barriers

Finally, bridging of a language barrier was often accomplished with family members of patients, and the use of professional interpreters was not standardized. The reason for the supposed underuse of interpreters was not among the research questions, but our data suggest a combination of reasons. First, our data showed that care providers sometimes thought that bridging of the language barrier is not their responsibility, but that of the patient, which was also shown internationally [18]. Second, interpretation with hand and feet and relatives was considered adequate. Diamond and colleagues found that the underlying reason of underuse of interpreters is complicated, and not only due to practical reasons such as time constraints. [8] A Dutch study shows that care providers do not consider the
language barrier as a problem. [19] A European study among five countries (TRICC) showed, like we did, that official policies are not consistent with daily practice when it comes to bridging language barriers in health care.[9]

**Strengths & limitations**

The mixed methods design is a strength of this study. The combination of quantitative and qualitative data provided us with both robust numbers on reporting and bridging of language barriers and insight in the mechanisms of the patient safety risks, in what exactly happens during hospital admissions of patients with low Dutch proficiency. The use of different data sources enabled triangulation within the study, supporting internal validity of the results. A potential limitation is the small number of cases sampled for the qualitative part of this study and the small number of interviews, however the data revealed no new patient safety risks and therefore we presumed data saturation. An interrater reliability analysis of reporting and bridging language barriers would have strengthened our conclusions, however, it is unlikely that two review nurses found opposite results, as they were instructed thoroughly before the study started. Another potential limitation is that we only have data of four Dutch hospitals, and thus we cannot generalise the results regarding reporting and bridging of a language barrier to Dutch hospital care in general. However, the four hospitals in our sample are a good representation of Dutch urban hospitals with an ethnically diverse patient population. The results regarding reporting and bridging of language barriers will not be internationally generalizable, however, the findings around patient safety risks are generalizable to each healthcare setting throughout the world.

**Implications for Practice and policy**

Adequate reporting is the first step towards adequately bridging language barriers and thus elimination of patient safety risks. We recommend, in accordance with the Joint Commission International (JCI) standards, that all hospitals have a standardized way of measuring and reporting of a language barrier in their patient records that indicates both the presence of a language barrier and the preferred language. The next step is successful and adequate bridging of a language barrier, which should preferably be done by professional interpretation services.

However, for the daily nursing tasks which are frequent and often quick (pain assessment, fluid balance management and birth-of date safety checks) the consultation of a professional interpreter is not feasible, and sometimes an ad-hoc interpreter is neither. For these another solution to eliminate patient safety risks is necessary. In the era of digital tools, one could think of technical help with animations or spoken instructions in the patient’s own language on a ‘tablet’ provided by the nurse to the patient.

In other cases which are usually not urgent, or not on a daily basis, and often planned; like history taking, diagnosis, risk-communication before surgery; professional interpreters should be used. Professional trained interpreters have been proved to provide better translations and cause less technical errors than non-professional interpreters like relatives [1]. In concordance, the use of interpreters should be ‘usual daily practice’ which should (technically) be made available by hospital and ward management. (i.e. education, availability
of suitable telephones, knowledge, and skills on how to use the interpreter service etc.), which is the case in some of the participating hospitals. Nevertheless, use of the services by care providers is limited.

In the Netherlands, theoretically there is an opportunity to consult professional interpreters, [9,20] but their availability does not guarantee their use. [21] As long as care providers do not know how to use them effectively, they will not improve patient care. Ikram and colleagues developed an e-learning module focussing on effective bridging of a language barrier using professional interpreters. [22] About the same recommendations were recently proposed in an US study concluding that trained professional interpreters can prevent medical error and thus enhance patient safety. [23]

Also, all hospital standards should contain elements on reporting and bridging of language barriers like the JCI Standards. However, JCI does not audit the actual interpreter use. [6]

**CONCLUSION**

The present study showed a wide variety of patient safety risks in hospital care for patients with language barriers. These risks can be reduced by adequately bridging the language barrier which, in the first place, asks for adequate signaling and reporting of a language barrier. This is currently not sufficiently done in most Dutch hospitals. Moreover, new solutions to bridge language barriers are needed for situations in which a professional or even informal interpreter is not feasible, such as routine safety checks performed by nurses.
APPENDIX 1. QUOTATIONS IN DUTCH


Q2 [D5: “Dhr. Begrijpt niet dat hij in urinaal moet plassen om het vocht op te meten dus plast in WC, waardoor vochtbalans niet goed kan worden bijgehouden”]

Q3 [N1: “Soms ging ze niks meer drinken en dan weer teveel”]

Q4 [D7: “Hr is nog pijnlijk. Gaf een vas van 10 aan. Hr uitgelegd dat een vas van 10 heel hoog is. Volgens hem was het echt een 10. Hr kwam bij mij echter over als een vas van 8.”]

Q5 [D8: “Komt vaak pijnlijk over, geeft dit alleen niet aan”]

Q6 [( nazorgformulier wat elektronisch ingevuld moet worden)
Datum nazorggesprek: 7-9-2012
Diagnose: dm deregulatie
Tijdsduur (minuten): 1
Patient bereikt: Vinkje gezet, en daarachter “dhr. Begrijpt mij niet aan de telefoon”
Rest van de vragen (hoe gaat het nu, hoe is het met de pijn, etc.) is niet ingevuld.]

Q7 [D8: “Mnr zelf lijkt niet goed de begrijpen dat hij eerst naar een KDO plek gaat voordat hij naar huis kan. Mocht er bezoek komen, bezoek vragen om uitleg te geven aan menr.”]

Q8 [N1: “Ik kan niet aan die mevrouw uitleggen dat ze net een ingreep heeft gehad en dat ze nu beter haar bed niet uit kan gaan”]

Q9 [D7: “Beeld moeilijk te interpreteren ivm taalbarrière”…..”Zijn beide benen, zonder neurologische uitval, wat aspecifiek voor radiculair, echter niet uit te sluiten gezien taalbarrière”]

Q10 [Ph2: “Iemand die goed Nederlands spreekt kan makkelijker zeggen “nee dat wil ik niet” dan iemand die niet NLs spreekt. […] dan heb je meer de neiging om dat mensen door de strot heen te duwen. Ik denk dat de gedachte daarachter goed is, maar dat mensen zich er niet bewust van zijn dat je dan een risico neemt […] Dat leidt er wel toe dat je iets meer de neiging hebt om dat te bagatelliseren. Kijk je hebt het beste met die patiënt voor, en je wilt wel dat hij op basis van goede gronden een afweging maakt. Die patiënt was ik meer aan het sturen dan bij een Nederlandse patiënt.”]

Q11 [D17: “Werkdiagnose: Onduidelijk waar patiënt voor komt, bij LO en aanvullend onderzoek geen afwijkingen, geen aanwijzingen voor nieuwe cardiale ischemie. Behandeling op SEH: Geen-Voldoende drinken-Volgende keer een tolk meenemen”]
Examples of ward policies in Dutch

1. “I.p bellen we de tolkentelefoon, we hebben nu ook een Roemeense meneer, waarbij we hen laten tolken. Soms zetten we eigen medewerkers in en laten dan een papier maken met de meest voorkomende zinnen: als: ik heb pijn etc”

2. “Contact via familie die wel de taal beheersen”

3. “In de dagelijkse omgang wordt met handen en voeten gecommuniceerd. Als er zaken uitgelegd moeten worden, dan wordt er gebruik gemaakt van medewerkers die de taal machtig zijn, of familie tolkt. Daarnaast wordt er bij belangrijke gesprekken en bij twijfel over het tolken van familie gebruik gemaakt van de tolken-telefoon.”
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