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Mississippi Registered Nurse Perceptions when Communicating with Limited-English-Speaking and Non-English-Speaking Patients

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MISSISSIPPI REGISTERED NURSE PERCEPTIONS WHEN COMMUNICATING

WITH LIMITED-ENGLISH-SPEAKING AND NON-ENGLISH-SPEAKING

PATIENTS

by

Mary Pipper Widdig

A Dissertation
Submitted to the Graduate School,
the College of Nursing and Health Professions
and the School of Leadership and Advanced Nursing Practice
at The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

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ABSTRACT

Communication serves as the foundation for safe and effective healthcare

practice. Effective nurse-patient communication is the cornerstone of the nurse-patient

relationship and is vital for the delivery of safe and effective healthcare. Research has

shown patients who are communication impaired are at a greater risk of medical error and

poorer health outcomes. A review of the literature revealed various nurse perceptions of

barriers when providing care for limited-English-speaking patients and non-English-

speaking patients. LEP and NEP patients also identified similar perceived barriers when

receiving care. Both nurses and patients revealed a distrust for interpreters and

interpreter services. The literature review revealed the need for further study into the

perspective of registered nurses when caring for LEP and NEP patients.

Communication is an important part of the nurse-patient relationship and is vital

for the delivery of safe and effective health care. Increasing diversity among patient

populations means healthcare professionals will find themselves caring for LEP or NEP

more frequently and highlights the need to identify strategies for positively impacting

healthcare encounters for LEP or NEP and healthcare providers. The purpose of this

study was to explore the lived experience of Mississippi registered nurses communicating

with LEP and NEP. A phenomenological approach was used to conduct the study.

Participants were recruited until data saturation occurred, resulting in a total of six

participants. Participants described experiencing anxiety when communicating with LEP

and NEP due to feelings of helplessness and fear, limited cultural competence

education/training, limited availability of interpreter services. Participants also described

feelings of detachment from LEP and NEP due to the role language plays in forming a

connection, especially in Mississippi. The study also found that participants feel that

healthcare facilities have not prioritized improving communication with LEP or NEP

which furthers the feelings of anxiety and detachment. The results of the study could

serve as the foundation for further research into improving communication between

nurses and LEP/NEP in the State of Mississippi.

ACKNOWLEDGMENTS

DEDICATION

No one achieves anything on their own. I could not have done this without my faith in Jesus Christ, my Lord, and Savior. He has blessed me beyond my wildest imagination. Every accomplishment from small to monumental is achieved with the help of countless individuals. This dissertation is dedicated to my wonderful husband, my family, and my friends. Without them, I would not be who I am or where I am today. To my husband who has supported and encouraged me throughout this entire process. To my parents for always urging me to reach higher and for allowing me to be myself. To my Sito for encouraging me when my spirits were low. To Day who will always serve as a reminder to relish even life's most simple moments. To my friends for being my biggest fans and helping me to keep my life balanced. To Susan Brown and my Surgicare family for being supportive and encouraging every step of the way. Words will never be able to express the gratitude I feel for the love and support I have been shown from these people over the course of my life and throughout this journey.

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LEP   Limited-English-speaking Patient

NEP   Non-English-speaking Patient

CHAPTER I - INTRODUCTION

Communication serves as the foundation for safe and effective healthcare practice. Webster defines communication as a technique for expressing ideas effectively (Communication, n. d.). Communication is a complex concept, particularly in nursing practice. Effective nurse-patient communication is the cornerstone of the nurse-patient relationship and is vital for the delivery of safe and effective healthcare.

The United States population is rapidly becoming increasingly diverse. Healthcare providers are providing care for a growing number of patients of different cultural backgrounds and different primary languages. Language is a common barrier in the healthcare setting. Language barriers in the healthcare setting increase the likelihood of adverse outcomes due to miscommunication. According to the United States Census Bureau, roughly 20% (60.6 million) of the American population (291.5 million) speak a language other than English at home (U.S. Census Bureau, n.d.). The United States Census Bureau also reported over 300 different languages are spoken in the United States. Of the 60.6 million people who speak a language other than English at home, 15.4% report not speaking English well, and 7% report not speaking English at all. In Mississippi, a reported 3.8% of the population speaks a language other than English at home. Of the 3.8%, 55.7% report they speak English very well, 16.9% report speaking English well, 19.0% report speaking English not well, and 8.4% report speaking English not at all.

Laws, regulations, and literature regarding the rights of limited English-speaking persons have been put into place in the United States. Title VI of the Civil Rights Act of 1964 was passed to ensure that federal money was not used to support discriminatory

programs or activities (Title VI, 2000). According to Title VI, people who speak a language other than English are entitled to treatment equal to that of English speakers. In 1980, the Department of Health and Human Services issues a notice stating, "No person may be subjected to discrimination on the basis of national origin in health and human service programs because they have a primary language other than English (NARA, 1980). In August of 2000, President Bill Clinton issued Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency*. EO 13166 reiterates Title VI requirements for institutions receiving federal funds and directs all federal agencies to ensure that their own programs provide equal access to LEP individuals (E.O. 13166, 2000).

The Office for Civil Rights (OCR) issued a Policy Guidance regarding compliance with Title VI in order to help healthcare providers and other federal fund recipients in fulfilling their obligations to LEP individuals (DHS, 2003). Policy Guidance emphasizes four factors that institutions should consider when establishing the extent and types of language assistance that is necessary: (a) the number or proportion of LEP persons served or eligible to be served, (b) the frequency of contact, (c) the nature and importance of service provided, and (d) resources and costs. In regards to resources and costs, the Policy Guidance states the following:

> Smaller recipients with more limited budgets are not expected to provide the same
> level of language services as larger recipients with larger budgets…Large entities
> and those entities serving a significant number or proportion of LEP persons
> should ensure that their resource limitations are well-substantiate(d) before using
> this factor as a reason to limit language assistance (DHS, 2003).

Healthcare institutions have a legal responsibility to provide language access. Healthcare providers and healthcare organizations such as hospitals and health systems have a special obligation to provide language access to all of their patients. Unfortunately, many healthcare providers remain unaware of their responsibility to LEP, have not prioritized the issue, or have not been held accountable (Chen, Youdelman, Brooks, 2007). The results of the literature review for this study suggest that Chen, Youdelman, and Brooks' (2007) assertion remains relevant today.

Research has shown patients who are communication impaired are at a greater risk of medical error and poorer health outcomes (Patak et al., 2009). The fact that roughly 20% of the United States' population does not speak English fluently raises concern surrounding fundamental healthcare practices such as nurse-patient communication. A lack of a systematic method for (a) nursing assessment, (b) evaluation and monitoring of patient-provider communication needs and interventions, and (c) standardized training of healthcare providers are all contributing factors to ineffective patient-provider communication.

Research has shown that the use of untrained interpreters such as family and friends to communicate with non-English-speaking patients can lead to miscommunication and medical errors (Bramhall, 2014). Several other strategies to improve communication with non-English-speaking and Limited-English-speaking patients have been implemented in health care facilities over the years. Support services such as interpreter services, improved educational materials, and providing longer visit times in managed care organizations all aim to improve communication between

healthcare providers and non-English-speaking patients (U.C. Davis Health, n. d.). However, these resources are either limited, infrequently, or ineffectively used.

According to the Joint Commission, LEP patients are at a higher risk of adverse events than English-speaking patients (Overcoming Challenges, 2015). A study was conducted analyzing adverse-incident reports from six Joint Commission accredited hospitals. The results of the study found that 49.1% of LEP experienced physical harm compared to 29.5% of English-speaking patients. According to the Joint Commission, LEP have longer hospital stays when professional interpreters were not used at admissions or discharge. LEP were also found to be at greater risk of line infections, surgical infections, falls, and pressure ulcers. LEP are also more likely to experience surgical delays due to difficulty understanding instructions. Most importantly, LEP are at greater risk of readmissions for certain chronic conditions due to difficulty understanding how to manage their conditions. Little is known about the interaction between nurses and LEP and NEP. Further research into this phenomenon is imperative if the nursing profession is to improve communication and, ultimately, health outcomes of LEP and NEP populations.

<center>Problem Statement</center>

Little is known about the interaction between nurses and LEP and NEP. Research surrounding the phenomenon is lacking, particularly in Mississippi. The purpose of this study was to utilize a sample of nurses to provide an in-depth description of Mississippi nurse's perspectives of communicating with LEP and NEP.

<center>4</center>

Theoretical Framework

The theoretical framework used to guide this study is the Purnell Model for Cultural Competence. The Purnell Model for Cultural Competence was developed to provide an organizing framework for nurses to use as a cultural assessment tool to which a diagram, metaparadigm concepts, and nonlinear cultural competence concepts were added the following year (Purnell, 2000). The Purnell Model for Cultural Competence provides a conceptual model of cultural competence that can be used by all health disciplines in all practice settings.

The Purnell Model for Cultural Competence is a product of the lived experiences, observations, personal readings, clinical practice, formal research, and teachings of Larry Purnell. Purnell asserts that care providers and recipients of care have a mutual obligation to share information to obtain beneficial outcomes. However, the health professional has the primary responsibility for creating an environment for openness to collect information. If nurses are unable to communicate with patients due to language barriers, the potential for creating an environment for openness to collect information is reduced. The model is conceptualized from multiple theories and a research base gained from organizational/administrative theories, anthropology, sociology, anatomy and physiology, biology, psychology, religion, history, linguistics, nutrition, and clinical practice settings in nursing and medicine.

The Purnell Model for Cultural Competence
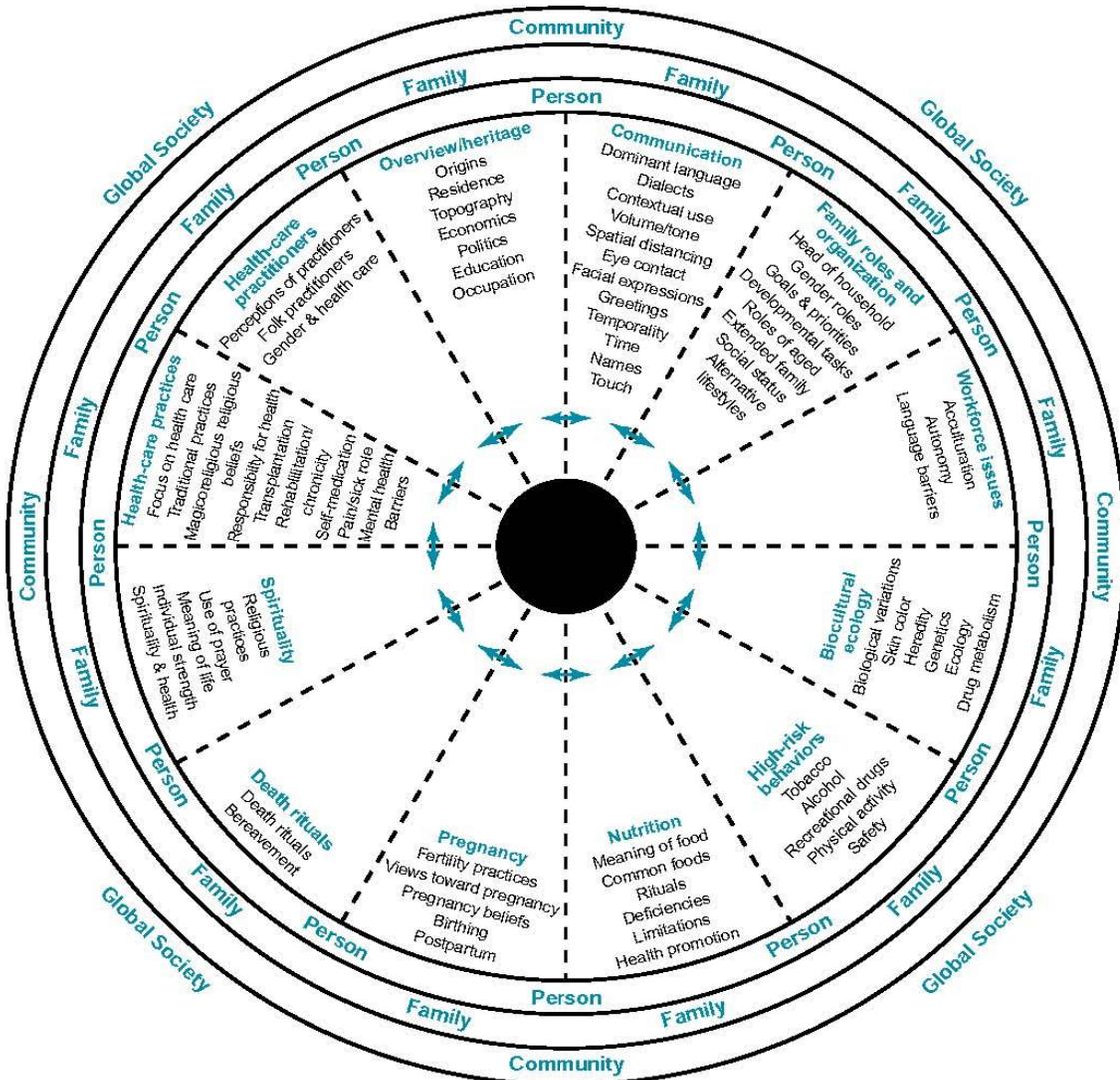
Unconsciously Incompetent - Consciously incompetent- Consciously competent - Unconsciously competent

Figure 1. Purnell Model for Cultural Competence

The Purnell Model for Cultural Competence is diagrammed as a circle. The outlying rim represents global society. The second rim represents community. The third rim represents family. The inner rim represents the person. The interior of the circles is divided into 12 pie-shaped wedges. Each wedge depicts a cultural domain and its concepts. The domains have bidirectional arrows. The bidirectional arrows indicate that each domain relates to all other domains and is affected by all other domains. Multiple concepts are under each domain. The center of the model is empty representing unknown aspects of that cultural domain. A saw-toothed line along the bottom of the model represents the nonlinear concept of cultural consciousness. The saw-toothed line primarily relates to the healthcare provider but can also relate to organizations depending on their stage of cultural competence as an organization.

The metaparadigm concepts identified in the model are: (a) global society, (b) community, (c) family, and (d) person. Global society is defined as seeing the world as one large community of multicultural people. Community is defined as a group or class of people having a common interest or identity living in a specified locality. Family is defined as two or more people who are emotionally involved with each other, may or may not live in close proximity to each other, and may be blood or non-blood related.

Twelve domains are identified in the model. The overview/heritage domain includes concepts related to country of origin, country of residence, economics, politics, and education status. The communication domain includes concepts related to dominant language, dialects, and cultural communication patterns (e.g. personal space, touch, and body language). The family roles and organization domain include concepts such as the head of household, gender roles, roles of the aged and of extended family members. The

workforce issues domain includes concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, individualism, and healthcare practices from the country of origin. The biocultural ecology domain includes concepts related to skin color, body type, diseases, and how the culture metabolizes drugs. The high-risk behavior domain includes concepts related to drug use, alcohol use, nicotine use, dangerous behaviors, use of safety equipment, high-risk behaviors, degree of sedentary lifestyle, and consumption of unhealthy food. The nutrition domain includes concepts related to the availability of food, rituals, and taboos associated with food, the meaning of food to culture, and how food is used in sickness and in health. The pregnancy and childbearing practices domain include concepts related to fertility practices, labor and delivery practices, practices that are considered taboo, prescriptive or restrictive during pregnancy, and labor and postpartum. The death rituals domain includes concepts related to how death is viewed, euthanasia, preparation for death, burial practices, and bereavement practices. The spirituality domain includes concepts related to practices that give strength and meaning of life to an individual, religious practices, and how prayer is used. The healthcare practices domain includes concepts related to the use of preventative versus acute treatment, magicoreligious healthcare beliefs, traditional practices, individual responsibility for health, self-medicating practices, views towards organ donation, mental illness, and rehabilitation, how pain is expressed, the sick role, and barriers to health care. The healthcare practitioner's role includes concepts related to the type of practitioners the culture uses, the status of the practitioner in that particular culture, and the significance of the gender of the practitioner.

Each of the 12 domains identified plays a significant role in the provision of culturally competent care by registered nurses. The phenomenon being examined falls within the communication domain of the Purnell Model for Cultural Competence as well as the workforce issues domain, healthcare practices domain, and healthcare practitioner's role domain. The nurse having an understanding of concepts related to dominant language, dialects, and cultural communication patterns of LEP and NEP is important. The gap in the literature surrounding the interaction between Mississippi registered nurses and LEP and NEP highlight the need for further study of the phenomenon. A better understanding of the perceptions of registered nurses communicating with LEP and NEP will help provide the foundation for further research, improvement in nurse practice, and improvement in the health outcomes of LEP and NEP.

The Purnell Model for Cultural Competence identifies 18 explicit assumptions. These assumptions originate from Purnell's personal values as well as those of the healthcare environment and include health promotion and wellness, illness and disease prevention, health restoration, and rehabilitation. Cultural Competence is seen as a nonlinear progression. According to Purnell, culturally competent healthcare providers develop an awareness of his or her existence, sensations, thoughts, and environment without allowing these factors to influence the care given to the patient. Cultural competence is the adaptation of care in a manner that is congruent with the culture of the patient and is a conscious and nonlinear process.

The Purnell Model is relevant for nurse and healthcare providers in various contexts. The model is holistic and flexible and maintains fluidity among domains and

levels. The model can be utilized for the development of assessment tools, planning

strategies, and interventions.

According to Purnell, culture includes patients and families as well as educational

and healthcare organizations. Because the model includes the domain workforce issues

and the nonlinear line of cultural competence, it can be used to assess organizational

culture and cultural issues among staff. Organizational culture reflects the social

structure, historical antecedents, values, traditions, management processes, policies,

procedures, and evaluation processes. The aspects of organizational culture reveal the

degree to which diversity in thinking, reflecting and behaving are promoted or accepted.

Little is known about the effect of the culture of healthcare organizations in Mississippi

in regards to providing care for and communicating with LEP and NEP.

Evaluation of the Purnell Model of Cultural Competence involves assessing the

clarity, simplicity, generality, empirical precision, and derivable consequences. The

model has clarity in that the arrangement of domains and concepts is logical and

adequate. As far as simplicity is concerned, the model cannot be described as simple due

to the multiple concepts and variations in human behavior as well as the overlap of

concepts between the domains. Generality is a strength of the model. The model is

developed from multiple midrange theories in nursing and other disciplines are

generalizable to all practice settings in nursing and can be used by other health-related

disciplines. Continued use by practitioners, educators, administrators, and researchers

will increase the models' empirical precision by validating and expanding existing

knowledge bases. Derivable consequences indicate how practically useful, important,

and generally sufficient the theory is in relation to achieving important health outcomes

(Meleis, 1999). The model can be used to guide practice, education, administration, and research. Guidelines for holistic assessment of patients, families, and communities are provided by the model for healthcare professionals.

Significance and Justification

According to the 2010 United States Census, the Latino and Hispanic population was 50.5 million which made up 16% of the total population in the United States (Ennis, Rios-Vargas, & Albert, 2011). This sector of the population alone increased 43% from 2000 to 2010. The increasing diversity in the United States population also means increasing diversity among patient populations. Increasing diversity among patient populations means healthcare professionals will find themselves caring for LEP or NEP more frequently and highlights the need to identify strategies for positively impacting healthcare encounters for LEP or NEP and healthcare providers.

Assumptions

The researcher's philosophical assumption is ontological. The researcher assumed there are multiple realities experienced by the participants (Creswell & Poth, 2018). The researcher also assumed that all participants have had some sort of experience communicating with LEP and NEP. The researcher also assumed that all participants told what they see as the truth throughout the entire interview process. The opinions and past experiences of the researcher did not influence the results of the study. The researcher remained as unbiased as possible and also remained truthful throughout the study.

Limitations

Participants met four criteria for inclusion in the study. Inclusion criteria for participants of the study required participants to (a) be registered nurses, (b) have practiced nursing in Mississippi within the last five years, (c) speak English, and (d) have had an experience communicating with LEP or NEP in Mississippi. Participants were registered nurses who have practiced in Mississippi within the last five years was important because the aim of the study was to capture the lived experience of Mississippi registered nurses when communicating with LEP and NEP. Advanced practicing nurses such as nurse practitioners and licensed practical nurses might have an altogether different perception than that of a registered nurse. It was necessary for participants to speak English because the author of the study is not fluent in any language other than English. In order to capture the lived experience of Mississippi registered nurses when communicating with LEP and NEP, it was imperative that participants have had and experience communicating with LEP or NEP in Mississippi.

Delimitations

Individuals who did not meet the four inclusion criteria were not utilized for the study. Exclusion criteria for participants for the study included: (a) not being a registered nurse, (b) nurses who have not practiced in Mississippi within the last five years, (c) nurses who have had no experience communicating with LEP or NEP in Mississippi, and (d) nurses who are bilingual. Individuals who were not registered nurses and who have not practiced nursing in Mississippi within the last five years were excluded from the study as the focus of the study was on the lived experience of Mississippi registered nurses. Nurses who have no experience communicating with LEP or NEP in Mississippi

were excluded from the study as the phenomenon of interest was the experience of Mississippi registered nurses when communicating with LEP or NEP. Nurses who are bilingual might also experience a different reality when communicating with LEP or NEP and were excluded.

Purpose Statement

Currently, little research addressing the nurse perspective of caring for LEP and NEP has been conducted. The purpose of this phenomenological study was to develop a description of the essence of the experience of nurses in Mississippi when communicating with LEP and NEP. The aim of the researcher was to identify the perspective of Mississippi nurses when communicating with LEP and NEP.

Objectives

Two objectives guided this study:

1. Capture and describe the essence of nurses in Mississippi's experience when communicating with LEP and NEP.

2. Identify contexts or situations that typically affect Mississippi registered nurses' experiences when communicating with LEP and NEP.

Research Questions

The following research questions guided this study:

1. What is the lived experience of Mississippi registered nurses when communicating with LEP or NEP?

2. What contexts or situations have typically affected Mississippi registered nurses' experiences when communicating with LEP or NEP?

These two questions focused on gathering data that is relevant and helped provide a textual and structural description of the experiences which will lead to an understanding of the common experiences of the participants (Creswell & Poth, 2018).

Operational Definitions

1. Registered Nurse: A licensed health-care professional who practices under the supervision of physicians, physician's assistants and nurse practitioners and is skilled in promoting and maintaining health (Registered Nurse, n.d.).

2. Limited-English speaking: A person whose first language is not English and who only has limited experience or proficiency when speaking English.

3. Non-English speaking: A person whose first language is not English and who no understanding or ability to speak English.

4. Patient: An individual who seeks or receives medical care and treatment.

5. Confidence: A feeling or consciousness of one's abilities or of reliance on one's circumstances.

6. Interpreter: A person who has had training and is certified to translate orally for individuals (specifically patients and healthcare providers) conversing in different languages.

7. Ad hoc interpreter: Someone who is thrown into interpreting due to circumstance rather than training or experience.

8. Healthcare provider: A healthcare professional whose job requires direct contact and interaction with patients and provides healthcare services for patients.

9. Communication: A technique for expressing effectively expressing ideas. A

    process by which information is exchanged between individuals through a

    common system of language, signs, or behavior (Communication, n.d.)

10. Barrier: Something that impedes or separates.

11. Visual aids: An item of illustrative matter, such as flash cards that contain

    pictures with words of the pictures in English and the patient's primary

    language.

Summary

Communication is an important part of the nurse-patient relationship and is vital for the delivery of safe and effective healthcare. The purpose of this study was to explore the lived experience of registered nurses communicating with LEP and NEP patients. A phenomenological approach was utilized to conduct the study. Assessing the lived experience of nurses when caring for LEP and NEP gave a new insight into nursing practice in Mississippi and has provided a foundation for further study.

CHAPTER II – REVIEW OF THE LITERATURE

A literature review was conducted via The University of Southern Mississippi's electronic database. Initially, the term "non-English-speaking" was used to find relevant literature relating to the experience of registered nurses when caring for NEP. The search yielded 447 peer-reviewed journal articles. A portion of the articles addressed topics such as cultural competence, cultural sensitivity, and the use of interpreters, but none of the resulting articles addressed the perspective of registered nurses when caring for NEP. Because of the limited results of relevant literature, the term "Limited-English-Speaking" was used as well. The search yielded 44 peer-reviewed journal articles. Of the 44 articles, three of the articles addressed aspects of the nurse perspective when caring for LEP. None of the articles addressed the perspectives of Mississippi registered nurses when caring for LEP or NEP.

According to Hull (2015), there are distinct differences between fluency, proficiency, and competence when speaking another language. Hull provides the conceptual foundation underlying the need for language proficiency assessments. Hull also identifies basic concepts of what makes a language. Medicine and nursing have their own languages that require developing competence.

One qualitative study addressed healthcare staff experiences with and perspectives of using professional medical interpreter services. Researchers found the addition of communication-based resources to healthcare settings may not be sufficient to impact providers' attitudes and behaviors regarding LEP. The overarching organizational culture regarding patients who have limited English proficiency might also be unaffected by the addition of communication-based resources alone (Michalec, Maiden, Oritz, Bell,

& Erenthal, 2015). The study found that barriers to the utilization of professional

medical interpreters can be categorized by distinct institutional- and individual-level

factors. Researchers found upon examining identified barriers that providers' use or non-

use of interpreter services simply scratches the surface of the challenges surrounding the

care for a patient with limited English proficiency. The researchers argue that the

availability of interpreter services is not the only factor affecting a healthcare provider's

ability to deliver safe and effective care to patients with limited English proficiency. The

results of this study indicate that there is a need for further investigation into the

perspective of registered nurses when caring for LEP or NEP.

Another study identified the importance of cross-cultural communication skills in

the healthcare setting (Gasiorek & Poel, 2018). The quantitative study addressed

language-specific skills in intercultural healthcare communication and compared

perceived preparedness and skills in nurses' first and second languages. The researchers

found that medical professionals do not necessarily receive sufficient education and

training in cross-cultural communication (Bardet et al., 2012). Lack of experience and

inadequate training are also cited as factors contributing to healthcare professionals' lack

of cross-cultural preparedness (Castillas et al., 2015). According to the study, nurses who

had received previous language-specific skills training felt more prepared to care for

patients from a different culture (Gasiorek & Poel, 2018). The results of the study

suggest the need to investigate the role cross-cultural preparedness plays in the

perspective of Mississippi registered nurses when caring for LEP or NEP.

A qualitative study exploring registered nurses' experiences with caring for NEP

revealed that nurses perceived three challenges when caring for NEP: (a) language

barriers, (b) cultural barriers, and (c) resource availability (Ian, Nakamura-Florez, & Lee, 2015). Nurses in this study identified numerous barriers and challenges when caring for NEP despite resources provided by the healthcare institutions. Participants also reported that caring for NEP was more challenging than caring for English-speaking patients. The results of the study indicate a need for easily accessible resources at healthcare organizations to improve communication with NEP and cross-cultural competence training to equip nurses to better provide culturally competent care. The results of the study also further establish the legitimacy for a study investigating the perspective of Mississippi registered nurses when caring for LEP or NEP.

Another study conducted addresses factors affecting care in NEP and families (Raynor, 2016). The author of the study asserts that communication barriers have the potential to affect patient compliance and possibly lead to adverse outcomes. The author also identifies errors in translation as a risk factor for adverse outcomes for NEP. Errors in translation occur with medically trained interpreters up to 12% of the time, while the error rate with lay interpreters (e.g. family member or Google Translate) can be up to 22%. The majority of errors in translation are due to omission errors followed by false fluency errors. Misinterpretation is responsible for up to 18% of adverse outcomes for NEP. The results of the study found that the majority of non-English speaking participants believed their children understood their own medical conditions and why they were being seen in the clinic. The majority of participants also indicated they did not know why they were seeing their provider, did not understand ordered tests, test results, or the treatment plan. Most of the respondents also reported not understanding how to administer medications and had difficulty understanding the interpreters. The

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participants who had difficulty understanding interpreters also felt interpreters were not translating their statements completely and accurately. The results of the study identify a distrust of healthcare providers by NEP. Furthermore, the study indicates a significant need for further inquiry into more effective methods of communication with NEP and emphasizes that the use of interpreters for communication is not the only answer. A study addressing the experience of registered nurses when caring for LEPs or NEPs could help to shed more light on the interaction between nurses and LEP or NEP. Gaining a better understanding of the perspective of registered nurses when caring for LEP or NEP.

A qualitative cross-sectional study was conducted to examine the accuracy of medical interpretations provided by nurses untrained in medical interpreting (Elderkin-Thompson, Silver, Waitzkin, 2001). The study concluded roughly one-half of the encounters had serious miscommunication problems that affected the physician's understanding of the symptoms or the credibility of the patient's concerns. The authors asserted that errors regularly occur in interpretations provided by untrained nurse-interpreters during cross-language encounters. The results of the study indicate non-English-speaking patients may be misunderstood by their physicians. Roughly 23-52% of physicians' questions were either misinterpreted or not interpreted at all by non-trained, ad hoc, staff interpreters. Professional interpreters allow patients to speak freely, and they provide patients with the opportunity to explain problems without modifications by family members who can bring their own objectives and perceptions to the encounters. The results of the study highlight the importance of the utilization of professional interpreters when caring for LEP or NEP. Before addressing whether Mississippi nurses are qualified to serve as interpreters during cross-language encounters, the reality of the

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encounter between a Mississippi registered nurse and an LEP or NEP must first be examined. Exploring the perception of Mississippi registered nurses when caring for LEP or NEP will help serve as the foundation for further study in this regard.

Another study was conducted examining Hmong- and Spanish-speaking patients' perceptions of interpreter service quality (Lor, Xiong, Schwei, Bowers, & Jacobs, 2016). Participants described how poor quality interpretation could lead to (a) poor interpersonal relationships among patients, providers, and interpreters, (b) inability of patients to follow through with treatment plans, and (c) emotional distress for patients. The study found: (a) LEP patients are dissatisfied with the quality of interpreter services, (b) LEP patients expect interpreters to interpret accurately clinical and emotional messages in a culturally sensitive way in both directions from providers and patients, and (c) LEP patients perceived lower quality of care due to poor interpretation. The results of the study highlight the LEP perspective when receiving medical care. Although the authors of the study address the LEP perspective, the results of the study are also relevant to nursing practice. The study has important implications because it suggests that healthcare providers and the system as a whole should be more sensitive to the process of interpretation to ensure that LEPs' needs are met. Addressing the nurse perspective is important as well because nurses might not realize the challenges LEP encounter when communicating with healthcare providers.

William Faulkner once said, "To understand the world, you must first understand a place like Mississippi (McNeese, 2017)." The State of Mississippi is home to a truly unique population with a distinctive culture. According to the CDC, Mississippi has one of the highest rates of sexually transmitted disease (Sexually Transmitted Diseases,

2018). With one of the highest poverty rates in the nation as well as diabetes, cancer, and

cancer deaths, Mississippi could be considered one of the least healthy states in the

United States (CDC, 2017). Surprisingly, Mississippi has a reportedly low prevalence of

binge-drinking and high immunization coverage among children (Nave, 2017). A small

disparity in health status by education level is also found in Mississippi. Mississippi

registered nurses care for some of the nation's most unhealthy and most impoverished

patients. The health disparities and socioeconomic status of Mississippi's patient

population provides a unique set of challenges for Mississippi's registered nurses. The

reality of being a nurse in Mississippi is a phenomenon too complex to address in a single

study. The perspective of Mississippi registered nurses is lacking in the literature on

several fronts, particularly when communicating with LEP/NEP. Mississippi registered

nurses have a unique perspective that can shed light on what it is like to communicate

with LEP/NEP.

Summary

The review of the literature yielded limited information surrounding the care of

LEP and NEP. The available literature covers a variety of topics, only one of which

addressed the nurse perspective. Nurse perceptions of barriers when caring for NEP

patients includes language barriers, further validating the need for investigation of the

reality of communicating with LEP and NEP. LEP and NEP also identified similar

perceived barriers when receiving care. None of the literature addressed the perspective

of Mississippi registered nurses when communicating with LEP and NEP. Both nurses

and patients revealed a distrust for interpreters and interpreter services. The literature

review revealed the need for further study into the perspective of registered nurses when caring for LEP and NEP.

CHAPTER III - METHODOLOGY

Introduction

Little research has been conducted regarding nurse perceptions of communicating with LEP and NEP patients. Prior to this study, no research had been conducted investigating Mississippi nurse perceptions of communicating with LEP and NEP patients. The purpose of this phenomenological study was to develop a description of the essence of the experience of nurses in Mississippi when communicating with LEP and NEP.

Design

A phenomenological design was used to conduct the study. Phenomenological studies describe the common meaning for several individuals of their lived experiences of a concept or a phenomenon (Creswell & Poth, 2018). Due to the lack of literature available regarding the perspective of Mississippi registered nurses when communicating with LEP or NEP, a phenomenological design was appropriate for this study. The phenomenon examined was the reality for Mississippi registered nurses when communicating with LEP or NEP.

The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of its universal essence. The purpose of this study is to capture the essence of the experience of Mississippi registered nurses when communicating with LEP/NEP. In phenomenological research, a researcher identifies a human experience, collects data from participants who have experienced the phenomena, and develops a description of the essence of the experience for all of the individuals. The description details 'what' participants experienced and 'how' participants experienced the

phenomena. This study detailed 'what' registered nurses experience when

communicating with LEP or NEP and 'how' nurses experience the phenomena as well.

<center>Role of the Researcher</center>

The researcher was the primary data collection instrument (Creswell, 2013). The

researcher constructed all interview questions. All interviews were conducted,

transcribed, and analyzed by the researcher. Biases were identified prior to data

collection. Previous experiences communicating with LEP or NEP as a registered nurse

was identified as a factor that could bias the perspective of the researcher when analyzing

data. Bias was reduced by assuming the transcendental phenomenological attitude which

involves bracketing and reduction. Bracketing involves putting aside all knowledge of

the phenomenon being explored that is not due to the actual instance of the phenomenon

(Husserl, 1977). All previous experiences of the researcher with LEP/NEP as a

registered nurse were put aside prior to the initiation of each interview and data analysis.

Reduction is refraining from postulating the existence of what is given. A rich

description of the data collection, data analysis, and conclusions of this study is given in

the subsequent chapters.

<center>Ethical Considerations</center>

Approval from The University of Southern Mississippi's Institutional Review

Board was acquired before participants were recruited for the study (protocol # IRB-18-

159, Appendix B). Participants were recruited through a variety of methods including (a)

social media outreach (Facebook, Instagram, etc.), (b) electronic communication via

phone or text messages, and (c) face-to-face. Participants were primarily recruited face-

to-face. Participants were insured of confidentiality and informed consent was obtained

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from each participant prior to the initiation of each interview. Each participant was

assured that participation in the study was voluntary and could be terminated at any time

at the participant's discretion. Potential participants were also assured that no

disciplinary action from employers would result if any potential participant were to

decline participation in the study. All interviews were recorded on an electronic

recording device. All interviews were de-identified. All data collected during the study

has been secured. Electronic data is secured on a password-safe computer. All hard

copies of interviews and transcriptions are stored in a home office that locks from the

outside. Every effort was taken to maintain the confidentiality of participants and the

integrity of the study.

Sampling

A purposeful sample, which is an intentional sample of a group of people that can

best inform the researcher about the research problem, was used for this study (Creswell

& Poth, 2018). Purposeful sampling is a type of non-probability sampling technique.

Non-probability sampling is useful when the units being investigated are based on the

judgment of the researcher. Purposeful sampling is useful in qualitative research with

limited resources, particularly research where a small number of cases can be decisive in

explaining the phenomenon of interest. Participants were strategically recruited for

participation in this study who were: (a) registered nurses, (b) have practiced nursing in

Mississippi within the last five years, (c) speak English, (d) have had an experience

communicating with LEP or NEP in Mississippi, and (e) are not bilingual. Polkinghorne

recommends interviewing from 5-25 individuals who have all experienced the

phenomenon (Polkinghorne, 1989). Five participants were recruited initially and then

participants were recruited until data saturation occurred, resulting in a total of six participants.

Data Collection

Data was collected during a series of semi-structured one-on-one interviews. Interviews were conducted in a private room at one of two public libraries. Permission to conduct the interviews at the facilities was acquired prior to recruiting participants. Interview questions were developed by the researcher and evaluated for face validity by a nurse expert prior to initiation of the first interview. Each participant was asked the same questions. All interviews were audio-recorded and then transcribed verbatim by the researcher for analysis. Immediately following the conclusion of each interview, the researcher reflected on the experience by journaling. Journal entries included a description of any memorable emotional reactions made by the participants, the overall demeanor and engagement of the participant, and any other factors that might not have been captured solely by an audio recording.

Data Analysis

To achieve transferability, a thick description of the phenomenon has been provided, including a detailed account of the data collection process (Lincoln & Guba, 1985). All interviews were audio-recorded and then transcribed verbatim by the researcher for analysis. Each transcription was de-identified to reduce the risk of interviewer-bias and to protect the identity of participants.

The Purnell Model of Cultural Competence guided the analysis of each transcript. Each transcription was reviewed individually in order to gain a general sense of the information and to reflect on its overall meaning (Creswell, 2013). Statements significant

to the study were identified from each interview transcription. The statements were then grouped into meaning units. The meaning units were then grouped and regrouped into 'meaning clusters.' The 'meaning clusters' were then grouped and regrouped until core themes emerged. Two themes emerged: *anxiety* and *detachment*. The theme of anxiety includes several subthemes: feelings of helplessness and fear, a need for improved cultural competence education and training, a need for prioritizing improving communication with LEP or NEP, and a need for increased access to interpretive services. The theme of detachment includes subthemes of language and connection. Member checking was performed during the data analysis process to achieve credibility. For every five participants interviewed, one participant was utilized for member-checking. The researcher asked the participant, "Is this what you were saying?" to clarify that the derived meaning units reflect the responses received from the participant. Member checking was conducted in the same manner and with the same consideration as the initial interview.

After member checking was complete, the identified themes were examined to identify overarching themes. Themes were also assessed to determine which of the twelve domains of the Purnell Model of Cultural Competence the theme falls within. Relevant quotations from the respondents are provided to give a thick description in support of the researcher's interpretation of the data. A description of 'what' participants experienced and 'how' the experience happened is provided.

<div align="center">Qualitative Rigor</div>

Rigor is the criteria for trustworthiness of data collection, analysis, and interpretation (Prion & Adamson, 2014). The criteria for rigor include credibility,

transferability, dependability, and conformability. Credibility is defined as the

truthfulness of the data and its interpretation. Credibility was ensured by validating data,

results, and interpretations with a committee of experts in the form of a dissertation

committee. Transferability is the applicability of the study results to other populations.

A meticulous, step-by-step description of the research methodology has been documented

to ensure transferability. The researcher kept a journal throughout the data collection

process for the purpose of reflection during the data analysis process. Dependability is

also known as auditability. A thick description of the entire research process has been

provided to ensure dependability. Conformability is the absence of researcher bias. All

efforts were made to eliminate any bias that may occur throughout the study; however,

any biases that may exist have been expressed.

Plans for Results

The results of this study were presented to a panel of experts in the form of a

power point and a formal paper. The results of the study will be submitted to various

scholarly journals and potentially be published and presented at conferences. The results

of the study will be also be utilized as the foundation for further research.

Summary

The purpose of this study was to develop a description of the essence of the

experience of nurses in Mississippi when communicating with LEP and NEP. A

phenomenological qualitative approach was used due to the gap in the literature and lack

of research that has been conducted surrounding this topic. Purnell's Model for Cultural

Competence was utilized to guide the study. Purposeful sampling was used to gain

participants until data saturation occurred. Participants were interviewed face-to-face.

Interviews were conducted, transcribed, and analyzed by the researcher. The results of this study will serve as the foundation for further research.

CHAPTER IV – PRESENTATION AND ANALYSIS OF DATA

Introduction

A qualitative phenomenological design, as well as the Purnell Model of Cultural

Competence, was utilized for this study to answer the following questions:

1. What is the lived experience of Mississippi registered nurses when

   communicating with LEP or NEP?

2. What contexts or situations have typically affected Mississippi registered

   nurses' experiences when communicating with LEP or NEP?

The methods for data collection and data analysis as well as the findings of this

research will be presented in this chapter. Support for the findings as well as any

discrepant cases or non-conforming data will be described in detail. A description of

how the findings of this study correspond to the research questions and Purnell's Model

of Cultural competence will also be presented in this chapter.

Description of Sample

A purposeful sample was utilized for this study. Participants were strategically

recruited for participation in this study who were: (a) registered nurses, (b) have practiced

nursing in Mississippi within the last five years, (c) speak English, (d) have had an

experience communicating with LEP or NEP in Mississippi, and (e) are not bilingual.

Five participants were recruited initially and then participants were recruited until data

saturation occurred, resulting in a total of six participants. Participants all currently

practice in a metropolitan area of Mississippi. All participants were willing to participate

in this study throughout the entire research process.

The sample of five females and one male with ages ranging from 28 to 58 provided a sample with diverse experience in the field of nursing. All participants have experience in the hospital setting including labor and delivery, neonatal intensive care, pediatrics, emergency room, and adult surgical intensive care units. Five of the six participants have moved from the hospital setting to privately owned clinics and outpatient facilities including pre-op, operating room, recovery room, case management, and pediatric clinic settings. One participant has exclusively worked in the hospital setting and has worked on the same unit in various roles for 23 years.

All participants currently work in a metropolitan area of Mississippi. Two participants have practiced outside of the area in previous jobs. Two participants have practiced outside of the State of Mississippi (one nurse worked remotely from Mississippi but dealt with patients outside of the State of Mississippi). Spanish was the primary language other than English encountered by all participants.

Table 1

Description of Sample

Participant	Age	Sex	Years of Experience	Worked Outside of Mississippi?	Primary language encountered other than English in Mississippi?
A	58	F	23	N	Spanish
B	28	F	5.5	Y	Spanish
C	48	F	24	Y	Spanish
D	29	F	7	N	Spanish
E	28	F	6	N	Spanish
F	30	M	5	N	Spanish

Findings

Two themes emerged during the data analysis process: *anxiety* and *detachment*. The theme of anxiety includes several subthemes: feelings of helplessness and fear, a need for improved cultural competence education and training, a need for prioritizing improving communication with LEP or LEP, and a need for increased access to interpretive services. The theme of detachment includes subthemes of language and connection.

Anxiety

Anxiety is defined as a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome (Anxiety, n.d.). In an article written by Oprah Winfrey describing her experience in the aftermath of Hurricane Katrina she said:

> I choose to rise up out of that storm and see that in moments of desperation, fear, and helplessness, each of us can be a rainbow of hope, doing what we can to extend ourselves in kindness and grace to one another. And I know for sure that there is no them - there's only us (Winfrey, n.d.).

Oprah's words could also be applied to the experiences described by the participants. Anxiety was described by all of the participants throughout the course of the interviews. Anxiety also seemed to be present in the body language expressed by participants when answering certain questions. The body language included diverted eye contact, long pauses before or during responses, limited hand gestures, and even the facial expressions of the participants. The subthemes accompanying anxiety all contribute to the overall feelings of anxiety described by the participants.

Helplessness and Fear. All participants described experiences they had

communicating with LEP or NEP both positive and negative. When describing the

experiences, participants expressed how they felt when communicating with LEP or NEP

and what made them feel that way. Anxiety when communicating with LEP or NEP was

a common theme among all participants. All six participants experienced anxiety when

communicating with LEP or NEP as a nurse in Mississippi. Participants expressed

experiencing feelings of helplessness when communicating with LEP or NEP.

You feel kinda helpless.

It makes me feel helpless in a way. You want to be able to communicate with

them. And you can try really hard and you can tell they're trying or they're

embarrassed. And you want to make them feel as comfortable as possible but

sometimes it's a helpless feeling.

I did realize that I was kind of helpless in terms of—it was just me and her, I

wasn't going to be able to get her to understand what I needed her to do or what

she was expected to do. And at the end of the day she ended up not having

surgery because she came to the clinic alone she didn't have anybody to help us

kind of translate, we didn't have access to a translator.

Participants also expressed experiencing feelings of fear when communicating

with LEP/NEP.

It's a little bit frightening because I want to know that they understand what they

are supposed to be doing. You know, it can be a dangerous thing. If I am telling

them, you know, that they should feed their baby 8 times a day and they think it's

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two times a day. Or if its formula and correct proportions to mix up their formula.

It can be a dangerous situation.

I hope I'm not projecting this but, I can imagine that I could project some fear as

well. So there's some fear there that happens in miscommunication.

Fear also plays into your liability as a nurse because you want to take good care of

your patients and you want to make sure they understand why and how and all the

aspects of their care.

Sadly, I would say that maybe practitioners as a whole might be a little more

reluctant. Again-I don't know if that's really the right word but…maybe. I mean,

just, because I do feel like it creates anxiety and that a lot of times healthcare

providers aren't comfortable and always when we're not as comfortable, we're

not as open, and maybe a little more guarded towards those patients 'cause we're

kinda scared.

I just feel like we're scared, it's something that we're not used to or accustomed

to… And it's always a concern that somethings gonna get lost in translation. And

sometimes I have left conversations feeling like, 'Did I really convey what I

needed to convey?'

It was kinda scary when consents were done and you weren't really sure what

they understood.

One participant described feeling aggravated when communicating LEP/NEP.

The participant felt aggravated at herself for not being able to speak any other languages

and ultimately not being able to communicate with LEP/NEP. The participant also

expressing feeling aggravated for not being aware of available interpreter services.

Um, aggravated. Not aggravated at them, more aggravated at myself, maybe, for

not knowing other languages than English. I mean, it's not their fault that I don't

understand their language, they don't understand my language either. And there

could be an easier way maybe…like an easier interpreter whatever brand or

whoever we do use as the interpreter that's out there. I just don't know of any.

Participants also described encountering fear from the patient as well. One

participant described experiencing fear when communicating with LEP/NEP. The

participant went on to describe that not only does she experience fear personally, but she

experiences fear from the patient as well.

I've encountered a lot of fear. Fear from these patients… I don't want my

patients to feel fear. I don't want them to feel like they can't communicate

because that's not safe and that's not healthy for either one of us.

The participant then goes on to explain why she feels she encounters fear from

LEP or NEP.

Or maybe they do trust us and they just don't know how to communicate that.

And that leads to just fear.

One participant described experiencing frustration from LEP or NEP. The

participant describes LEP or NEP feeling frustrated due to difficulties communicating

with healthcare practitioners.

I mean if they speak Spanish, let's say, and they come to an English-speaking

clinic, and there's not anyone there that speaks Spanish. For them, that's gotta be

frustrating for them to not be able to communicate and explain what's wrong with

them or their child.

Need for improved cultural competence training. The anxiety experienced by the

participants is attributed to limited interactions with LEP or NEP, limited cultural

competence education/training, and limited access to interpretive services. Participants

were asked how often they encounter LEP and NEP as a nurse in Mississippi. Five of the

six participants report encountering LEP or NEP infrequently.

> When I worked at the hospital. I can't really remember. It wasn't a memorable
>
> amount. Where I work now, that I've worked at for two years, I've probably seen
>
> two or three Spanish-speaking patients.
>
> In my current role, I would say, not very often…maybe a time or two every six
>
> months. The hospital I would say very rarely-not very often.
>
> Where I am now, not often. Maybe two out of 10.
>
> Now, we have none.
>
> It's…I would say, overall, rare. Where I work, maybe once a month. Once every
>
> couple of weeks depending on how busy we were. I'd say once every two to
>
> three weeks.

Three of the six participants report encountering LEP and NEP more frequently in

the hospital setting. One participant currently works in the hospital setting, the other two

participants previously worked in the hospital setting.

> I would say uh...at least weekly.
>
> When I was in the NICU, it was almost on a daily basis.
>
> In the ER, um…often.

One participant described never encountering an LEP or NEP in the hospital

setting. The participant describes the feeling that the inability to communicate might

have a negative impact on patient care. During the description given by the participant, the participant frequently looked down at the floor and spoke with a softer volume than at other points during the interview. There were also several periods of silence during the response given by the participant.

> I can honestly say that I don't know that I encountered it at the hospital. Which is interesting to think about because, in the intensive care setting, you wonder if those patients make it there. I guess that's a morbid thing to say…um… but I mean…you wonder if they couldn't get there for certain reasons. If they weren't able to communicate something that was going on or weren't able to get the right treatment. I think it's a time-sensitive thing. But to answer your question specifically, I don't know that I encountered that in the ICU…

Participants described cultural competence training they received during nursing school and their nursing careers. When asked if they had ever received any formal cultural competence training, the participants responded:

> I have one time.
>
> Um, you know…I may have.
>
> Um…I mean, we do…
>
> No.
>
> No. We did do a course in nursing school.
>
> Not necessarily, no.

During the responses given by the participants, there were long periods of silence from each participant. The periods of silence during the response to this question were significantly longer than at any other point during the interviews. Participants also broke

eye contact during their response to this question and began looking down at the table or down at their hands. One participant visibly winced when answering the question. The body language during this question was in stark contrast to other points during the interview when participants were visibly engaged; leaning forward, maintaining eye contact and smiling.

Four participants described the cultural competence training that they received. Two participants described the cultural competence training they received while in nursing school.

I was still in nursing school at another hospital and, uh, they picked about 10 women from all different positions on our unit to go to a, uh, I can't remember what they called it. But it was a workshop and it was to help different cultures get along. There had been some racial issues and some unkind words spoken and just not really understanding one another. And so they just picked a random group of people to go and attend this workshop.

We did do a course in nursing school. I think we had like one test…it was on a couple of chapters and it was on cultural competency for some basic things that I don't even honestly remember…It wasn't like we took a whole lot of time. It was one test and we were done with it.

One participant described the cultural competence training the received at the healthcare facility in Mississippi where the participant currently works. The participant describes annual online learning modules required by the facility where the participant works.

Um…I mean we do…like…there's learning, not CEU's but, um…I can't think of what it's called. Just annual what's called 'learning' competencies that do touch on culture. But…I mean… not really. I mean…nothing in-depth. I feel like it's just surface level cultures but nothing like in-depth that can impact my daily work in a significant way.

One participant described the cultural competence training received at the healthcare facility in Mississippi where the participant previously worked. The training was also in the form of annual online learning modules. The participant did not go into detail about the cultural competence training.

I did during health stream activities at the hospital.

Need for increased access to interpretive services. Two participants did not feel anxiety when communicating with LEP or NEP while they were practicing outside of the state of Mississippi. One participant describes her experience communicating with LEP and NEP as a nurse in another state. The participant describes the differences in the diversity of the patient population and the nursing population at the hospital where she worked. The availability of interpreter services in the form of a language line is also described as attributing to the participant's decreased feelings of anxiety when communicating with LEP and NEP as a nurse outside of Mississippi. During the participants' response, the participant was leaning forward with her elbows on the table, using hand gestures, raising her eyebrows and maintaining eye contact. The participant

When I worked *there*, there was a lot of Pharsee, Indian, Korean-there's a lot of Korean…What I found helpful there—there was a Spanish-speaking nurse and there were two Hispanic techs that were also all certified in translating. And I

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think that has to do with the multicultural area that it is. There are these patients that you encounter on a daily basis. There were even some nurses that knew Pharsee because they encountered so many Arabic patients. There was a Korean nurse that would speak to all of our Korean patients. It had to do with the diversity of the patient population matching the diversity of the nursing population. That enabled us-especially if the nurses were educated-you were able to educate other nurses about these simple phrases, about what they do in their culture. It was interesting. And I think in comparison to Mississippi, we don't have a very diverse nursing population. So I think that does affect how we handle our patients and our diverse patient population. So, I found that to be interesting. But also, we used the language line a lot *there*. It was a very common practice. Holding the phones up to each other was a very common practice. It wasn't something that was an issue. You had the phone right in front of you and you had the number right in front of you so that if you needed it you just did it. It wasn't a big thing.

One participant describes her experience communicating with LEP and NEP as a case manager. The participant explained that she worked remotely from her home in Mississippi with patients from all over the United States. The participant describes frequent use of interpreter services in the form of a language line to communicate with patients. The participant describes how the availability of interpreter services improved her experience when communicating with LEP and NEP. During her response, the participant was leaning forward, maintain eye contact, waving her hands, and smiling.

In my previous job, I worked from home and I worked for an insurance company

doing high-risk pregnancy case management. And primarily, our clientele was

different state-not in Mississippi. And daily, I would interact with non-English

speaking patients… All types. Spanish of course-primarily Spanish. But French,

German, um, Ukrainian, South Africa there are several different dialects. Some

of them I had never even heard of before. It's really crazy! I had no idea there

were so many different languages! They (language-line interpreters) were really

very professional and I never really encountered problems. As a whole, I think it

was a great benefit to have them. Very professional. I rarely encountered a

situation where they didn't have an interpreter available, even in the rarest of

languages. But yeah it was good! I always had good experiences with it.

Participants described how a contributing factor to the anxiety experienced when

communicating with LEP and NEP is also due in part to the limited availability of

interpreter services. Two participants described using a person other than an interpreter

(such as family, friend, healthcare provider) for communicating with LEP and NEP. One

participant describes how utilizing family members makes communicating with LEP and

NEP easier.

If they have a family member present, and they agree that that can be their

translator, that makes things lots easier. I'm not sure if it's by law but, I think it

is, we are required to use the language line and provide a translator for them.

One participant describes how limited access to interpreter services results in the

use of a family member or friend for communicating with LEP and NEP. The participant

is unsure as to whether or not there are interpreter services available at the facility where she works.

I think we should have educational materials in Spanish. I'm saying Spanish because, in Mississippi, I feel like that's the language, the second most spoken language. Um, but there's not that, unfortunately, where I work right now. We don't have, um, that I'm aware of, numbers to an interpreter or a language service. We kind of just rely on a person that's with the patient. The family, friend…Participants described having limited access to interpreter services. You're supposed to use an interpreter but where we are, we don't have an interpreter, we use a phone interpreter that didn't always work. Working in the ER we were always told to call the interpreter, which we would do. And they may or may not be available. There would only be a few there. There's really not a whole lot that can be done because there's no one there to translate or help you out. The availability of an interpreter is a big deal. There were interpreters on staff at the hospital. There was one assigned to our area that was there a lot but she wasn't always there. So it was wonderful if she was there or if you could get her on the phone and get her there…But, otherwise, using an interpreter line was difficult.

One participant described her experience at the facility where she currently works. The facility had a language line that was not always reliable which made communicating with LEP and NEP difficult. The participant explained that cell phones and Google translate were used to communicate with the patient.

A lot of times we guessed at what she was saying. So that was hard not having an interpreter. We also used our phones. We would Google translate.

Participants described how limited access affected patient care. Two participants described witnessing LEP and NEP not receiving care due to the absence of interpreter services. Both participants looked both surprised and disappointed when describing their experience. The participants sat very still when describing this experience and spoke in a quieter tone than at other points during the interview.

At the end of the day she ended up not having surgery because she came to the clinic alone and didn't have anybody to help us kind of translate, we didn't have access to a translator so I do think that kind of…roadblock is the best word.

I do remember one day we had a patient who came in. *The patient* didn't speak English and we actually turned the patient away that day because *the patient* didn't bring a family member to interpret. So *the patient* went home. And I think that stuck out to me the most. I said, "Don't we have a language service available?"

Need for prioritizing improving communication with LEP or NEP. Participants all personally felt that improving communication with LEP and NEP should be a priority for nurses, healthcare providers, and healthcare facilities in Mississippi.

I think it is very important. Basic needs need to be met if someone can't tell you that they need to go to the bathroom or that they're hurting, those are basic human needs that need to be met.

I do feel like it's a priority…Honestly, I feel like it's a bigger issue than just putting a simple policy in place. Although those would help and you've got to

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start somewhere. Putting policies into place about changing practice, making sure interpreter services are available, making sure Spanish-speaking written material is available. Those are all important aspects.

I think it's definitely becoming more of a priority. It should be. It definitely should be something that is taken into consideration because we are just seeing- and I feel like in years to come we'll see more and more non-English speaking as our country changes and more with…I don't wanna get into politics or anything but yes. I think yes it should be a priority.

Personally, I think it's a priority, especially when you work with someone that doesn't speak the same language as you. It's hard to give 100% patient care if you can't even speak to that parent.

For me, yeah. Absolutely. Like I said before, it was kinda scary when consents were done and you weren't really sure what they understood. So, absolutely. Like, that's not ok!

Um, yes….personally, yes. I think it's inevitable that you're going to encounter it more and more and that its changing every day. Mississippi not so much, it's a little behind…but I do think it's inevitable especially with Spanish speaking patients…I do think it's a necessity to learn basic Spanish for I think that would be a good place to start. Especially with the generation behind us just knowing they are going to encounter it more and more. And we are too and if we don't put things in place to figure that our we're just gonna be behind.

Detachment

The theme of detachment includes subthemes of language and connection. Willie Morris described it best in an article he published where he attempted to describe the South. He recounts a friend's description of Southerners saying, "Southerners hate to be strangers to each other…Southerners like to see you and say, 'Hi, how are you?' Morris goes on to explain what he feels makes the South different than other regions. Morris describes a heightened sense of community and mutuality in the South:

> To this day, when Southerners get together, no matter where, be it Richmond, Washington, New York or London, they do not wish merely to exchange pleasantries or casual information. Listen to them. They are seeking background on families, relatives, friends, events, landmarks, memories. They know somebody who knows somebody. Things are going on at different levels in this sly, subtle premonition of kindredship.

Language. Participants described the importance of language and the role it plays it forming a connection with a patient. This connection parallels the sense of community and mutuality described by Willie Morris. Participants also described how important it is for nurses to build a connection with their patients. The use of language and conversation to create connections was also described by participants as unique to Mississippi. One participant described a connection that is shared between English-speaking nurses and English-speaking patients.

> I think there's this brotherhood-if you speak English with somebody y'all are on the same page. Especially if you compare them side-by-side, you're going to feel more comfortable and more natural speaking English with someone than someone

who speaks. Spanish because there is that barrier and you can't communicate with one another.

One participant described a language unique to Mississippi.

We speak a very different kind of language in Mississippi anyways. So a person who doesn't speak English at all or has learned English or has attempted to learn English properly, um, it's still, I think, is very difficult in Mississippi to understand, um, just, the vernacular as a whole. When it comes to rural areas and people who talk very fast or talk very differently, even as a person who speaks English just fine, it can very difficult to understand.

One participant described the importance of spoken language in forming a connection.

You know, sometimes it's hard to express emotions when you don't have the words. I know that body language is important, but words are helpful too.

Connection. During the interviews, participants described the differences between communicating with LEP and NEP as well as English-speaking patients. One participant described a connection that is shared between Mississippians. The connection the participant describes parallels the heightened sense of community and mutuality described by Morris.

Southerners, I guess, are known for being friendly so I guess…you know at the grocery store, you'll meet anybody you know you'll talk to the person behind you in line half the time. People are friendly and we'll just talk to-of course you have shy people but overall, you'll talk to anyone. People just kind of talk to each other even though they don't know each other.

Participants expressed that communicating with English-speaking patients is different than communicating with LEP or NEP. Participants describe a manner of communication with LEP and NEP that hinders them from developing a connection with the patient who they would be able to if they spoke the same language. Participants described differences in the pattern of conversation between English-speaking patients and LEP/NEP and the effect it has on forming a connection with a patient. One participant describes how limited communication is with LEP and NEP even with a language line.

> Well, just being able to have a casual conversation to introduce myself and to just reassure them that I am there to help them and help them not be afraid. That is hard to do when you cannot speak the same language. Or, especially if you don't have a family member there to be a translator, you know, you don't want to go through the language line for every single conversation that you are having just walking in and saying, "Are you doing alright?" you know those little things are kind of impossible to do. It is important that we are able to communicate with people just on a continual basis all day long. So yeah, it definitely affects it.

When asked how communicating with LEP and NEP differs from communicating with English-speaking patients, one participant describes how she keeps everything short and to the point. The description the nurse gives of the pattern of communication between herself and LEP or NEP shows an acknowledgment of language unique to Mississippi. During her response, the participant broke eye contact multiple times and either looked down at the table or to the side. The participant had a more solemn facial expression during her response as well and did not smile or wave her hands as she had

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during previous responses. There were also several periods of silence during the participant's response.

> Well, I just want to be very careful about what I say. I don't wanna be too wordy.
> I try to be more direct. And…you know…just not use hand gestures or words that
> maybe are not slang words but just maybe phrases or words that we are
> accustomed to saying in Mississippi like "hey y'all" or… you know…I don't
> know…really I just want to be more direct and as short-winded as possible.

The previous description is given by the participant also describes a disconnect between the way the participant typically communicates with patients. When asked to describe being a nurse in Mississippi, the participant describes how she uses her profession as a means to share her faith with people.

> I have definitely enjoyed- I have loved it! I have definitely feel like it has been
> my calling, a way for me to minister to people. And I feel like that has not been
> frowned upon in any way. I feel like we've been pretty free to show-be more
> caring on a more personal level in Mississippi just as a whole.

The participant was smiling, leaning forward, and using hand gestures when describing what it was like to be a nurse, as opposed to when the participant was describing how she communicates with LEP and NEP. The above description given by the participant parallels the sense of mutuality described by Morris as well as the importance of language enabling a connection to be made between nurse and patient. The participant describes being able to connect with patients on a more personal level which was not reflected in the manner in which she communicates with LEP and NEP.

One participant describes a similar experience in communicating with LEP and NEP as opposed to English-speaking patients. The participant describes how communicating with LEP and NEP is more difficult than communicating with English-speaking patients.

I wouldn't say that we communicate well. So…not purposefully…maybe not as thoroughly as I would with an English-speaking parent because I can just talk and talk and talk and talk and they understand. But with the non-English speaking…it's harder to get everything out that you're trying to say. So, you just kind of have to pick and choose what's important.

One participant describes the differences in the pattern of conversation between English-speaking patients and LEP or NEP. She describes a lack of a two-way conversation between nurses and LEP and NEP that is present between nurses and English-speaking patients.

When you're communicating with an English-speaking person, their understanding comes much easier. Um, you can get to the point rather quickly, you're able to do more back and forth communication. Um, as far as, they're able to ask questions and you're able to answer those versus with a non-English-speaking, you have to go through an interpreter. Um, a lot of times, I felt like the parents would just say yes and nod with what little bit of information just because it was so hard to communicate. And they didn't feel comfortable asking questions and they didn't feel like they were able to ask more questions. It was more of just, "here's the information" versus having like, a two-way conversation where

they ask questions and get more information and find out things they wanted to know.

One participant describes the use of body language to help patients understand when communicating with LEP and NEP. The participant also describes simplifying explanations by limiting the use of medical terminology.

Um…the pattern of conversation is different…it's very different. I'm very aware of the fact that I try to use a lot more body language, um because I do think that's just kind of basic language. I do think that's kind of basic understanding, just body language to kind of um not only make the patient feel more comfortable but to try to help them understand what I mean. And I do try to make a point of simplifying anything that I'm explaining or simplifying anything that I'm saying. Because for those limited English-speaking patients, you try to stray away from the medical jargon, all the diagnosis and everything like that and try to stick to just a basic um…get to the point a whole lot quicker than adding in a whole lot of details that aren't necessarily gonna translate well to what you're trying to accomplish I guess.

One of the participants gave an example of a positive interaction she had with a LEP or NEP. What made the interaction a positive one was the ability of the nurse and the patient to make a connection through the use of interpretive services in the form of written instructions and pictures. The connection described by the participant embodies the heightened sense of community and mutuality described by Morris. The participant was visibly happier (smiling, raising her eyebrows, and clapping her hands) when telling this story than at any other point during the interview.

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When I used to print out the sheets of the language, the teaching, and the pictures I would walk into their room and I would show it to them. I remember a Chinese lady one time just going *GASP* And chattering away in her language and pointing to it and her *smile*. She was so thrilled that we connected and that I had made an extra effort to help her see something in her language.

Five of the six participants admitted they do not assess that an English-speaking patient has understood what has been said to them the same way they assess that an LEP or NEP has understood what has been said to them. Participants describe that they assume that English-speaking patients understand them.

I just kind of go off of their, how they're responding when I'm talking to them. I do try to be mindful though and ask "Do you have any questions about what we just discussed?" But I can't say that I do that every single time. I feel like there's sort of an assumption that they get it.

Well, you're supposed to ask the patient if they understand or get them to repeat what you said or get them to demonstrate. But…I just-honestly- kind of assume that they understand what I've said…

I think it's pretty easy to tell when someone understands and when they don't in terms of eye contact and when you finish a sentence and when you don't.

One participant describes how the manner in which she assumes an English-speaking patient has understood is also the same manner in which she assumes an LEP or NEP has not understood what has been said to them.

When I'm speaking to an English-speaking patient, I just assume they understand me. I don't really confirm validation or interpretation. I just get a head nod or a

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yes and I go on. Um…And I don't trust that from Spanish-speaking. If they give

me a head nod I understand that as 'You don't understand what I just said'…

Um…and that makes you feel like…'I need to do something more.'

Summary

The purpose of this study was to capture the essence of the experience of

Mississippi nurses when communicating with LEP and NEP. A phenomenological

qualitative approach was used due to the gap in the literature surrounding this topic.

Chapter IV presents findings that describe what Mississippi nurses experience when

communicating with LEP and NEP as well as what influences those experiences. A

description of the participant sample was provided as well as the data analysis process.

The lived experience of the Mississippi nurses supported the formation of two

themes. The two themes that emerged from the data regarding what Mississippi nurses

experience when communicating with LEP and NEP are *anxiety* and *detachment*. The

study results were then aligned with the research questions to provide an explanation as

to how Mississippi nurses experience communication with LEP and NEP.

CHAPTER V – DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

A phenomenological qualitative study was conducted in order to gain a better understanding of the lived experience of Mississippi nurses when communicating with LEP and NEP. Two questions guided the study: (a) What is the lived experience of Mississippi registered nurses when communicating with LEP/NEP? and (b) What contexts or situations have typically affected Mississippi registered nurses' experiences when communicating with LEP and NEP? Purnell's Model of Cultural Competence served as the foundation for inquiry and interpretation of participant data. A series of six semi-structured face-to-face interviews were conducted with nurses practicing in a metropolitan area of Mississippi who has had an experience communicating with LEP or NEP. Participants were recruited until data saturation occurred. A thematic analysis of the interview transcriptions was conducted until themes began to emerge. Themes and subthemes were identified and supported in the previous chapter.

Interpretation of Findings

Two main themes of anxiety and detachment were identified. Anxiety was accompanied by subthemes of (a) feelings of helplessness and fear, (b) a lack of cultural competence education and training, (c) a lack of prioritizing improving communication with LEP or NEP, and (d) a lack of access to interpretive services. Detachment was accompanied by subthemes of (a) language and (b) connection. The results of the study adequately answered the two research questions. The lived experience of Mississippi registered nurses when communicating with LEP and NEP was anxiety and detachment. Feelings of helplessness and fear, limited cultural competence education and training, and

limited access to interpretive services affected that participants experience when communicating with LEP and NEP. Two participants who have practiced outside the state of Mississippi and encountered LEP and NEP did not feel as anxious as they did when in Mississippi due to the availability of interpretive services. Participants described the role language plays in forming a connection with patients. Participants also described how the language barrier between nurses and LEP and NEP hinders the formation of a connection which results in detachment.

Purnell's Model for Cultural Competence

Purnell's Model for Cultural Competence was used to form the interview questions used in this study. The Purnell model focuses on both the emic and etic views of the client, family, and community (Purnell, 2000). Although all 12 domains were not identified during the study, in the model the domains have bidirectional arrows which indicate that each domain relates to and is affected by all other domains. The two domains addressed were communication and workforce issues.

Purnell's paradigm asserts that care providers and recipients of care have a mutual obligation to share information to obtain beneficial outcomes. However, the health professional has the primary responsibility for creating an environment for openness to collect information. Participants expressed an inability to create an environment for openness to collect information due to limited access to interpretive services which could easily fall into both the communication domain and the workforce issues domain. Limited access to interpretive services hinders communication but is also reflective of the organization where the interaction occurred.

According to the Purnell, culture is not limited to clients and families but includes educational and healthcare organizations as well. The model can be used to assess organizational culture and cultural issues among staff because it includes the domain workforce issues as well as the nonlinear line of cultural competence. The organizational culture reflects the social structure, values, traditions, management processes, policies and procedures which reveal the degree to which diversity in thinking, reflecting and behaving are encouraged or tolerated. Participants felt that improving communication with LEP and NEP should be a priority but did not feel that it was a priority at the facilities where they worked. One participant explained that administrative staff does not prioritize improving communication with LEP and NEP because they do not experience it the way nurses do. The experience described by the nurse suggests a sense of detachment of facility administration from nurses.

I don't know that they have experienced it like we do, speaking of administration. I'm sure that the language line is in place but, they don't experience on a daily basis… If they had more experiences, I'm sure they would have a higher priority on coming up with some answers.

Another nurse described the reason she felt improving communication with LEP and NEP was not a priority at facilities where she has worked.

We had access to an interpreter line, but it never worked and there was never any correction for that with people higher than me. There was never, "We need to get that fixed." And then in the hospital, whenever I had to page an interpreter they never came. Like, where is the interpreter? There was never like, "Where's the interpreter?" "We need to hire more interpreters" I mean- I don't think. I didn't

ever see that happen. I just know that probably seven times out of 10 I could

never get one to help me so…I just didn't see that it was a priority.

Cultural consciousness is a nonlinear concept and is represented as a saw-toothed

line at the bottom of the model. The line can serve as a representation of the health care

provider, or nurse in this instance, as well as organizations such as health care facilities or

educational organizations. The revelation of participants regarding the limited cultural

competence training received during nursing school or by their employers speaks to the

cultural consciousness of the participant, healthcare facilities, and the nursing programs

attended by the participants.

<div align="center">Implications for Change</div>

According to the 2010 United States Census, the Latino and Hispanic population

alone increased by 43% from 2000 to 2010 (Ennis, Rios-Vargas, & Albert, 2011). The

increasing diversity in the United States population also means increasing diversity

among patient populations. Increasing diversity among patient populations means

healthcare professionals will find themselves caring for LEP or NEP more frequently and

highlights the need to identify strategies for positively impacting healthcare encounters

for LEP or NEP and healthcare providers.

Participants in this study identified Spanish as the primary language they

encounter other than English in their practice which is in a metropolitan area of

Mississippi. The participants also acknowledged the increasing diversity among patients

encountered in practice. One participant stated, "I feel like in years to come we'll see

more and more non-English speaking as our country changes."

Participants also described feelings of anxiety when communicating with LEP and NEP due to limited cultural competence education/training and limited access to interpretive services. Participants also expressed that they felt improving communication with LEP and NEP should be a priority, although based on their experiences, it is not viewed as a priority at healthcare organizations in Mississippi. Participants indicated that cultural competence training would prove to be beneficial as evidenced by the following statement made in response to questions related to cultural competency training.

I think it would be very helpful. I think that we would have higher patient satisfaction because their needs would be communicated and we could understand and provide their needs. A decrease in frustration among the nurses because we would understand what's going on. I mean, communication is basic.

I feel like we do need more of that… at least an awareness of maybe how non-communication affects these patients and how it affects your nursing practice. An awareness would equip them with tools when they do encounter that situation. And I feel like new nurses want that information. They want to know how to handle a situation. They don't want to feel sidelined by a situation. So, by having that preparation up front, they could better handle that. Because that is going to happen. You are going to encounter a patient that doesn't understand you.

I think it would be helpful in the sense that again, for awareness and maybe just more information, more specific ways that we can be aware and maybe something that we can do to bring a level of comfort to patients that we encounter. Help reassure them that they will get care that's just the same as someone who speaks

the language. Um because I would feel like maybe they wonder that sometimes.

I would if I was… I would. I definitely think it would be beneficial.

Absolutely. I mean, even just some basic things, especially if you know-say we

had another Spanish speaking patient here. Just to learn more about where this

family is from. Even if it's just patient-specific…that would be great!

Yes, for sure…Because going back to, "What's the biggest difference? In terms

of time?" We're a timely culture these days. If it's not efficient then it's not

worth it. I think it would make it worth it to provide better care to non-English

speaking patients and you would be more efficient. And also, just things as

simple as, you know, Do you shake hands? Do you bow? Do you hug? What's

the best way to make the patient feel more comfortable and just get on a better

level so the patient can understand you and you can understand them? It could

only be beneficial to gain more knowledge in that respect in terms of different

cultures and different languages and different cues…knowing how to show that

patient and their family the right interaction to gain their respect and get the

outcome you need.

Participants also felt that increased access to interpreter services would improve

their experience when providing care for LEP and NEP by improving communication.

Four participants suggested increased awareness and increased the availability of

interpreters.

Being aware of the interpreter services would help.

Just being aware. Seeking out- I am *sure* that there are options for

interpreters. So I guess it just requires someone seeking them out and

whatever the procedure is for getting them accessible to the staff whether it

just be a phone call or a contract for services…I…just…probably just

reaching out and doing a little research in this area. And to be honest, I have

no idea what, in our area, what that looks like. I mean… I know that phone

number, you know, that I've worked with in the past. But I feel like that's not

ideal in the setting that I'm in now. I think in the setting I'm in now, it's more

ideal to have a person, you know, present.

…More real life interpreters. Just like you have a night shift/day shift.

Having someone there at any time and at any point and having them readily

available would change so much.

Four of the six nurses expressed a need for nurses to learn Spanish.

I would like to see nurses know those basic phrases. "Tiene dolor"…Do you have to

use the bathroom?. What's your pain number. We ask every patient, "What's your

pain on a scale of 0-10?" It would be nice to know those basic phrases…We tell

these patients that they need to learn English when maybe we need to learn some

Spanish. As our culture and American society get more infused with Spanish-

speaking patients…maybe we should learn some languages too.

Well…um…I think…when we went to school, Spanish wasn't even offered until

high school. So like, why isn't it offered first or second grade like other countries

teach English straight from the bat. I think if we were educated in other

languages that would help too.

I feel like we need education for, especially Spanish in this area…And just have

better education and more access to it.

I do think it's a necessity to learn basic Spanish. I think that would be a good

place to start. Especially with the generation behind us just knowing they are

going to encounter it more and more. And we are too and if we don't put things

in place to figure that out, we're just gonna be behind.

Participants suggested the use of technology for the provision of written

information in the patient's language that is easily accessible for healthcare providers,

particularly nurses.

Probably if we had more information available in all languages. Something that

we could just readily access. Or maybe in a care plan or something, maybe we

just put in a language and it produced a wonderful book to give them. Something

like that because our *floor* educators do have something wonderful that they

give out. It's a spiral notebook that has everything from A to Z on *patient* care.

You know, what if we could do that in every language? If it went to some sort of

bank that had languages available and it would automatically print that up for

them. And also, their discharge instructions, if it could be put into their language.

With today's technology and software, you can click one button and translate

something. Um, which I think is another good resource that we should have

available immediately. Maybe we should have an Ipad at the front desk which

you can click a button and translate immediately. And help somebody out.

I do think a software option would be the easiest and most time efficient. Just

because someone doesn't speak your language doesn't mean they can't read

so…some kind of software that would translate a simple packet of instructions or

a sheet of instructions or a sheet of lab work or diagnoses to explain to

patients…Honestly, at this point, all it takes is a click.

Participants identified a need for increased cultural competence education/training

and increased access to interpreter services as factors that would improve their experience

when communicating with LEP and NEP. Participants also expressed that increased

cultural competence training and increased access to interpreter services would help to

decrease the fear perceived by both nurse and patient by being able to connect with the

patient.

<center>Recommendations for Action</center>

The results of this study could be of value useful to healthcare facilities in the

State of Mississippi. First, healthcare facilities could assess their own organizational

cultures to determine how the nurses feel when communicating with LEP and NEP and

why. Each healthcare facility could also assess the extent to which it has prioritized

improving communication with LEP and NEP. Then, healthcare facilities could

collaborate with its own nurses and healthcare providers to develop effective strategies

for improving communication with LEP/NEP including (a) the implementation of

improved policies and procedures, (b) availability of interpretive resources relevant to

that healthcare setting, (c) improved cultural competence training, and (d) promoting a

more culturally conscience environment.

Educational organizations such as schools of nursing could also benefit from the

results of this study in the same manner discussed for healthcare facilities. Educational

organizations and healthcare facilities could also collaborate to enhance cultural

competence education of Mississippi nurses of all experience levels. Educational

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facilities could also conduct a curriculum assessment to determine areas that could be improved with regards to cultural competence education and training. Improving cultural competence education and training for nurses could help to better prepare nurses for encounters with LEP/NEP and potentially decrease feelings of anxiety. Collaboration between Mississippi healthcare facilities, educational organizations, nurses, and other healthcare providers is essential for the provision of population-specific interventions that are efficient, effective, and relevant.

<div align="center">Recommendations for Future Research</div>

The purpose of this study was to describe the lived experience of Mississippi nurses when communicating with LEP and NEP. A phenomenological qualitative study was conducted. The results of this study articulate a need for further research on this topic. Six participants were utilized for this study. The inclusion criteria for this sample required participants to be registered nurses who have worked in Mississippi and had an experience communicating with an LEP and NEP within the last five years. Future research utilizing this set of inclusion criteria could prove to be beneficial, but with a larger sample. The use of a small sample was adequate in capturing the essence of the experience. However, a much larger sample would be necessary to achieve generalizability. Also, it should be noted that the sample utilized for this study all worked in a metropolitan area of Mississippi. Future research comparing the experiences of different regions of the state might also be beneficial for improving the understanding of this phenomenon.

The responses from participants when asked if they had ever received formal cultural competence training stood out from the other questions. The silence given

during the response from each participant was significant. Participants also looked uncomfortable when answering this question. Further research investigating why the participants may or may not have felt so uncomfortable during this question could help to shed more light on the experiences Mississippi nurses have when communicating with LEP and NEP.

Further research into this topic could also involve the inclusion of bilingual nurses. Bilingual nurses might have a unique perspective and an altogether different experience when communicating with LEP and NEP. Future research could address the differences as well as the similarities in the experiences of bilingual nurses and strictly English-speaking nurses. Capturing the essence of Mississippi bilingual nurses when communicating with LEP and NEP could enrich the results of this study by adding another context in which the phenomenon is experienced.

Future research addressing the experience of Mississippi nurse practitioners when communicating with LEP and NEP would also be beneficial to nursing practice. Nurse practitioners take on a different role in patient care than registered nurses. Research could address the similarities and differences between the experiences of Mississippi nurses and nurse practitioners when communicating with LEP and NEP.

Future research addressing the perspective of Mississippi healthcare facilities as it pertains to the provision of cultural competence education/training and interpreter services for LEP and NEP would be beneficial as well. Future research addressing the perspective of educational facilities in Mississippi as it pertains to the provision of cultural competence education/training could also prove to be beneficial. Identifying the perspectives of Mississippi healthcare facilities and educational organizations could serve

as the foundation for further research regarding the implementation of improved policies and procedures regarding cultural competence education and training and the implementation of interpreter services.

<center>Reflection</center>

Personal reflection was done prior to the initiation of participant interviews in an attempt to identify any biases that might exist in relation to this study. The only known potential biases were personal experiences of communication with LEP and NEP during my career as a nurse. Admittedly, it was my own experience that sparked my interest in this particular topic. However, I set my experiences to the side as this study was not intended for me, but for others. I made sure to go into each interview with no expectation as to what the participant would express. Member checking was also utilized to confirm that the identified themes were reflective of what the participant truly experienced and not an inadvertent projection of my previous experiences.

Though I went into each interview without any expectations, I must say I was still surprised at the results. I was surprised at how passionate each participant was about improving communication with LEP and NEP. The participant's suggestion that nurses learn Spanish also surprised me. Each participant seemed very engaged in the interview and invested in their profession as a nurse. I gained a better understanding of my own experiences communicating with LEP and NEP and have a new appreciation for Mississippi, the importance of language, and the role it plays in forming a connection with a patient as a result of this study.

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Conclusion

Communication is a complex concept, particularly in nursing practice. Effective nurse-patient communication is the cornerstone of the nurse-patient relationship and is vital for the delivery of safe and effective healthcare. Increasing diversity among patient populations means healthcare professionals will find themselves caring for LEP or NEP more frequently and highlights the need to identify strategies for positively impacting healthcare encounters for LEP or NEP and healthcare providers. The results of this study show that Mississippi nurses experience anxiety and detachment when communicating with LEP and NEP due to limited cultural competence education/training, limited availability of interpreter services. The study also found that Mississippi nurses feel that healthcare facilities have not prioritized improving communication with LEP and NEP which furthers the feelings of anxiety and detachment. The results of the study could serve as the foundation for further research into improving communication between nurses and LEP and NEP in the State of Mississippi.

APPENDIX A – Interview Questions

1. Tell me about yourself:

    a. How old are you?

    b. How long have you been a nurse?

    c. What areas have you worked in?

    d. How long have you worked as a nurse in Mississippi?

    e. Have you worked as a nurse in other states? If so, where?

    f. What is the highest degree you have earned?

2. How would you describe the culture in Mississippi?

    a. People, education, food, music, values, the pace of life, social
       structures/interactions, etc.

3. Describe being a nurse in Mississippi?

    a. Describe the patient population you typically encounter.

    b. Describe the organizational culture you encounter. Describe the social
       culture.

    c. How does the culture you described effect your role as a nurse?

    d. What unique challenges do you encounter?

4. How often do you encounter LEP/NEP as a nurse in Mississippi?

    a. What languages have you encountered?

    b. What language (other than English) do you encounter the most?

5. Thinking about your experiences working as a nurse, described an experience
   caring for LEP/NEP?

    a. Describe how you feel when communicating with an LEP/NEP?

   i. What makes you feel this way?

   ii. How does this influence the way you communicate with

    LEP/NEP?

  b. Discuss how you think the cultural background of an LEP/NEP

   influences their communications with healthcare providers?

  c. In what ways have you seen culture impact healthcare decisions or

   practices?

6. Does communicating with an LEP/NEP differ from communicating with a

 patient whose primary language is English? If so, describe the differences.

7. Describe how you assess that a patient has understood what has been said to

 them?

  a. English-speaking?

  b. LEP/NEP?

8. Thinking about your experiences working in Mississippi, describe any factors

 that have positively and/or negatively influenced your experiences when

 communicating LEP/NEP?

9. Describe what you feel are the most significant barriers nurses face when

 communicating with LEP and/or NEP?

  a. Describe what could be done to improve this?

10. Do you feel that improving communication with LEP/NEP is a priority?

  a. Do you feel this is a priority at the organization where you are

   currently working?

b. Do you feel this is a priority at the organization(s) you have worked at previously?

c. What makes you feel this way?

11. Have you had any formal cultural competence training?

a. If so, describe what that training entailed.

b. Was the training offered or required by your employer or nursing program?

c. If not, do you feel cultural competence training would be beneficial?

d. If so, what benefits would you expect to result from cultural competence training?

12. Is there anything else you would like to share?

From: irb@usm.edu
Sent: Tuesday, January 22, 2019 4:27 PM
To: Kathleen Masters; Mary Pipper; Michael Howell; Michaela Donohue
Subject: IRB-18-159 - Initial: Sacco Committee Letter - Exempt

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident template on Cayuse IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER: IRB-18-159
PROJECT TITLE: Mississippi Registered Nurse Perceptions When Communicating With Limited-English-Speaking and Non-English-Speaking Patients
SCHOOL/PROGRAM: College of Nursing & Health Pr, School of LANP
RESEARCHER(S): Mary Pipper, Kathleen Masters

IRB COMMITTEE ACTION: Exempt

CATEGORY: Exempt
　　　　Category 2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

APPROVED STARTING: January 22, 2019

Donald Sacco jr.

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

APPENDIX C – Permission for Use of Visual Model

Absolutely no problem. You can use the model for the said purpose and I wish you much

success in your dissertation. Here is an update of the model, mostly with the variant

characteristics of culture. This is a word document so you can resize it if you need to.

Larry Purnell Ph.D., RN, FAAN
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