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Lost in Translation

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Clinical leadership theme

The purpose of breaking down language barriers and having clear and concise conversations between the health care provider and client is to create a positive trust relationship, exchanging medical options and making treatment plans (Ong, Haes, Hoos, & Lames, 1995). Title VI of the Civil War act in 1964 (US DOJ) prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance (2016). Breaking down language barriers and implementing ways to help improve health literacy will improve over all patient outcomes in those having low health literacy (Howard, Gazmararian, and Parker, 2005). According to healthy people 2020 health disparities in access to health information, services, and technology can result in lower usage rates of preventive services, less knowledge of chronic disease management, higher rates of hospitalization, and poorer reported health status (2010). If we can improve patient access to these modalities then we can hope to improve their outcomes as well and one way we can improve the information is to provide it in a language they can understand. An article by Schwei et al. (2016) states that patient's in the United States (US) have had compelling federally funded plans to provide ways to communicate with limited English proficient (LEP) individuals since 1964, as noted in Title VI of the Civil Rights Act. Although this has been in place since 1964 Schwei et al. state implementing and enforcing the Act has not been widely achieved nor is it easily understood how to enforce it in order to be used to the populations advantage. Patient involvement in their care plan gets you to plan ahead when the moment arises to help yourself when help is needed. Patients who are involved in their own care or share decision making when there is two-way communication, may

be necessary for developing the patient skills and confidence needed to self-manage their health and prevent chronic disease progression (Gittner, 2015).

Statement of the problem

Three purposes of breaking down language barriers and having communication between health care providers and patients is to create a good interactive relationship, exchanging information and making treatment related decisions (Ong, Haes, Hoos, & Lames, 1995). Healthcare administrators are constantly pushed to improve quality, provide state-of-the-art care, and increase efficiency with no direction, language barriers is one of those examples needing improvement (Gittner, 2015). Hispanics account for over 60% of the United States (US) population growth and 25% of them speak little to no English (Dunlap et al., 2016). Language barriers have been shown to be a constant threat to quality of hospital care not only in the US but internationally (van Rosse, de Bruijne, Suurmund, Essink-bot, & Wagner, 2016). Communication barriers decrease patient understanding and builds walls from the health educators such as the Registered Nurses (RN). Those immigrant patients in the US who do not speak English as a primary language and have numerous verbal obstacles and health knowledge challenges need to have some cultural thoughtful strategies in place to provide them with needed medical knowledge. Kreps and Sparks state patients with serious or chronic medical conditions are more susceptible to medical risks and need far more collaboration in order to help them preserve their own health. Furthermore the increased vulnerability in immigrant patients with serious health disparities has unhealthier outcomes, higher morbidity and mortality rates than their non-immigrant counterparts (Kreps & Sparks, 2008). The tools currently available to the health care providers for the public are human translators, phone service, smart phones, and

family members. But in reality how readily available are these tools and who knows how to

access them in the first place?

Project overview

Limited English proficient individuals utilize the Zuckerberg San Francisco General

Hospital's (ZSFGH) services daily. In order to help them better understand their discharge

instructions translator services are available and can be used by registered nurses to translate in

their preferred language. In order to help improve communication and patient outcomes at the

microsystem level their needs to be a step-by-step process to gradually increase those desired

effects. By using a translator service, by phone or in person, in the language the patient speaks

while reviewing discharge instructions will help the patient better understand their role (Howard,

Gazmararian, and Parker, 2005). Patients who are able to understand their role in their own well

being will have improved outcomes and be able to utilize emergency services for emergencies

instead of as their primary care provider. Being able to speak to someone in their own language

will help them in not only getting engaged but will also prompt them to ask questions about their

disease and medications, follow ups can be better understood and clear as to why they must

follow up (Dunlap et al., 2016).

At the conclusion of a patient's hospitalization the RN will review all discharge

instructions in the patients room in their preferred language. It is best to plan some time for this

and to facilitate a calm quiet environment such as the patient's room with the door closed, if

possible. If able to get the discharge instructions printed out in their preferred language and a set

for yourself would be best so you are able to review the instructions line by line with them.

When the patients medical team, such as but not limited to, medical doctors, pharmacists,

physical therapists, and social work have completed their parts of the discharge planning then the

RN can review the instructions for their own understanding. The RN can take into consideration their own experience with some of the common questions patients ask given the final diagnosis and be ready for those, they can gather brochures or informational handouts, and have the patient's medications ready or know where they can get them when leaving the facility. When ready to present the instructions to the patient try to ensure your other patients are set for the duration of the discharge and inform your charge nurse or break nurse that you are going to be discharging a patient so they may tend to your other patients needs as necessary. Conduct the discharge by selected option via phone or in person translator and be attentive to the patient and to remember basic communication skills and be aware of your non-verbal communication as well. Always conclude with them asking questions and be sure to ask them questions of understanding in open ended format. Over all utilizing the translator services to teach limited English proficient patients increases patient outcomes and helps the registered nurse understand if teaching has been successful. By decreasing over utilization of the emergency department as a primary care provider it enables decreased wait times for patients needing emergency services.

Rationale

Zuckerberg San Francisco General Hospital and Trauma Center is a level I trauma center, according to American Trauma Society (2016), it means having 24 hour in house coverage by general surgeons with specialties in orthopedics, neurology, anesthesiology, emergency medicine, internal medicine, radiology, oral and maxillofacial, pediatric and critical care. ZSFGH is located in San Francisco on Potrero Street between 22nd and 24th street, the heart of San Francisco. It is a level I trauma center managing all aspects of care for patients with or without insurance coverage. There are seven levels or floors where care is provided along with a ground and basement level totaling 9 floors. There is a cafeteria, chaplain services, pharmacies

for in patients' and outpatient care, gift store, and so much more to offer in various buildings

with in the campus.

It means ZSFGH is a great resource for the community, provides leadership in prevention

and public education along with an organized teaching and research effort in order to help direct

new innovations in trauma care. This is a great responsibility to the patients and surrounding

community it serves. The patients that are served by the emergency department (ED) are the

general population of San Francisco, including those with no housing. ZSFGH cares for

everyone no matter if they have insurance, immigration status, ability to pay, sexual orientation

or preference and also those that are insured. The work environment between staff is mutual

respect and open communication for learning and teaching in order to provide excellence in

patient care and outcomes. Environment among the patients and staff can some times be

difficult, the homeless population and those intoxicated by alcohol or drugs can be challenging to

handle and provide care for. When you are trying to provide the best patient care for them they

want the care they want when they want it or they threaten to leave and/or refuse to leave. Those

people who work in the ED need to have a tough shell in order to deal with the every day

patients that come to SFGH.

The microsystem being the emergency department (ED) has three main pods (A, B, and

C), a resuscitation pod, ambulance bay with triage, along with a main triage center and two

waiting rooms for patients and their families. There are metal detectors and sheriffs at the

entryway for employee and patient safety. All three pods have a capacity of holding fifty-eight

patients. They are single patient rooms all providing different levels of care for the varying

patient acuities. When fully staffed there are a total of twenty-four registered nurses (RN), eight

medical evaluations assistant (MEA), three patient care assistants (PCA), four nurse practitioners

(NP), eight medical doctor (MD) attending's, and fourteen MD residents to care for all the patients coming through the ED. The staff skill sets all vary under the supervision of the MD's. An MEA is a licensed medical assistant or emergency medical technician with a phlebotomy license and their main function is to assist the RN with providing direct patient care. The PCA is a certified nurse assistant or unlicensed medical assistants who has the ability to assist the RN along with providing sitter abilities or at ZSFGH they are known as coaches. The coaches monitor patients and observe them for safety to avoid pulling out lines, tubes, or if the patient has suicide ideations or mental illnesses they observe them to keep them safe at all times. ZSFGH also has a falls prevention trial going on in the ED where patients are assessed for their risk of falling, if they are a risk for falling then they are placed in yellow gowns, a yellow wrist band is placed on them, yellow slip resistant socks are placed on them, a yellow falls sign is placed outside there room, and a coach is placed to watch them to decrease the chances of falling. The RN's have varying degrees from associate's degrees to master's degrees in nursing with varying certifications in emergency nursing, nurse specialist, and nurse leaders.

Since ZSFGH has the responsibility of providing care to a large population most also do not speak English. In fact the second language spoken by the patients being cared for at ZSFGH is Cantonese and Spanish. That is also forty-eight percent of the patient population according to hospital records. With less than ten percent of the ED staff being able to speak another language and also being certified to translate instructions to patients who do not speak English. The need for using translator services is needed in order to communicate with these patients and most importantly to deliver discharge instructions so they can understand them and follow them. The expectation would be for the RN to track the patients who have a primary language other than English and use the translator services and then be able to track it.

The strengths to breaking down language barriers would be in the patient's best interest, they would better understand and are able to participate in their own health care. It would also help to decrease the use of the ED for primary care or as a source to obtain medication refills. Weaknesses would be the nursing staff not using translator services in order to explain patient discharge instructions or the language of choice not being available at the time of discharge. Nurses and MD will have opportunities to use their best interest and critical thinking when preparing and applying their experience in order to discharge patients in their preferred language. Those opportunities arise if they are in a time crunch or not, as with anything else it is dependent on the RN to always use their best judgment and time management to handle their patient load. Threats that can be conceived if the RN discharging a patient with out language assistance would be a chronic patient in the ED using their services instead of seeking the guidance from a primary care provider (PCP). It would end up being a patient lost in the healthcare system with out having the guidance to get out of the ED system and being able to utilize the PCP of their choosing.

Although all services to improve communication may be used, there still is a chance the patient would not use the options provided nor contact a PCP and will continue to use the ED as its primary care. Each visit to the ED should always be used as another teaching opportunity to utilize a PCP for their care. Since ZSFGH has all these services already in place it would be up to the RN to access services in order to get discharge instructions interpreted so the patient can understand what is being given and told to them.

The expected costs of this policy improvement would be mainly in teaching the process to the RN's by the use of a CNL student costing about $56,000 as demonstrated in Appendix A. The budget as demonstrated in Appendix A, proposes the CNL student to perform the teaching

lasting two weeks, see Appendix B, of education for a three-month trial period. Since there are 240 RN's staffed in the ED and teaching would take approximately an hour of their time plus the instructor the cost would be $26,800. The work for the CNL to assess the problem and implement the policy would cost $29,156. Should we continue to not utilize the interpreter services at an average of sixty-eight admissions per day costing an average of $21,500 each or $1.4 million per day then we would expect not to save $236,000 per day or $86.1 million a year. This would be the initial and only cost for the first and second year together. Should new FTE's get hired during this time frame then the cost would be rolled into the new hire orientation budget for it to be taught during the on board process. The patient would gain a better understanding of their discharge instructions and would ask more questions participating in their own health.

Methodology

In order to help improve communication and patient outcomes at the microsystem level their needs to be a step-by-step process to gradually increase those desired effects. By using a translator service, by phone or in person, in the language the patient speaks while reviewing discharge instructions will help the patient better understand their role (Steinberg, Valenzuela-Araujo, Zickafoose, Kieffer, & DeCamp, 2016). Patients who are able to understand their role in their own well being will have improved outcomes and be able to utilize emergency services for emergencies instead of as their primary care provider. Being able to speak to someone in their own language will help them in not only getting engaged but will also prompt them to ask questions about their disease and medications, follow ups can be better understood and clear as to why they must follow up (Dunlap et al., 2016).

The focus would be those patients whose primary language spoken is not English and to be able to redirect there health care needs to a PCP. The RN would be able to assist the patient in finding a PCP so the limited English proficient (LEP) patients do not exploit the ED and department can focus on those actual emergencies. The RN and the ED would be helping the patient better understand their disease process, answer their questions, and direct them to utilize their healthcare needs. The resistance, Appendix C, which may come from the RN's, would be addressed when the research starts to come back and the results are improved patient outcomes. Documentation by the RN's will be tracked by having the CNL student and CNS work together to collect the accountability logs every shift in order to provide weekly feedback to the RN's participating in the policy improvement. In order to ensure training will be completed in the two week period, Appendix B, the CNS and CNL student will have a list of all RN's in the department and have them sign in when training has been completed. By the end of week 1 the CNL student and the CNS will compare the list of RN's not present for training and follow up with the broadcasted schedule to be sure they will receive training by the second week.

If the translator services worked the number of questions would increase and the expectation would be to not see that patient in the ED for something they can utilize their PCP for. The final expectation would be for the RN to use the translator services 100% of the time explaining discharge instructions when they have a patient that does not speak English as a primary language within 6 months. The goal would be to see a 20% decrease in patients utilizing the ED for the same reason due to not understanding their discharge instructions in one-year.

The Pender's Health Promotion Model (HPM) Theory illustrates a client as a multidimensional individual, which is able to interact both interpersonally and physically along with emphasizing as a participatory individual in order to achieve their own improved healthy

state. The HPM is made of self-identifying characteristics and life experiences, behaviors that are specific to the client's own cognition and affect, along with outcomes that are related to the clients own development (Alkhalaileh, Bani Khaled, Baker, and Bond, 2011).

Literature review

In an article by Jaramillo, Snyder, Dunlap, Wright, Mendoza, and Bruzoni titled *The Hispanic Clinic for Pediatric Surgery: A model to improve parent-provider communication for Hispanic pediatric surgery patients* (2016), they mention in the US population there are 26 million Americans in the US with LEP and of those 62% are Spanish speakers. Jaramillo et al. state when this 62% attempt to utilize the healthcare system barriers with language are an apparent challenge. This language barrier demonstrates why this population, in the healthcare setting, is highly vulnerable. Jaramillo et al. (2016) have found evidence showing patient dissatisfaction has been linked to halting care altogether and negative health outcomes.

The study was designed to determine the impact of patient-provider language barriers on asking questions and overall patient satisfaction for pediatric surgery patients. The study by Jaramillo et al. (2016) shows patients who are able to ask more questions are interactive in making decisions, follow their provider's instructions, and are more satisfied with the care provided to them. In ethnic and racial minority group's research has demonstrated they ask less questions in the healthcare setting, especially when there is any kind of language barrier. The study was a prospective study from a convenient sampling recruited from an academic setting. Patients were between the ages of 0 and 18 years of age with written consent obtained from parents, in their primary language. It was a blinded study, as the families did not know the study was to measure question-asking behavior. Audio recording was performed in attending

physician-patient consultations and following the appointment there was a 5-point Likert survey conducted.

The results of the research performed by Jaramillo et al. (2016) demonstrated that the 156 participants involved with the study their mean number of questions asked by the patients had a high variation ($p=0.002$). Those with language barriers reported they would have liked to ask more questions but were limited because they could not speak English ($p=0.001$). Having staff on hand, of which provides direct patient care, which are able to speak the language increases the number of questions asked by patients during a medical visit and improves over all communication. Having staff members on hand may help decrease a source for health inconsistencies in accessing information that is vital to patient satisfaction and positive health outcomes.

To gain more perspective on the research available, a Dutch study performed by van Rosse, de Bruijne, Suurmond, Essink-Bot, and Wagner (2016) also focused on language barriers posing a threat to the quality of hospital care to patients. In their article, *Language barriers and patient safety risks in hospital care,* patient well being during a routine hospitalization was examined. They looked at the challenges presented by language barriers along with how to detect, report, and bridge this into Dutch hospitals. Some of the areas where language barriers can potentially harm patients include daily nursing tasks, patient-physician communication regarding diagnosis, risk communication and urgent situations.

The study conducted by van Rosse et al. (2016) consisted of 576 racial subgroup patients who were hospitalized in thirty wards within four metropolitan hospitals. Qualitative study measures included nursing and medical records of seventeen admissions with language barriers. They were qualitatively analyzed and 12 interviews with care providers, patients, and/or their

relatives were conducted in order to help facilitate the identifying of safety risks during their

stay. The interviews were semi-structured and took between thirty and one hundred twenty

minutes. The 576 patients medical records were also screened for language barrier identifying

markers. Of the charts examined 30% of the patients reporting a low Dutch competence had no

language barrier documented in their records. Quantitative measures were completed through a

questionnaire and record review of data regarding language proficiency using the variables of

age and sex. The information was gathered and compiled into a Chi-square test in order to

conclude statistical significance.

Von Rosse et al. (2016) states there are international guidelines set forth by the Joint

Commission International (JCI), which provides rules in order to overcome language barriers.

The JCI state "1) patient education, follow up instructions, and informed consent must be given

in a language the patient can understand: 2) the hospital should seek to reduce language barriers:

and 3) the patient's language must be assessed and noted in the patient record." The research

showed that healthcare workers assumed bridging the language barrier was the sole

responsibility of the patient and interpretation through gestures and the use of relatives were

sufficient. As in the US, official policies are not consistent with daily practice in talking about

closing the language barrier gap. The study went on to show a wide variety of patient safety

risks in their care and can easily be reduced by bridging the language barrier, which in order to

do must be adequately detected and documented in a patients record.

The research from Dunlap, Jaramillo, Koppolu, Wright, Mendoza, and Bruzoni (2015)

researched language barriers and patient satisfaction. The United States population has grown by

27 million people with Spanish speakers being responsible for 55% of that growth over the past

ten years (Dunlap et al., 2015). The study wanted to determine the effects of provider-patient

language barriers in a pediatric surgical clinic. Language barriers in ethnic minorities have been found to negatively impact access to healthcare and the superiority of health care received. This results in inferior patient satisfaction, extended hospital stays, and medical errors among LEP groups.

The study by Dunlap et al. (2015) was a prospective study with a convenience sampling from the General Pediatric Surgery Clinic at Lucile Packard Children's Hospital (LPCH). The young children with their parent's present that were being seen by the clinic were approached after the visit but prior to any surgical or hospital admission. Consent was obtained for the 7-point Likert scale questionnaire containing 14 questions. They administered 226 surveys to three different groups; control group or English speaking, Spanish speaking only families using LPCH interpreting services, and the Spanish speaking only families with providers who also were able to speak to them in Spanish. Since patient satisfaction questionnaires have been evaluated to provide the most useful information regarding over all patient quality of care they were used in this study. In both the Spanish speaking (M=6.96, S.D.=0.19) and interpreter groups (M=6.60, S.D.=0.83) satisfaction was higher when the language barrier was addressed compared to the English group (M=6.15, S.D.=1.43). To conclude, the study found, when language barrier concerns were addressed overall patient satisfaction and understanding for Hispanic families greatly improved.

In a journal article by Gittner (2015) called Empowering patients to become better partners looked at ways for patients to get more involved in their own care and also how improved communication can improve patient outcomes. Leadership and healthcare expects improvements in patient satisfaction scores but there is no method or teaching on how to accomplish this. One method that is cost effective and can occur with ease is to improve

communication methods and by breaking down language barriers. A method in getting this accomplished is by teaching healthcare workers proper ways to communicate with no biases. Another barrier it discusses is time. If time becomes a barrier for practitioners to overcome with those patients who speak English then the time it takes to use the translator services will also become something overlooked with ease.

Gittner (2016) continues on mentioning to be organized will help the patients get the time they need and deserve. The main emphasis from this article is the importance of communication, using your time wisely, and in order to improve patient outcomes health care providers must use translator services.

In a cross sectional study by Schwei, R., Del Pozo, S., Agger-Gupta, N., Alvarado-Little, W., Bagchi, A., Hm Chen, A., Diamond, L., Gany, F., Wong, D., and Jacobs, E. (2016) researchers looked at what was being done since 2003 to increase awareness of language barriers and how to decrease those barriers. The research was conducted because language barriers are becoming so important around the world. Barriers are affecting patients in more ways than one regarding their access to healthcare, understanding and sticking to a care plan, LEP satisfaction with their providers, and the type of care they receive when utilizing the healthcare system. It has shown that research has increased since 2003 with 60% of them being descriptive and only 12% had interventions. The year 2003 was chosen because the United States made a national policy guide that would help LEP access language services making healthcare easier for them to utilize when they are seeking medical care. Data was looked at prior to and after 2003 in order to see what the foundation was prior to the policy change.

The researchers studied 136 studies prior to 2003 and 426 studies from 2003-2010. The research demonstrated a new method of research, which is to get the view from the medical

providers. This research also mentioned the Title VI of the civil rights act of 1964 requiring all

federally funded programs to provide services to the LEP individuals seeking medical care. The

suggestion is to begin focusing research on how decreasing language barriers can help increase

patient satisfaction and outcomes. The research will then lead to interventions and assess the

cost of providing these interventions to patients with language barriers.

In order to review what the effects of language barriers have on all populations and age

groups I looked into an article dealing with pediatrics. The main focus of the research conducted

by Steinberg, E. M., Valenzuela-Araujo, D., Zickafoose, J. S., Kieffer, E., & DeCamp, L. R.

(2016) was dealing with children whose parents had LEP. Two qualitative interview studies

were conducted in two urban cities in the United States of Latina mothers. The research

demonstrated similarities with the adult population with the exception that they felt more

helpless because they could not help their children. They looked at six different themes that

came out from the research. Those six things were managing the actual language barrier, the

mothers preference for language provider, negative prejudice toward translation services,

healthcare professionals "getting by" with their limited language skills, don't want to bother the

healthcare provider, and stigma felt by LEP families.

The research was comprised of 48 interview questions. Each of the participants was paid

$25 and the interviews generally last about 45-90 minutes. The results demonstrated if they had

a PCP they had positive outcomes since it was someone they built a relationship with and

generally spoke their preferred language. They describe the hard and trying part was seeking

urgent, emergency, or specialty services where they felt discouraged to seek such help, as they

did not want to be a burden. Most of the mothers preferred to seek help from a bilingual

provider than to use translator services by their provider.

In order to get positive outcomes and improved patient satisfaction then improved patient experiences are vital by using services for their preferred language. The negatives to the research were the small sample size and the geographic location. This was only conducted with Latina women and no other ethnic group, which may have given different results dependent on their culture. They concluded partnering with families in order to manage the language barriers as needed in order to improve the quality of healthcare and safety for these patients.

In order to find articles a broad topic was entered and then the scope became narrowed. Research on language barriers is not important there were very little articles available. The topic then started to focus on understanding language barriers and focusing on discharge improvements. P-language barriers and understanding discharge instructions, I-utilize translating services already available to health care staff, C-lack of time and just giving discharge instructions with out explanation, O-reduction of Emergency Department use as a Primary Care Provider.

Timeline

The Clinical Nurse Leader (CNL) will conduct the training with the Clinical Nurse Specialist over looking as the preceptor and expert on the matter of training of staff. The CNL is to assist to better understand the highly systematic process of microsystem care delivery as a resource to clinical nurses to review patient outcomes, teach change management and evidenced based practices to nursing teams (Sotomyer, 2017). A CNL is also responsible for maintaining a multimodal communication channels, multi-professional relationship building, teamwork, and staff engagement in order to maintain consistent quality and safety outcomes for patients (Bender, William, Su, and Hites, 2016).

The CNL works with all levels of management in order to get new initiatives and policies implemented into the microsystem. Some of the biggest barriers a CNL faces when presenting new ideas and getting them implemented is the staff (Sotomyer, 2017). The staff fears change especially when something is already working and they are used to doing it a certain way. A CNL must encourage the staff of how this will improve their practice, improve safety, and greatly improve patient outcomes.

The first two weeks of September will be the CNL conducting and discussing rationale of the improved policy via nursing huddle. At this time the timeline in which the study will be conducted will be presented so they know how long they will be participating prior to the teaching. Teaching will be conducted regarding policy implementation and documentation recommendations and finally implementing the policy improvement over the last two weeks of September will occur simultaneously as teaching is completed. During the next ten weeks while the policy is being implemented the CNL would make themselves available for any questions, thoughts, or concerns the RN's may have. During the final two weeks data would be collected to see if the RN's were using the translator services and to see if questions being asked did increase.

At the conclusion of the final two weeks the CNL will assess the expectations. With improved questions and the RN's implemented translator services during discharge instruction teaching the CNL will prepare to present the findings to the shareholders. The first week of December the findings would be presented to the shareholders and proposal for implementation. If there is implementation then the CNL will prepare the teaching to be taught to all new RN's during the onboard process for the nurse educators.

Expected results

Implementation of this policy is in its infancy stage and there is more to accomplish and do in order to see vast results. With the presented policy the expectation would be to see increased patient satisfaction scores, patient outcomes to become positive with a decrease use of the ED as their PCP, and most importantly this policy will increase patient safety and understanding of their discharge instructions. My expectation would also help increase the number of questions being asked by the patient without feeling any. The final expectation would be for the RN to use the translator services 100% of the time explaining discharge instructions when they have a patient that does not speak English as a primary language. The goal would be to see a 20% decrease in patients utilizing the ED for their original presentation due to not understanding their discharge instructions.

Nursing relevance

The conclusions from the policy improvement would be to prove to the medical staff how important it is to use translator services all the time when the patient does not speak English as a primary language. The hope is to get rid of the days of the clinicians "just getting by" as they will hopefully see the disservice they are providing their patients and how it decreases the chance of a positive outcome in the long term care of chronic diseases (Steinberg et al., 2016).

Summary report

Purposes of breaking down language barriers and having communication between health care providers and patients is to create a good interactive relationship, exchanging information and making treatment related decisions (Ong, Haes, Hoos, & Lames, 1995). The macro-system for the policy improvement was Zukerberg San Francisco General Hospital and Trauma Center and the micro-system being the Emergency Department (ED). The population was made up of

Limited English Proficient (LEP) patients that depend on the ED for health care and the benefits

it provides. In order to implement the project teaching needed to be conducted in order to get the

medical staff on board with the policy improvement. Time was set aside at the beginning of the

policy improvement to educate all staff effected by the policy improvement at the beginning of

their shifts then the CNL student would be available on that shift to help get the project started.

The CNL student would also be available to initiate the project by assisting with time

management or communication for getting proper staffing to assist with the discharges as

needed. The "do" part of the project would last 6 weeks and then the project was evaluated for

implementation ease and facilitating time to perform all parts of the policy improvement.

The LEP patients utilize the ED services at a higher rate than any other population due to

not understanding how the system works and is best utilized. This was not only recognized by

the cities need but also by the federal government as they implemented Title VI of the Civil

Rights Act in 1964 (Schwei, et al., 2016). This act has been in place since 1964, however,

implementing and enforcing it has not been achieved or how to enforce it to help improve the

LEP population. The project would take us one step closer to helping the LEP patient population

by helping them to understand their discharge instructions so that follow up care can be initiated

and primary care can be developed. With the help of the registration department finding them

temporary medical coverage and putting them in the right direction to manage their own

healthcare is just the beginning. The hope is then the resources being offered will help them get

involved in understanding the system and being able to manage their chronic illnesses.

The expected outcomes would be to see a dramatic decrease in LEP patient population

utilizing the ED for their primary care and be able to manage their chronic diseases. I would also

expect the medical staff performing discharges to utilize the translator services available one

hundred percent of the time in order to help the LEP patient understand their directions and to become more involved in their own care. Some sure signs would be visible by the number of questions being asked by the patients and a decrease in repeat patients for the same complaint. A utilization of the ED for emergency services instead of primary care by those patients not understanding how the system works. Because this project is conducted over a long period of time prior to be able to notice change there was no data collected other than documentation by the medical staff if translator service were utilized.   Improvement in repeat patients would be expected after a period of six months to a year. The expectation would be to see a decrease in LEP patients utilizing the ED repeatedly and to see improved patient outcomes by them participating in their care.

In order to keep the policy improvement maintained is to ensure the teaching upon the on board process to new hires who will be delivering discharge instructions. Teaching would need to be conducted in order to let them know what is available and how to utilize such services. The final prospectus would be given the CNS's in order to utilize it in the future and have as a reference. The energy by the staff and the improvements they are seeing will help to also keep it on the forefront of their practice. Preceptors to new staff members would be the main "super users" to keep language barriers at bay.

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Appendix A

Interpreter Services for Discharge Teaching						
Costs						
Staff needs						
	hrly rate	hrs	# of staff	Hrly salary	Benefits	Total Salary
CNL (student)	$78	267		$20,826	1.40	$29,156.40
Education	$80	1	240	$19,200	1.40	$26,880.00
Total Staff Costs						$56,036.40
Cost of ED admit/day		# of admit/day				
	$21,500	68				$1,462,000
Reduce Rate	20%					$292,400
Savings						$236,363.60

Appendix B

Communication Barriers Policy Improvement Project

Description/Name of Person Assigned	2017				2018									
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Discuss rationale at nursing huddle; present timeline to nurses prior to teaching (CNS/CNL)	■													
Begin teaching regarding policy implementation and documenting recommendations (CNL)		■												
Implement policy improvement (CNL)		■	■	■										
Assess expectations of policy improvement (CNL)				■										
Present to shareholders results of improvement (CNL)				■										
Teaching improved policy to new hires during on board process, as needed (CNS)					■	■	■	■	■	■	■	■	■	■

Appendix C

S | **Strengths**

•Experience, knowledge
•Unique characteristics
•Resources readily available
•Competence, capabilities
•Patients will use primary care provider for follow up care
•Involve patient in their own care

W | **Weaknesses**

•Documentation is on the honor system
•Gap in experience, knowledge
•Financially costly to start with the training process
•Reliability and trust
•Loss of key staff
•Nurse compliance and follow through
•Adding another task to the nurse

O | **Opportunities**

•Increase positive patient outcomes
•Product development
•Patient centered care with a focus on follow through
•Reducing discharge instructions miscommunication
•Innovation an technology development in the use of translator equipment
•Increase of patient satisfaction scores

T | **Threats**

•Nurses refusing to comply
•Loss af alliances and partners in the community
•What is the reason for continued use of emergency department for primary care

Appendix D