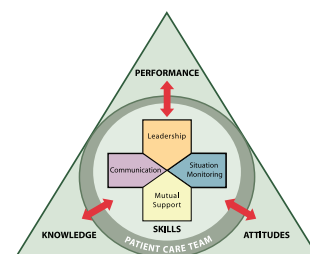




# Improving Patient Safety Systems for Patients With Limited English Proficiency

## A Guide for Hospitals



**TeamSTEPPS<sup>®</sup>**  
 Team Strategies & Tools to Enhance Performance & Patient Safety



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# Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals

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## Foreword

The landmark Institute of Medicine report *To Err Is Human* was an influential and transformative call to action, urging our health care system to ensure that patients not be harmed by care that is intended to help them. This led to a national effort in patient safety that was deep and broad and remains both a key pillar of quality and an essential aim of effective health care delivery. Although the principles of patient safety and the science of preventing medical errors have evolved and advanced over the years, recent evidence tells us that for minority patients and patients with limited English proficiency (LEP) we may be falling well short of our goals.

Research suggests that adverse events affect LEP patients more frequently, are often caused by communication problems, and are more likely to result in serious harm compared to those that affect English-speaking patients. Effective provider-patient communication is vital, especially in areas as critical as medication reconciliation, hospital discharge, informed consent, and surgical care (pre-, peri-, and post-op), to name a few. In fact, these communication-sensitive processes don't just put patients with LEP at risk. Patients with limited health literacy, those who may be affected by disabilities, and those who are subject to other vulnerabilities face an increased risk of misunderstanding and, in turn, medical errors.

The Joint Commission recently developed a new set of standards on Patient-Centered Communication that emphasize the importance of focusing on LEP, cultural competency, and patient-centered care in all aspects of quality. Starting this year, hospitals seeking accreditation will be expected to comply with these recommendations. As hospitals prepare for these standards and work to better ensure equity in patient safety, they will look for resources in this critical area of patient safety.

*Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals* and its companion *TeamSTEPPS® LEP Training Module* are two such resources – one focused on how hospitals can better identify, report, monitor, and prevent medical errors in patients with LEP; the other a training module that teaches a set of team behaviors and structured communication tools designed to reduce medical errors for LEP patients. Built on solid research and well-tested patient safety methodology, these tools provide the case for why this field is important, as well as the basic strategies necessary to build safety systems that truly protect all patients, especially the most vulnerable. The guide and TeamSTEPPS module are practical, actionable, and respectful of competing priorities. They provide a menu of activities to choose from that can immediately be integrated in a broader set of patient safety activities.

Recently the American Hospital Association stood with the Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems in a call to action to eliminate health care disparities. I'm hoping you will join me and other leaders across the country who are striving to meet the challenge of achieving equity and ensuring safe, high-quality care for all we serve and think that this guide will be an important tool for your organization in that journey.

Rich Umbdenstock  
*President and CEO*  
*American Hospital Association*



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# About This Guide

## Goal of the Hospital Guide

The goal of this guide is to help hospital leaders better understand how to address the issue of patient safety for limited-English-proficient (LEP) and culturally diverse patients.<sup>1</sup> The guide can help hospital leaders:

1. Foster a Supportive *Culture* for Safety of Diverse Patient Populations.
2. Adapt Current Systems To Better *Identify* Medical Errors Among LEP Patients.
3. Improve *Reporting* of Medical Errors for LEP Patients.
4. Routinely *Monitor* Patient Safety for LEP Patients.
5. *Address* Root Causes To Prevent Medical Errors Among LEP Patients.

## Target Audience

This guide is intended for hospital leaders and executives in quality and safety, as well as other hospital leaders who work in related fields, such as directors of patient registration, nursing, and interpreter services. It can also be used by individuals within hospitals who are in a position to advise their leadership to take action on patient safety for LEP and culturally diverse patients or who are responsible for encouraging hospital leaders to address this issue. It is applicable to all types of hospitals (e.g., rural, urban, public, private, Veterans Affairs) and is constructed to be clear, concise, practical, and easy to read.

## Organization of the Guide

The guide is organized to present:

1. Evidence on the issue of patient safety for LEP and culturally diverse patients, including common causes and high-risk scenarios. We also present key reasons for addressing this issue, including the impact of an increasingly diverse nation on health care delivery, quality and cost drivers, and role of risk management and accreditation standards in patient safety efforts.
2. Strategies and tools to improve patient safety systems. These include five key recommendations that aim to both improve detection of medical errors across diverse populations and prevent high-risk scenarios from becoming safety events.
3. Team behaviors to improve LEP patient safety, presented in a new TeamSTEPPS® training module: *Enhancing Safety for Patients With Limited English Proficiency (TeamSTEPPS LEP Module)*. The TeamSTEPPS LEP Module applies an evidence-based teamwork system to improve communication and reduce the number and severity of patient safety events affecting LEP and culturally diverse patients.
4. Additional resources and case examples that can be used to implement these recommendations.

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<sup>1</sup>Note that we include sign language users among LEP patients. American Sign Language is a language in its own right and not a manual representation of English.

It is well understood that hospitals may have resource or other limitations that preclude a full rollout of this guide’s recommended strategies all at once. In such cases, we recommend that hospitals begin incrementally by choosing strategies that can be readily implemented. At minimum, hospitals should focus on addressing the root causes that lead to high-risk scenarios for medical errors among LEP patients, for example, by improving access to interpreters and training staff using the new TeamSTEPPS LEP Module.

This guide was created as part of a larger project called “Improving Patient Safety Systems Implementation for Limited English Proficiency Populations,” funded by AHRQ. This project used a robust mixed methods approach (Figure A) to:

1. Identify the role language and cultural barriers have on patient safety events;
2. Document how hospitals are addressing the safety of LEP and culturally diverse patients; and
3. Provide guidance and tools to help hospitals address these issues.

The final products include this guide and a TeamSTEPPS LEP Module focused specifically on improving team communication to reduce medical errors for LEP patients. For more information on our methods, refer to Appendix D.

#### **Figure A. Data Sources**

**Environmental scan.** Searched the peer-reviewed and grey literature on the topic of patient safety and LEP and culturally diverse patients.

**Interpreter pilot.** Analyzed the results of a project where interpreters were asked to anonymously document information about incidents that had a negative impact on the safety of LEP patients.

**Qualitative interviews.** Interviewed frontline staff and clinical and administrative leaders to obtain input on conditions affecting safety of LEP and culturally diverse patients.

**Town hall meeting.** Conducted a town hall meeting with a diverse group of hospitals from across the Nation, as well as hospital associations and accrediting organizations, to get their thoughts on best practices for preventing, reporting, and documenting medical errors affecting LEP patients.

# Executive Summary

## What We Know About Safety and Limited English Proficiency

The Institute of Medicine (IOM) report *To Err is Human: Building a Safer Health System* states that patients should not be harmed by the care that is intended to help them, and they should remain free from accidental injury.<sup>1</sup> The 2001 IOM report *Crossing the Quality Chasm* defined patient safety as one of the essential components of high-quality health care.<sup>2</sup> Patient safety efforts are now a central component of strategies to improve the quality of care for all patients.

The role of language barriers and their impact on adverse events is now receiving greater attention. Recent research suggests that adverse events that affect limited-English-proficient (LEP) patients are more frequently caused by communication problems and more likely to result in serious harm compared to English-speaking patients.<sup>3</sup> Further, the Joint Commission has developed a new set of standards on Patient-Centered Communication that emphasize the importance of language, cultural competence, and patient-centered care. Hospitals seeking accreditation will be expected to comply with these recommendations starting in 2012.<sup>4</sup>

Figure B provides an example of how language barriers can contribute to medical errors.

## Why Focus on LEP and Patient Safety?

### A Large and Growing Vulnerable Population

Our Nation is becoming *increasingly diverse* and these issues will be magnified in the future:

- Approximately 57 million people, 20 percent of the U.S. population, speak a language other than English at home.
- Approximately 25 million, 8.6 percent of the U.S. population, are defined as being LEP.<sup>5</sup>

Thus, at least 8.6 percent of the U.S. population is at risk for adverse events because of barriers associated with their language ability.

### Patient Safety, Quality, and Cost Drivers

Quality and cost drivers are emerging in support of work in this area:

- Longer length of hospital stays for LEP patients when professional interpreters were not used at admissions and/or discharge.<sup>6,8</sup>
- Greater risk of line infections, surgical infections, falls, and pressure ulcers due to LEP patients' longer hospital stays compared to English-speaking patients with the same clinical condition.<sup>6</sup>
- Greater risk of surgical delays and readmission due to LEP patients' greater difficulty understanding instructions, including how to prepare for a procedure, manage their condition, and take their medications, as well as which symptoms should prompt a return to care or when to follow up.<sup>7,8</sup>
- Greater chance of readmissions for certain chronic conditions among racial and ethnic minorities compared to their white counterparts.<sup>9,10</sup> This difference may be caused by limited English proficiency, low literacy, or other communication barriers that make patients more likely to misunderstand discharge and medication instructions.<sup>11,12</sup> With the advent of financial disincentives for excessive readmissions, greater attention should be paid to ensuring effective communication, including appropriate medication reconciliation, at discharge.

## Risk Management

*Risk management* remains a critical concern and is directly linked to patient safety. Multiple liability exposures arise when providing care to LEP populations.<sup>13-15</sup> These may include situations related to:

- Patient comprehension of medical condition, treatment plan, discharge instructions, complications, and followup;
- Inaccurate and incomplete medical history;
- Ineffective or improper use of medications or serious medication errors;
- Improper preparation for tests and procedures; and
- Poor or inadequate informed consent.

## Accreditation Standards

*Accreditation standards* mandate advances in the field.

The Joint Commission published Patient-Centered Communication standards in *2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook*. These standards emphasize the importance of effective communication, cultural competence, and patient-centered care in providing safe care.<sup>16</sup>

### **Figure B. Why Addressing Language Needs in Patient Safety Matters: Case 34-2010: A 65-Year-Old Woman With an Incorrect Operation on the Left Hand**

**Background:** A 65-year-old woman was admitted to a hospital's day surgery unit for release of a trigger finger of the left ring finger. She spoke only Spanish. The day of surgery, no interpreter was available. The doctor, who spoke Spanish, was asked to act as the interpreter during her preoperative preparation. The usual prep procedure was followed with the patient and the correct surgery was confirmed, along with risks and benefits.

#### **Lack of Communication and Teamwork Impede Surgical Procedures:**

- Stress on the day surgery unit was high because several other surgeons were behind schedule. Staff decided to move this patient to another operating room, which resulted in a change in personnel. In particular, the nurse who had performed the preoperative assessment was not in the room during the procedure.
- Before the procedure, the nurse, surgeon, anesthesiologist, and patient should have held a timeout to agree on the patient's identification, operation type, and correct surgical site. When the doctor spoke with the patient in Spanish, the circulating nurse mistook this for a timeout. Therefore, no formal timeout took place before the procedure started.
- Confused by having performed a carpal-tunnel release operation immediately prior and in a state of agitation due to an encounter with an upset patient, the surgeon performed the wrong surgery (a carpal-tunnel release instead of a trigger-finger release) on the patient. Had the doctor's conversation in Spanish with the patient been interpreted for the rest of the team, this error could have been averted.

**Resolution:** Shortly after, the doctor realized his mistake and followed hospital safety protocols. The correct procedure was performed that day and the patient was discharged. All charges were waived. A legal financial settlement was negotiated shortly after the event. The patient did not return for followup care at the hospital and reported a loss of faith in the doctor.

Ring DC, Herndon JH, Meyer GS. Case 34-2010 – a 65-year-old woman with an incorrect operation on the left hand. *N Engl J Med* 2010;363:1950-7.

# Common Causes of Adverse Events for LEP and Culturally Diverse Patients

Below is a summary of common causes of adverse events for LEP and culturally diverse patients from our research and existing research in the field.

## **Use of Family Members/Friends or Nonqualified Staff as Interpreters**

- Family members and friends typically may not understand the subtle nuances of language and culture that may influence the interaction and may not question the use of medical terminology that they and the patient do not understand. Further, issues of confidentiality may prevent patients from disclosing critical health information.
- Research confirms that untrained hospital staff often serve as interpreters for LEP patients, despite evidence that hospital staff who serve as interpreters on an ad hoc basis are more likely to make clinically significant mistakes than qualified medical interpreters.<sup>17,18</sup>

## **Use of Basic Language Skills To “Get By”**

- Clinicians with basic or intermediate foreign language skills often attempt to “make do” or “get by” without the use of a competent interpreter, increasing patient risk.<sup>17,19</sup>

## **Cultural Beliefs and Traditions Affecting Patient Care**

- Cultural beliefs and traditions, such as minimizing reports of pain, deferring to authority figures, and following certain gender roles, can influence the medical encounter and compound the risk for LEP patients.

# Systems and Strategies To Improve Safety for LEP Patients

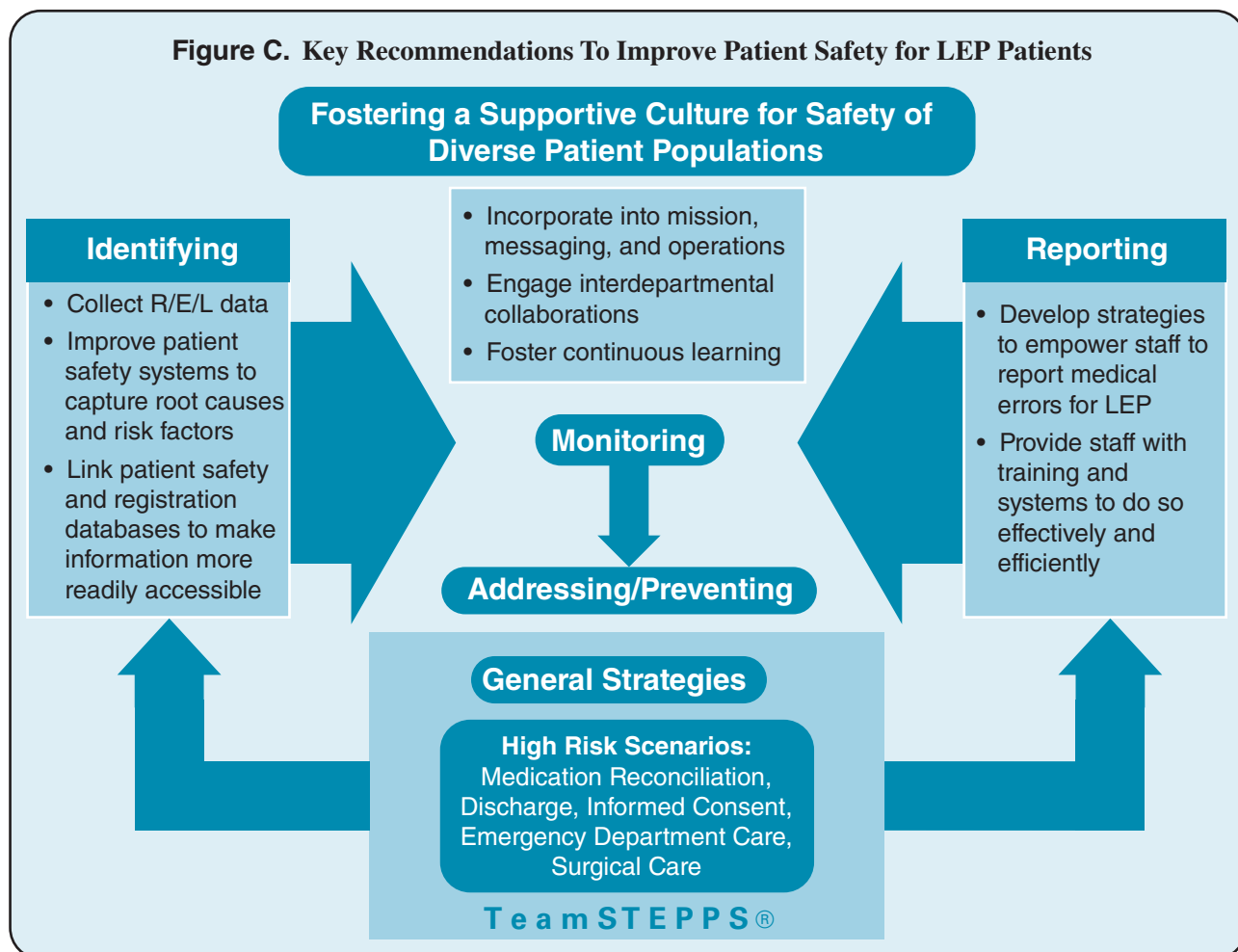
Hospitals can engage in a systematic approach to better identify and prevent medical errors and adverse events that commonly occur among LEP patients. Our research has identified **five key recommendations** to both improve detection of medical errors across diverse populations and prevent high-risk scenarios from becoming safety events. It is important to emphasize that these recommendations represent the ideal system. Hospitals, however, do not need all of these pieces in place to prevent errors for LEP patients.

Some recommendations can be adopted immediately. Other recommendations can be added at a later date, allowing hospitals to work toward preventing errors incrementally. Figure C summarizes key recommendations.

## **Foster a Supportive *Culture* for Safety of Diverse Patient Populations**

Foster a supportive culture for safety of diverse patient populations, articulated clearly by leadership, operationalized in strategic planning for the organization, and supported by providing staff with key tools and resources to accomplish this successfully.

- Link the goal of overcoming language and cultural barriers into the overall message and mission of the culture of quality and safety, and frame this within existing operational policies and standards related to quality and safety for all patients.
- Share lessons learned from patient safety events with all staff to help build an institutional culture sensitive to issues that affect LEP patients and ensure ongoing continuous learning and training in this area.
- Involve patients in family advisory councils or cultural advisory groups to incorporate patient perspectives.



### **Adapt Current Systems To Better *Identify* Medical Errors Among LEP Patients**

- Adapt current systems to better identify medical errors in LEP patients, improve the capacity of patient safety systems to capture key root causes and risk factors, and link databases so that information is readily accessible.
- Document data in the electronic medical record on race, ethnicity, and patient language and interpreter service needs to allow ongoing monitoring and easy integration with other reporting systems for quality of care monitoring purposes.
- Include these data fields in patient safety systems to track the role of language and culture in the patient safety events reported by staff.

### **Improve *Reporting* of Medical Errors for LEP Patients**

- Develop institutional strategies to empower frontline staff and interpreters to report medical errors, and provide them with training and systems to do so effectively and efficiently.<sup>ii</sup>
- Develop targeted messages so that frontline staff and interpreters are empowered to report any patient safety events they might encounter.
- Train all staff, particularly frontline staff and interpreters, on the full spectrum of what constitutes a patient safety event (including near misses) and how to report them.
- Consider other methods of identifying errors outside of standard reporting.

## Routinely *Monitor Patient Safety for LEP Patients*

- Develop systems to routinely monitor patient safety among LEP patients, as well as processes to analyze medical errors and near misses that occur among these populations.
- Develop routine (quarterly, yearly) hospitalwide safety reports or dashboards that focus on patient safety among LEP patients.
- Create routine forums for analyzing cases of medical errors and near misses that occur among LEP and culturally diverse populations to better understand root causes and high-risk scenarios, and develop strategies for improvement and error prevention.

## Address Root Causes To Prevent Medical Errors Among LEP Patients

- Develop strategies and systems to prevent medical errors among LEP patients by strengthening interpreter services. Improve coordination with the provision of clinical services, provide translated materials, and develop training for health care providers and staff on interpreter use, cultural competency, and advocacy. Immediate strategies that can be implemented are improving access to interpreters (Figure D presents an overview of benefits and challenges of interpreters providing cultural brokerage) and offering TeamSTEPPS® training (Figure E).
- Develop dedicated services for medical interpretation that include either in-person or telephonic qualified medical interpreters, or both.<sup>iii</sup>
- Provide patients with written materials – such as for informed consent or procedure preparation – in their preferred written language.
- Create a mechanism to schedule an interpreter automatically at clinical points of service for patients who are identified as having LEP.
- Train staff on team communication, use of interpreter services, cultural competency, and advocacy by using the new TeamSTEPPS LEP Module.

## Specific Recommendations for High-Risk Scenarios

Our research suggests that certain *high-risk clinical situations* need immediate attention to prevent adverse events among LEP patients. These high-risk scenarios include: **medication reconciliation, patient discharge, informed consent, emergency department care, and surgical care**. Ensuring that resources are available to address these high-risk clinical situations should be a priority.

Three key recommendations to address these high-risk scenarios are:

- Require presence of qualified interpreters.
- Provide translated materials in preferred language.
- Use “teach-back” to confirm patient understanding.

Requiring the presence of qualified medical interpreters is necessary for all high risk scenarios. Further, providing translated materials in plain language is critical, especially in the case of discharge instructions, informed consent, and surgical care (e.g., pre- and post-op instructions). Using “teach-back” is an effective strategy to confirm patients’ comprehension of care processes, specifically instructions for self-care.

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<sup>i</sup>The term “frontline staff” includes all patient-facing staff such as registrars, medical technicians, medical assistants, interpreters, and nurses.

<sup>iii</sup>Fluent bilingual staff are also a form of language assistance and medical interpretation proficiency should be verified.

### **Figure D. Benefits and Challenges of Interpreters Providing Cultural Brokerage**

Interpreters who serve as cultural brokers in addition to interpreting:

- Assist providers in understanding the patients' cultural beliefs and practices.
- Assist the patient in understanding the dominant culture.
- Mitigate cultural misunderstandings between patients and providers and prevent critical and costly errors.
- Improve team communication by using structured tools (e.g., check-backs), in conjunction with the care team, to ensure patient comprehension.

While these benefits may reduce medical errors, challenges to interpreters serving as cultural brokers include:

- Confusion of role boundaries among care team during medical interaction.
- Challenges associated with interpreters acting as patient advocates and retaining impartiality and objectivity required of professional interpretation.
- Institutional culture and resistance of interpreters stepping outside of traditional role.

### **Improving Team Communication To Foster Safety for LEP Patients: TeamSTEPPS® LEP Module**

It may take some time to create a system to monitor and prevent errors for LEP patients. Fortunately, several activities can be implemented to prevent errors in the short term. Primary among these is use of the TeamSTEPPS LEP Module.

In November 2006, the Agency for Healthcare Research and Quality, in collaboration with the Department of Defense, released Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) as the national standard for team training in health care.<sup>20</sup> TeamSTEPPS is an evidence-based teamwork system designed to optimize patient outcomes by improving communication and other teamwork skills among health care professionals. The approach is scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles.

TeamSTEPPS was originally successfully implemented through military health care and has recently been expanded nationally and implemented at hospitals across the country. Recent research has shown that TeamSTEPPS is effective in multiple settings at improving care outcomes, team communication, and team attitudes.<sup>21-24</sup> Unlike other team-based trainings, TeamSTEPPS is evidence based, field tested, comprehensive, and customizable. It provides easy-to-use teamwork tools and strategies and is publicly available at no cost.

AHRQ has created the TeamSTEPPS LEP Module to help hospitals improve patient safety for LEP patients. The purpose of the TeamSTEPPS LEP Module is to train interprofessional care teams working together in hospital units (such as OB-GYN, emergency departments, and surgery) on the knowledge, attitudes, and team behaviors needed to reduce the number and severity of patient safety events affecting LEP and culturally diverse patients in their unit (Figure E).



The TeamSTEPPS LEP Module trains doctors, nurses, technicians, front desk staff, and interpreters together to improve team dynamics and prevent miscommunications when working with LEP patients. TeamSTEPPS creates a psychologically safe environment for others to clarify misunderstandings through the use of tools such as briefs, check-backs, and teach-backs. The TeamSTEPPS LEP Module can be used in hospitals that have not implemented any other TeamSTEPPS training.

### **Figure E. TeamSTEPPS LEP Module Objectives**

Participants in the TeamSTEPPS LEP Module will be able to:

- Identify high-risk situations for LEP and culturally diverse patients.
- Assemble the most appropriate and effective care team for LEP patients.
- Apply new TeamSTEPPS strategies to enhance the safety of LEP and culturally diverse patients.
- Use TeamSTEPPS structured communication skills to identify and raise patient communication issues with the care team.

## **Frequently Asked Questions**

### **With everything else that hospitals are dealing with, why focus on the safety of LEP patients?**

Currently, approximately 57 million people, or 20 percent of the U.S. population, speak a language other than English at home. Approximately 25 million, or 8.6 percent of the U.S. population, are defined as limited English proficient (LEP), meaning that they speak English less than “very well.”<sup>25</sup> This number is expected to grow, as projections indicate the United States will continue to become more diverse. This growing segment of the U.S. population is at risk for adverse events because of barriers associated with limited English proficiency. Furthermore, failing to address language barriers can lead to significant financial risk, as well as human cost.

From the standpoint of quality, poor communication that leads to ineffective medication reconciliation at discharge may lead to avoidable rehospitalizations that will not be reimbursed. Poor communication may also lead to delays in informed consent or postponing procedures due to inappropriate preparation. The cost of delayed surgical procedures was estimated in 2004 as \$70 per minute.<sup>25</sup>

Improving safety for LEP patients may also reduce malpractice liability. A recent study examined medical malpractice claims of a malpractice carrier that insures in four States. Researchers found that 35 claims (2.5 percent of the carrier’s total claims reviewed) were related to language barriers.<sup>14</sup> The carrier paid \$2,289,000 in damages or settlements and \$2,793,800 in legal fees from January 2005 to May 2009. Many of the cases reviewed resulted in patients suffering death or irreparable harm. Most were due to failure to use an appropriate interpreter.

As we look toward the future, this issue will take on greater importance and hospitals must be prepared to provide safe, high-quality care to patients from diverse social, cultural, and linguistic backgrounds. Finally, Joint Commission standards require hospitals to document all relevant data to help staff coordinate communication assistance (e.g., language, cultural or religious accommodations), create processes to identify patients with unique needs, and provide the necessary equipment throughout the care continuum.

**We know that LEP patients may have trouble communicating with the health care team, but how does that relate to patient safety?**

Evidence shows that unaddressed language barriers put patients at high risk for adverse events. For example, LEP patients are more likely to experience medical errors due to communication problems than English-speaking patients and are more likely to experience physical harm when errors occur.<sup>3</sup> Further, pediatric patients with LEP families who speak Spanish have a much greater risk for serious medical events during hospitalizations than patients whose families are English proficient.<sup>26</sup> Given the communication challenges LEP patients face, it is critical that hospitals make special efforts to address the role of language and cultural factors so that LEP patients receive safe and effective care.

**Only a few patients at our hospital don't speak English well enough to at least get by, so why should we spend time and resources on professional interpreter services?**

This is a very reasonable question. Your hospital may have more patients with language barriers than you think since many LEP patients appear to communicate reasonably well in English. However, many LEP patients may not understand critical information and may not be able to express important concerns or ask relevant questions. Numerous studies on language barriers in health care confirm this situation.

Poor communication can lead to medical errors, patient safety events, and overall lower quality of care. Patients may not feel comfortable revealing that they have trouble communicating in English. Thus, it is important to offer professional interpretation services, even when patients seem to speak enough English to “get by.” In addition, the Department of Justice and the Department of Health and Human Services have stated that failure to provide appropriate interpreter services can be considered discrimination based on national origin. Such discrimination is prohibited by Title VI of the Civil Rights Act of 1964 for any entity receiving Federal funding such as Medicare or Medicaid payments.

**It is the responsibility of immigrants to this country to learn English, so why do we need to focus so much attention on providing care in their own language?**

While it is certainly helpful when patients learn English, this is not a requirement for receiving medical care or for living in the United States. Regardless of your perspective on this issue, learning a new language takes time and can be particularly difficult, especially as we advance in age. Helping patients gain access to English as a second language (ESL) courses is one step.<sup>27</sup> However, LEP patients, including those who speak English but are not comfortable discussing important medical issues in English, still deserve to receive effective health care that they can understand.

Medical information is difficult to understand even if English is your native language; it is even more difficult for LEP patients who may struggle with both linguistic and other cultural barriers. Further, the law requires that LEP patients seeking health care be afforded the same opportunity to communicate with the care team as English-speaking patients. Generally, this means effective interpreter services. Interpreter services benefit not only the patient, but also staff members who otherwise struggle to ensure the provision of high-quality care.

**Many LEP patients come with family members or friends who can interpret for them. Isn't this enough to communicate with them in the clinical setting?**

Health care staff should understand the risks of using nonqualified interpreters, including family members, friends, or untrained staff. These “ad hoc” interpreters are not trained or skilled in the interpretation process, such as the need to interpret everything the clinician and patient say, to interpret manageable chunks of information, and to avoid paraphrasing long explanations.

Family members are not neutral parties to the medical encounter; they may withhold information from the clinical care team or from the patient, or may add their own perspectives. They may also be distressed, interfering with their ability to interpret. Research has shown that all of these problems can lead to miscommunication and patient safety issues, as ad-hoc interpreters have been shown to commit more communication errors of clinical significance than trained interpreters. Family members may also suffer psychological harm if they make an error in interpretation that results in harm to the patient. Staff should inform patients that they have a legal right to an interpreter at no cost, and that family members are welcome to be involved in the conversation if the patient wants but should not bear the burden of serving as interpreters.

### **Our hospital has in-person interpreters for many languages and phone interpretation for the rest. Isn't that enough to make sure we're providing safe and effective care for LEP patients?**

Although it is critical to ensure that you have qualified in-person medical interpreters (or access to telephone or video) for the languages reflecting the patient populations you serve, this is not enough to ensure safe and effective care for LEP patients. For example, staff may not call interpreters when needed, service may be delayed, and interpreters may not be empowered to speak up when they recognize miscommunication or a potential adverse event.

Having interpreter services available is not helpful if they are not used effectively. All staff should have training on how to use interpreter services and should understand the interpreter's role in the patient encounter. This includes fostering a culture of safety for LEP patients where the entire care team, including the interpreter, is prepared to identify and address potential safety issues. Interpreters should receive standardized training in how to interpret effectively and in relevant aspects of clinical care. The National Council on Interpreting in Health Care and the International Medical Interpreters Association have developed national certification standards to guide the design of services, processes, and programs to ensure quality control and accountability.

### **Aren't interpreters supposed to simply translate what is said word for word rather than getting involved in any other aspect of patient care?**

The role of an interpreter has traditionally been limited to strictly interpreting word for word the conversation between patients and clinicians (or other health care staff). However, research<sup>3,26,28</sup> has shown that interpreters can play a critical role in helping to reduce medical errors given their unique position in the medical encounter. Therefore, they should be empowered to more fully participate in the interaction to ensure patient safety.

Interpreters should be welcomed and treated as core members of the care team for LEP patients. They should be empowered to speak up if they recognize that a patient's safety is at risk, particularly due to miscommunication or cultural misunderstandings. They can act as cultural brokers to improve the interaction between clinicians and patients. Further, interpreters can be integrated into team meetings, especially for complicated LEP patients, and can participate in huddles, briefings, debriefings, handoffs, and discharges as described in this guide.

## **Our organization has not focused much attention on this area before, so where do we start?**

An important first step is to assess whether current language assistance meets the needs of patients speaking common languages other than English in your hospital. If it does not, work on hiring bilingual staff and building up interpreter services. Once your language assistance is well matched to patients' needs, you can launch other initiatives. These include clarifying hospital policies about how patient language needs are assessed, when interpreters should be called, and how proficiency of bilingual staff is established.

Even if your hospital collects language and interpreter needs data, it is important to make sure that the questions are asked effectively and the data fields are appropriate. You may need to modify tracking and reporting systems by creating fields to capture language preference and interpreter use. This process can help you more accurately track how patients' language affects patient safety.

Finally, you can use the new TeamSTEPPS LEP Module, which is designed to engage staff in improving patient safety for LEP patients. This guide will present more information on how to start building a safe and effective care environment for LEP patients.

## **What are the key barriers to implementing initiatives to address LEP patient safety and how might these be overcome?**

First, awareness about safety risks for LEP patients may be low. Educating hospital staff at all levels about the need to create a culture of safety, particularly for LEP patients, will be key in getting staff buy-in. Second, many hospitals do not have the information technology in place to capture data to ensure timely language assistance. Adding the necessary fields and functionality, however, is always possible if leadership makes it a priority.

Third, even if the technology is in place, the data need to be collected properly. The good news is many successful models can help you achieve this goal. Evidence demonstrates that the registration process should include standardized mechanisms to collect and verify language needs, such as specific templates for data collection. It is also important to train registrars. Fourth, the data frequently are not used to access language assistance. Hospitals need to have interpreter services available (in person and by phone or video) and train staff to call for interpreters and to interact with them effectively.

This brings us to the fifth barrier, the hierarchical structures in hospital that frequently prevent subordinate staff from speaking up when they see a patient safety threat. This is particularly a problem with interpreters who are often not integrated into the care team. Training, such as the TeamSTEPPS LEP Module, can empower staff and provide them with communication tools to prevent, identify, and report medical errors among LEP patients.

# Chapter 1:

## Background on Patient Safety and LEP Populations

The Institute of Medicine (IOM) report *To Err is Human: Building a Safer Health System* states that patients should not be harmed by the care that is intended to help them, and they should remain free from accidental injury.<sup>1</sup> The 2001 IOM report *Crossing the Quality Chasm* defined patient safety as one of the essential components of high-quality health care.<sup>2</sup>

Several types of situations are considered patient safety events (Figure 1). Studies both in the United States and abroad report high rates of harmful patient safety events.<sup>29,30</sup>

### Figure 1. Patient Safety Terminology

#### Medical errors\*:

Medical errors happen when something that was planned as part of medical care does not work out or when the wrong plan was used in the first place. Medical errors can occur anywhere in the health care system: hospitals, clinics, outpatient surgery centers, doctors' offices, and pharmacies. Errors can involve medicines, surgery, diagnosis, equipment, and lab reports. They can happen during even the most routine tasks, such as when a hospital patient on a salt-free diet is given a high-salt meal. Most errors result from problems created by today's complex health care system, but errors also happen when doctors and their patients have problems communicating.

#### Adverse event\*:

Any injury caused by medical care. Examples include pneumothorax from central venous catheter placement, anaphylaxis to penicillin, postoperative wound infection, and hospital-acquired delirium (or "sun downing") in elderly patients. Identifying something as an adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. Similarly, postoperative wound infections count as adverse events even if the operation proceeded with optimal adherence to sterile procedures, the patient received appropriate antibiotic prophylaxis in the perioperative setting, and so on.

#### Near miss/close call\*:

An event or situation that did not produce patient injury, but only because of chance. This good fortune might reflect robustness of the patient (e.g., a patient with penicillin allergy receives penicillin but has no reaction) or a fortuitous timely intervention (e.g., a nurse happens to realize that a physician wrote an order in the wrong chart).

#### Never event\*\*:

The term "never event" refers to a particularly shocking medical error (such as wrong-site surgery) that should never occur. Over time, the list has been expanded to signify adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable. The National Quality Forum initially defined 27 such events in 2002 and revised and expanded the list in 2006. The list is grouped into six categories: surgical, product or device, patient protection, care management, environmental, and criminal.

\* From AHRQ Patient Safety Glossary, [www.psnet.ahrq.gov/glossary.aspx](http://www.psnet.ahrq.gov/glossary.aspx).

\*\* From AHRQ Patient Safety Primer, [psnet.ahrq.gov/primer.aspx?primerID=3](http://psnet.ahrq.gov/primer.aspx?primerID=3).

The existence of racial and ethnic disparities in health and health care has been well documented.<sup>31</sup> IOM’s *Unequal Treatment* was the first major report to highlight that in addition to racial and ethnic disparities in *health*, there is evidence of racial and ethnic disparities in *health care*.<sup>32</sup> Patient safety efforts are now a central component of efforts to improve the quality of care for all patients. However, the role of language barriers and its impact on adverse events is less well documented.

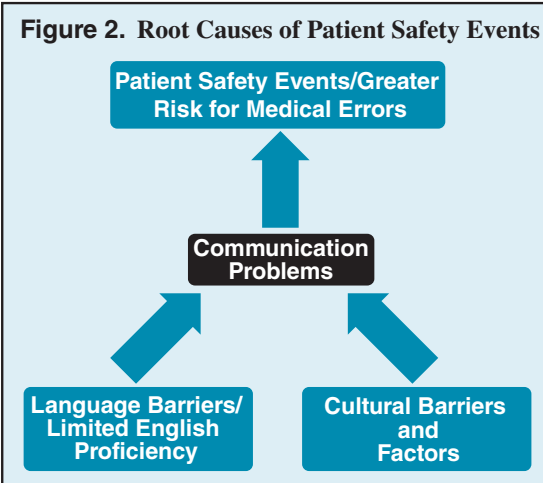
Nearly 25 million people in the United States (8.6 percent) are defined as limited English proficient (LEP), meaning that they speak English less than “very well.”<sup>33</sup> Therefore, at least 8.6 percent of the U.S. population is at risk for adverse events because of barriers associated with their language ability.

## What We Know About Safety and Limited-English-Proficient Patients

Communication problems are the most frequent root cause of serious adverse events reported to the Joint Commission’s Sentinel Event Database.<sup>33</sup> The root causes of patient safety events for LEP patients are related to communication and lack of use of qualified medical interpreters (Figure 2). Research demonstrates that language barriers can have a significant impact on multiple aspects of health care and contribute to disparities in patient safety between English-speaking and LEP hospital patients.<sup>3,26,28</sup>

For example:

- A study of six hospitals across the United States showed that LEP patients are more likely than English-speaking patients to suffer from physical harm when errors occur.<sup>3</sup> (Figure 3 illustrates results from a study by Divi, et al.)
- A study of audiotaped and transcribed pediatric encounters over a 7-month period showed that most medical interpretation errors have potential clinical consequences. Those committed by ad hoc interpreters are significantly more likely to have potential clinical consequences than those committed by hospital interpreters.<sup>28</sup>
- Pediatric patients with Spanish-speaking LEP families have a much greater risk for serious medical events during hospitalizations than patients whose families are English proficient.<sup>26</sup>

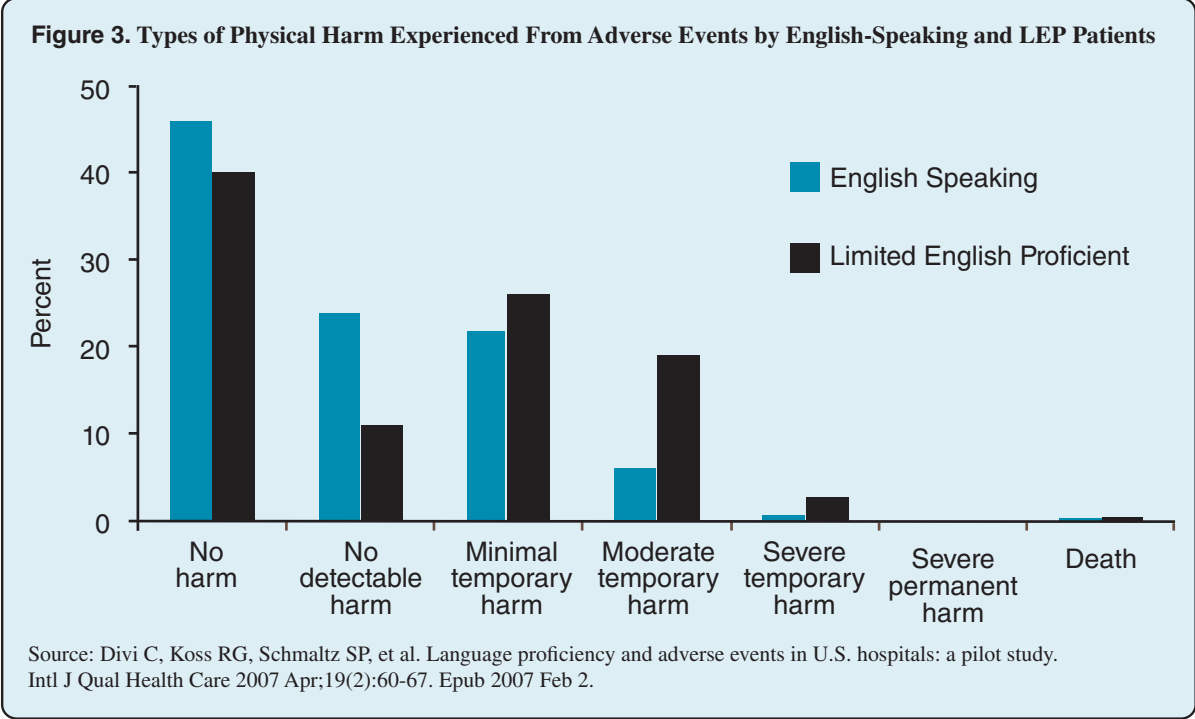


## What We Know About Hospitals’ Response to LEP Patient Safety

Very limited data are available on how health care organizations nationwide address issues of LEP patient safety and reporting. The Joint Commission’s *Hospitals, Language, and Culture: A Snapshot of the Nation* (HLC) study was designed to gather information about the activities hospitals are undertaking to address cultural and language needs among an increasingly diverse patient population.<sup>34</sup> Beginning in February 2005, members of the HLC research team recruited a sample of 60 hospitals from 32 States across the country and conducted surveys and site visits.

The HLC study revealed that although 43 percent of the hospitals identified a direct relationship between patient safety issues and patients’ linguistic needs, only one hospital reported stratifying their adverse event data by language. When the link between patient safety, language, and culture was discussed during site visits, only a few hospitals indicated that they were able to quantify this connection. The one hospital that stratified their adverse event data by language found clusters of adverse events in patients with English as a second language. The ability to demonstrate the link between language and safety had sensitized this hospital to the challenges of providing care to LEP patients.

Findings from our research confirm this finding. A town hall meeting we conducted with hospitals from across the country and representatives from hospital associations revealed similar challenges to linking patient safety reporting with language fields. Therefore, none reported actively monitoring patient safety events by language. If anything, errors related to LEP are bundled as being caused by “communication errors,” which does not allow analysis based on language, culture, or other LEP-related factors.



### Why Hospitals Should Focus on Patient Safety for LEP Populations

Several major trends justify the need for hospital leaders to better identify, prevent, and address medical errors among LEP patients.

#### A Large and Growing Vulnerable Population

The U.S. population is becoming increasingly diverse, as is the number of LEP individuals. According to a recent report by the Brookings Institute, minority groups are the Nation’s fastest growing demographic, accounting for one-third of the U.S. population.<sup>35</sup> Recent reports from the U.S. Census Bureau state that the minority population increased from 86.9 million to 111.9 million between 2000 and 2010, indicating a growth of 29 percent.<sup>36</sup> Since 2000, the Asian population has increased by 43.3 percent, making it the fastest growing major racial group.<sup>36</sup>

In 2008, metropolitan areas contained 68 percent of the Nation’s multiracial population, and roughly one in six of these residents was foreign born. Minority groups, including immigrants, also rapidly contributed to high growth rates in smaller metropolitan areas and nonmetropolitan areas.<sup>35, 37, 38</sup> For example, between 1990 and 2008, the immigrant population grew fastest in nonmetropolitan areas (183 percent), followed by smaller metropolitan areas (122 percent).<sup>35</sup>

Between 2000 and 2010, the Hispanic-origin population increased by 43 percent, which accounts for more than half of the 27.3 million increase in total population of the United States in that decade.<sup>36</sup> Projections suggest that the Hispanic-origin population will contribute 45 percent of the growth from 2010 to 2030 and 60 percent from 2030 to 2050.<sup>39</sup> Most important, studies of language maintenance and language shifts suggest that Hispanics, more than any other ethnic group, tend to remain loyal to their native language.

Even third-generation bilingualism is higher among Hispanics than among other ethnic groups; Mexicans tend to be the most committed Spanish speakers.<sup>40</sup>

Both the growth and wider dispersal of minority and LEP populations signify the broadening relevance of policies aimed at more diverse communities, including immigrants. With the passage of health care reform and an additional 32 million uninsured Americans having access to health insurance, it is anticipated that hospitals will care for a more diverse patient population than ever before. Further, these numbers likely underestimate the number of patients seen by hospitals as many undocumented immigrants with language barriers also present to hospitals for care. As we look toward the future, this issue will take on greater importance and hospitals must be prepared to provide safe, high-quality care to patients from diverse social, cultural, and linguistic backgrounds.

### **Patient Safety, Quality, and Cost Drivers**

The Institute of Medicine Report *Crossing the Quality Chasm* states that quality means that patients are not harmed by the care that is intended to help them, and they remain free from accidental injury, misdiagnosis, and inappropriate treatment. Communication between patients and health care providers, and the barriers many LEP patients face in this regard, has an important impact on quality, cost, and patient safety and may lead to misdiagnosis and inappropriate treatment.<sup>19</sup> For example:

- Both published research<sup>3,26,28</sup> and our research suggest that LEP patients who may not be able to communicate effectively with their health care providers may be at greater risk for medical errors.
- LEP patients are at greater risk of line infections, surgical infections, falls, and pressure ulcers due to longer hospital stays than English-speaking patients with the same clinical condition.<sup>6</sup>

Medical errors are not the only result of communication difficulties in the inpatient setting that are problematic and costly:

- Longer length of hospital stays for LEP patients when professional interpreters were not used at admissions and/or discharge.<sup>68</sup>
- LEP patients have greater difficulty understanding discharge instructions, including how to manage their condition, take their medications, recognize symptoms that should prompt a return to care, and know when to follow up.<sup>11,12</sup>
- Racial and ethnic minorities are more likely to be readmitted for certain chronic conditions than their non-Hispanic white counterparts.<sup>9,10</sup> This difference may relate to the greater likelihood for a patient with limited English proficiency, low literacy, or other communication barriers to misunderstand discharge and medication instructions.<sup>11,12</sup> When financial disincentives exist for readmissions, greater attention should be placed on ensuring effective communication, including appropriate medication reconciliation, at discharge.

These situations have significant cost implications for hospitals, given the potential for unnecessary and prolonged hospital stays, as well as the occurrence of nonreimbursable “never events.” These all can be prevented by ensuring that patients can communicate clearly with their health care providers.<sup>41-43</sup>

This issue will take on greater financial importance because as part of the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services will limit reimbursement to hospitals that have excessive readmissions.<sup>41,44</sup> It also has direct implications for length of stay, complications, and readmissions related to surgical care.

As our health care systems move toward improving quality and controlling costs, particular focus needs to be placed on how to prevent medical errors for all patients in general and for vulnerable patients in particular.



## **Risk Management**

Identifying areas that expose the hospital or its health care providers to liability is critical in managing risk. Multiple liability exposures arise when providing care to LEP populations.<sup>13-15</sup> These include situations related to<sup>45</sup>:

- Patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and followup.
- Inaccurate and incomplete medical history.
- Ineffective or improper use of medications or serious medication errors.
- Improper preparation for tests and procedures.
- Poor or inadequate informed consent.
- Use of interpreters who are not properly trained, cannot operate effectively in a health care environment, or are not proficient in the patient's and clinicians' languages.

A recent study analyzed medical malpractice claims of a malpractice carrier that insures in four States to identify when language barriers may have resulted in harm to the patient.<sup>14</sup> In 35 claims (2.5 percent of the carrier's total claims reviewed), the carrier paid \$2,289,000 in damages or settlements and \$2,793,800 in legal fees. These claims highlight several points related to the failure to provide appropriate language services:

- The cases resulted in many patients suffering death or irreparable harm.
- In the claims analyzed, 2.5 percent of malpractice suits were related to language/interpretation problems at a cost of approximately \$5 million to the malpractice carrier.
- In 32 of 35 cases, the health care providers did not use competent interpreters. In 12 cases, family members or friends were used as interpreters, including minor children in two cases.
- Twelve of the claims involved the failure to translate important documents such as informed consent forms and discharge instructions.
- Nearly all the cases demonstrated poor documentation of a patient's limited English proficiency or the need for an interpreter (as well as documentation of other basic information).

The root causes of many of these claims constitute patient safety issues that expose hospitals to liability risks. For example, a patient's ability to read, understand, and act on health information has a direct impact on the physician-patient interaction and patient safety. As it relates to prescriptions, patients' ability to know if they have received the correct medication, or their ability to follow instructions regarding their medication (including dose, frequency and time), both constitute safety and risk management scenarios.

Written communications, in the form of appointment slips (appropriate time, date, location), referral slips (reason for referral, name and location of provider, instructions regarding preparation), intake and discharge instructions, and most commonly, informed consent, are all open to liability. As we look toward the future, developing provisions to address issues related to LEP will become a critical requirement of any risk management and patient safety strategy. If hospitals address LEP safety issues, many of these cases can be avoided.

## **Accreditation**

In August 2008, the Joint Commission, recognizing that the accreditation and regulatory environment provides a strong impetus for health care systems to respond to the needs of diverse patient populations, strategically charted a path for hospitals. The initiative advances the issues of effective communication, cultural competence, and patient- and family-centered care in hospitals. The project focused on developing

accreditation standards for the hospital program and resulted in the monograph *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*.

The Joint Commission monograph helps hospitals address unique patient needs, meet the new Patient-Centered Communication standards, and comply with existing Joint Commission requirements.<sup>46</sup> Several standards have direct relevance to patient safety. They include the following requirements:

- Hospitals orient staff on sensitivity to cultural diversity based on their job duties and responsibilities.
- Hospitals identify, and document in the medical record, the patient’s oral and written language and communication needs.
- Hospitals communicate with patients in a manner that meets these needs, including through the provision of language interpreting and translating services.

(Figure 4 contains the Joint Commission position on qualifications for medical interpreters.)

#### **Figure 4. Joint Commission Position on Qualifications for Medical Interpreters**

The hospital defines staff qualifications specific to their job responsibilities:

**Note 4:** *Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. (Inclusion of these qualifications will not affect the accreditation decision at this time.)*

Advancing effective communication, cultural competence, and patient- and family-centered care: a roadmap for hospitals. Oakbrook Terrace, IL: Joint Commission; 2010.

## **Common Causes of Adverse Events for LEP and Culturally Diverse Patients**

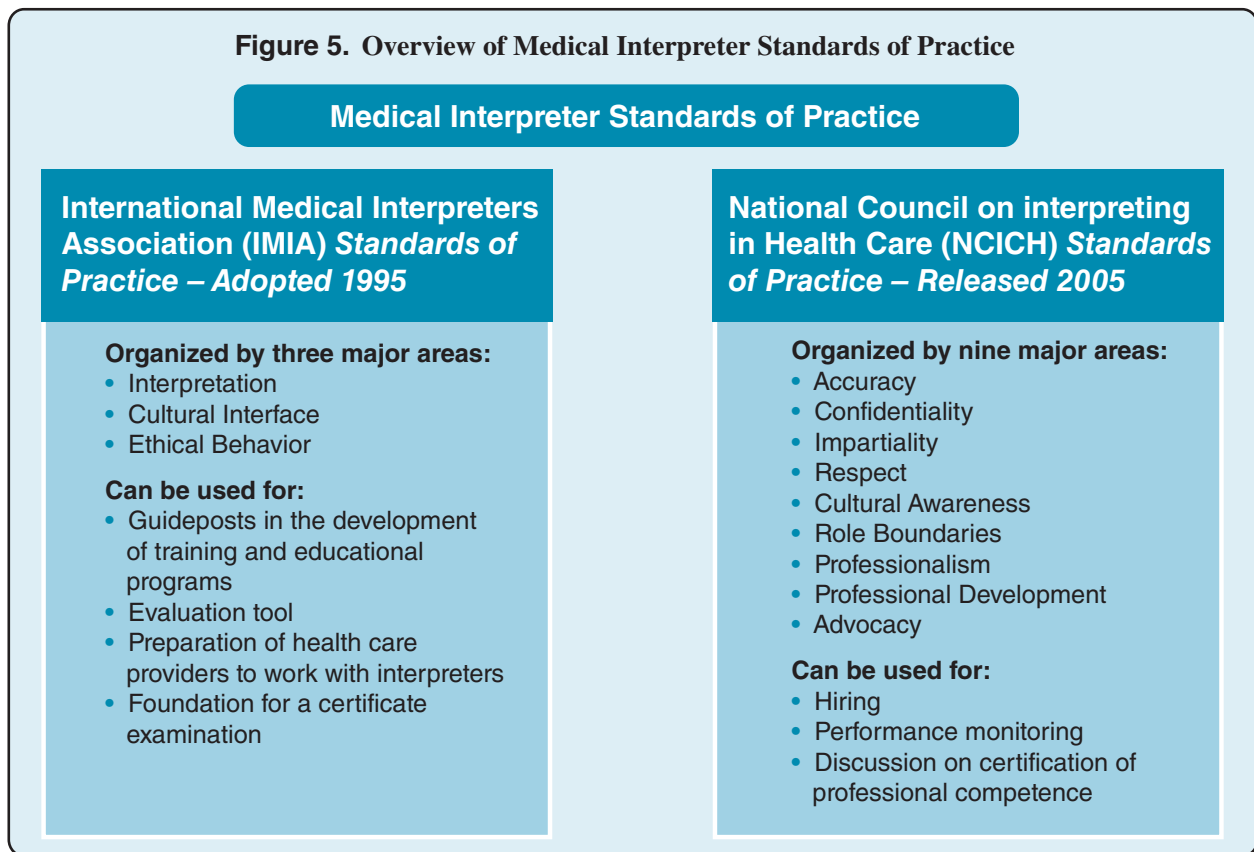
In addition to gathering the empirical data presented above, we conducted qualitative interviews and reviewed incident reports submitted by interpreters as part of an Interpreter Pilot. (Appendix D discusses methods.) We identified three common causes of errors (or potential errors) for LEP and culturally diverse patients: (1) use of family members, friends, or nonqualified staff as interpreters; (2) provider use of basic language skills to “get by”; and (3) cultural beliefs and traditions that affect care delivery.

Participants identified nonqualified interpreters as a primary root cause, as described above, and pointed more specifically to three situations affecting the safety of LEP patients. Qualified medical interpreters should receive basic training on medical interpretation and meet the standards of practice of the International Medical Interpreters Association or the National Council on Interpreting in Health Care (Figure 5). Use of the term “interpreter” in this guide refers to a qualified medical interpreter, unless otherwise specified.

### **Use of Family Members, Friends, or Nonqualified Staff as Interpreters**

- This is the most commonly reported cause of errors by frontline staff and leaders.
- It can lead to significant miscommunications between the patient and providers/care team.
- Time and time-related stressors (impatience by patient or provider, overbooked schedules, and prolonged waiting time for interpreters) contribute to the use of nonqualified interpreters.

- Family members and friends typically may not understand the subtle nuances of language and culture that may influence the interaction and may not question the use of medical terminology that they and the patient do not understand. Further, issues of confidentiality may prevent patients from disclosing critical health information.
- Research confirms that hospital staff often serve as interpreters for LEP patients, despite evidence that hospital staff who serve as interpreters on an ad hoc basis are more likely to make clinically significant mistakes than qualified medical interpreters.<sup>17,18</sup>



### Provider Use of Basic Language Skills To “Get By”

- This is the second most commonly reported behavior by frontline staff and leaders.
- Clinicians with basic or intermediate foreign language skills often attempt to “make do” or “get by” without the use of a qualified interpreter.<sup>17,19</sup> In some cases, providers mistakenly used seemingly similar languages, such as Spanish for Portuguese or French for Haitian Creole.
- A major factor contributing to errors are providers’ assumptions that patients understand the information exchanged based on nonverbal clues, such as nodding or smiling.
- Using a provider’s language skills instead of an interpreter may also contribute to the risk of patient safety events, even if the provider is proficient, by adding to the provider’s cognitive load. In addition, nonbilingual team members cannot identify potential patient safety concerns.
- It is critical that bilingual staff are language certified and receive training in interpretation if they are used when medical interpreters are not present or are unavailable for the medical encounter. Language and interpretation skills should be tested and validated on a regular basis.

## **Cultural Beliefs and Traditions Affecting Patient Care**

- LEP patients may also have cultural beliefs and traditions that can influence the medical encounter and subsequent health outcomes in subtle and often invisible ways. These include minimizing reports of pain, respecting authority, and adhering to specific gender roles, as well as class biases.
- If providers or the medical team do not have the general knowledge of cultural traditions or beliefs of their patients, these cultural nuances are easily overlooked.

Real-life case examples, taken from a participating hospital's patient safety reports, provide insight into commonly reported LEP safety issues (Figure 6, below).

## **High-Risk Scenarios**

Our research has identified several clinical situations, which we call *high-risk* scenarios, where adverse events and medical errors are most likely to occur among LEP and culturally diverse patients.

### **Medication Reconciliation**

Medication reconciliation is essential to ensure patient safety. It requires both patients and providers to communicate accurately about the patient's medications, including mode of administration, allergies, and potential side effects. This is complicated for all patients and may be even more difficult for LEP patients due to language barriers.

### **Patient Discharge**

Understanding discharge instructions, such as information on how to manage the condition, what should trigger a return visit, when to return for routine followup, and how to take prescribed medications, is important and challenging for all patients. LEP patients have been shown to have limited understanding about discharge instructions. *Speaking Together: National Language Services Network*, a project funded by the Robert Wood Johnson Foundation, found the need for greater use of interpreters at key moments of information exchange, such as at assessment and discharge, not just during the acute phase of treatment.<sup>47</sup>

### **Informed Consent**

Ensuring patient safety requires that patients be informed and participate in their own medical decisionmaking as fully as they want and can. LEP patients should not be excluded from learning about uncertainty, risks, and treatment choices that might affect their health and well-being. Obtaining informed consent for diagnostic and therapeutic procedures, including for emergent or elective surgery, can be a complicated and difficult process. But it remains a hallmark of patient safety and a critical medical and legal responsibility. Due to language and cultural barriers, achieving truly informed consent for LEP patients may require extra effort.

### **Emergency Department Care**

Care in the emergency room is commonly provided in a hectic and hurried fashion, especially given the high volume and breadth of issues managed in that environment. Frequently, important decisions need to be made quickly, and accurate information about previous conditions, surgeries, medications, and allergies are paramount to high-quality patient care and the prevention of medical errors.

### **Surgical Care**

Several key provisions are essential to a successful, uncomplicated surgical procedure. For example, prior to surgery, patients need to understand when to begin fasting and which medications to continue, discontinue, or alter. Surgeons must know whether the patient has had any prior complications with

surgery. Anesthesiologists need to ensure that the patient can tolerate anesthesia and intubation and does not have any allergies that might pose a risk. Just before surgery, the surgical team needs to ensure that they are performing the correct procedure on the correct side on the correct patient. After surgery, patients must have a clear understanding of how to care for themselves in the hospital (e.g., whether to get up without assistance or call for help). Miscommunication at any of these stages can have serious, if not fatal, consequences.

Figure 6 shows examples from actual patient safety reports that illustrate the delays and errors that can occur without appropriate language assistance.

### **Figure 6. Real-Life Case Examples of Patient Safety Reports**

The following are real patient safety reports from one hospital in our study that illustrate key issues related to language assistance.

#### **Delays**

1. Patient arrived in Hemodialysis Unit to do stat chest x-ray; patient had no identification wristband and could not verify because does not speak English.
2. Patient did not have a stress test because a Spanish interpreter was not available. This delayed discharge at least 24 hours.
3. New patient arrived in infusion unit for 1st IP taxol appointment without orders, consent, or a recent physician's note. Patient did not speak English. Interpreter and MD called. Delay in treatment resulted.

#### **Medical Errors**

4. Patient is Ethiopian speaking. On multiple occasions there had been a failure to provide an interpreter. She has been using family members to translate, and they are not always available. This is unacceptable, as we have had issues with medications (i.e. which to take, when) and I believe her worsening diabetes is a direct result of my inability to have effective clinical meetings with her.
5. Patient came down with his mother for a KUB film. Most exams that are automatically scheduled are chest exams and so I performed one in error. Usually I verify the exam with the patient but he was eleven years old and his mother couldn't speak English. Immediately after I realized I had done the wrong exam I called the doctor and had him reorder the exam and I performed the correct one.
6. Informed consent obtained with no Spanish interpreter in Emergency Room; patient did not understand the procedure when asked by interpreter.
7. Patient was just admitted to the Step Down Unit from the Medical Intensive Care Unit and was reported to be AOx3 (awake and alert) but Greek speaking primarily. Patient was found on the floor, cardiac monitor attached, and foley still attached to bed. Patient gestured she was going to the bathroom unassisted.
8. LEP Patient arrived in the Step Down Unit s/p Thoracic Surgery. Hypertension in OR and upon arrival to Recovery Room, 205/97. Patient with history of CVA in past month, no past medical history or medication list available. Anesthesia unable to give proper report or orders for hypertension management due to lack of information.

## Chapter 2:

# Five Key Recommendations To Improve Patient Safety for LEP Patients

Hospitals of all types can engage in a systematic approach to better identify and prevent medical errors and adverse events that occur commonly among LEP patients. This chapter contains five key recommendations to improve detection of medical errors across diverse LEP populations and prevent high-risk scenarios from becoming safety events. Resources and tools from the TeamSTEPPS® LEP Module, which is further described in Chapter 3, are also highlighted throughout this chapter.

As with any organizational change, some activities build on current capacities and are easier to implement, while others might require more time, effort, and resources. Hospital quality and safety leaders have many opportunities to meet their obligation to build a patient safety system that takes the issues of LEP and patient diversity into account.

The following chapter will provide an overview (see Figure 7) of the following strategies:

- Foster a Supportive *Culture* for Safety of Diverse Patient Populations.
- Adapt Current Systems To Better *Identify* Medical Errors Among LEP Patients.
- Improve *Reporting* of Medical Errors for LEP Patients.
- Routinely *Monitor* Patient Safety for LEP Patients.
- *Address* Root Causes To Prevent Medical Errors Among LEP Patients.

We will then provide specific guidance on how to address the *high-risk scenarios* we have defined previously.

The recommendations provided here represent the *ideal* situation in which these issues can be addressed. We understand that hospitals may have resource or other limitations that preclude a full rollout of these strategies all at once. Therefore, we recommend that hospitals with resource or other limitations begin incrementally by choosing any strategies that can be readily implemented and, at a minimum, focus on addressing the root causes that lead to high-risk scenarios for medical errors among LEP patients.

## Foster a Supportive Culture for Safety of Diverse Patient Populations

### Background

Patient safety requires an organizational culture that supports identifying, reporting, and discussing near misses and medical errors, as well as developing strategies to prevent them. Leadership must communicate the importance of a just culture, where a balance is maintained between a blame-free approach to facilitate a focus on systems and accountability for reckless behavior.<sup>48,49</sup> Leadership must also communicate the importance of a blame-free environment and the need to learn from mistakes to improve quality of care.

Although creating this environment can be challenging, evidence has shown it has been accomplished more generally by many hospitals across the Nation.<sup>50</sup> However, our research reveals that little attention has focused on creating a culture that supports safety for diverse populations in particular, including LEP patients. Systems for identifying, reporting, and monitoring errors across diverse populations, and strategies to address the root causes of these errors, are few and far between and rarely if ever include a focus on leadership. The institutional culture needed to support work in this area has not been created but remains essential if efforts in this area are to succeed.

## Findings

Our research revealed several key areas for improvement to ensure that addressing issues of LEP and culturally diverse patients is seen as an essential part of the **safety culture**:

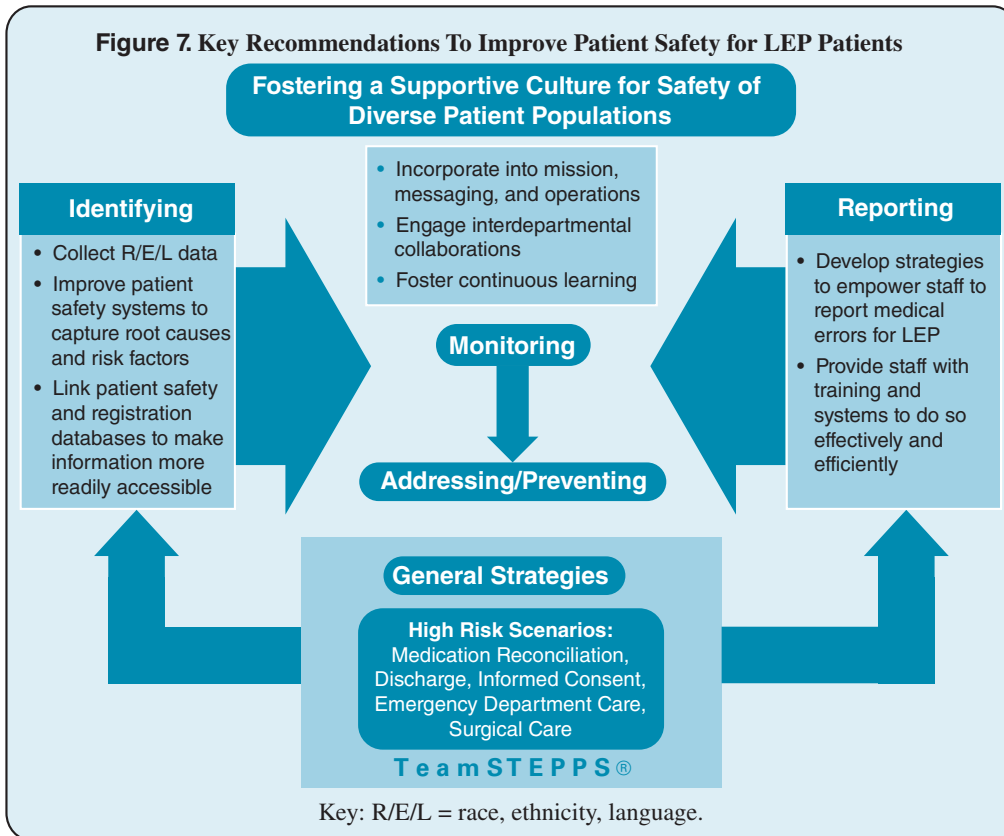
- Support from leadership is currently absent but required.
- Institutional buy-in must be achieved within the organization and the message must get on the staff's radar-screen, as it is not there now.
- A set of policies and strategies is needed to support individuals' work and to ensure that the tools and processes are in place for them to succeed. These are largely missing today.
- Although historically physicians have shied away from discussing errors with patients, when done properly, disclosure can create a culture of safety and reduce the likelihood of a lawsuit.

## Recommendations

Foster a supportive culture for safety of diverse patient populations, articulated clearly by leadership, operationalized in strategic planning for the organization, and supported by providing staff with the key tools and resources to accomplish this goal.

1. Assess the current safety climate<sup>51-54</sup> and interweave language and cultural barriers into the overall message and mission of the culture of quality and safety. Frame messaging within the existing efforts and standards related to quality and safety for all patients.
2. Share lessons learned from patient safety events with all staff to help build an institutional culture sensitive to issues that affect LEP patients; and ensure ongoing learning and training in this area. Involve patients in family advisory councils or cultural advisory groups to incorporate patient perspectives.
3. Include the goal of improving care and patient safety for LEP patients within the organization's operating plan. Recognize leadership's role in supporting staff to better care for LEP patients and families by building expectations into staff training, new employee orientations, and performance management systems.
4. Develop collaborations between quality and safety departments and interpreter service departments to help align the message among diverse staff. These types of collaborations (e.g., training forums, information sessions, patient rounds) and messaging can also help dispel the power dynamics between staff, interpreters, and physicians that deter the reporting process.
5. Ensure that clinicians communicate effectively about errors with patients and their families.<sup>55-57</sup> Clinicians should receive training on guidelines for disclosing medical errors to patients,<sup>58</sup> specifically for LEP patients when additional factors (e.g., language and cultural beliefs) may affect the discussion.

The TeamSTEPPS LEP Module provides hospitals with tools to assess organizational readiness and provides all staff with communication skills that help build a supportive culture of safety for LEP patients.



## Adapt Current Systems To Better Identify Medical Errors Among LEP Patients

### Background

To accurately identify and analyze medical errors that occur due to language barriers and cultural differences, data on race, ethnicity, language preference, and English proficiency must be collected routinely on all patients.<sup>59</sup> This task may be especially difficult in pediatric settings where race, ethnicity, and language preference data are collected on the parent or caregiver as well as the patient. Without this information (ideally collected at patient registration), hospitals are limited in their ability to address high-risk scenarios that may prevent safety events among LEP patients.

### Findings

Our research revealed several key areas that need improvement to ensure that patient safety systems are able to identify medical errors among LEP and culturally diverse patients.

- The current capacity to identify medical errors in LEP patients is severely limited by the lack of systematic collection of race, ethnicity, and language preference (REL) and English proficiency data across the country. This data collection is absolutely necessary.
- Even when REL data are collected, they are rarely linked to the patient safety reporting system. Creating these links would facilitate identification of errors involving LEP patients.

The TeamSTEPPS LEP Module encourages frontline staff to collect REL data early in the care process and encourages hospitals to document REL and cultural factors in patient safety reporting systems.



- The role of cultural values and beliefs may also be an important component in patient safety issues affecting LEP and culturally diverse patients. However, current patient safety systems in hospitals are not tailored to capture the specific contributing factors that may compromise care for LEP patients. Capturing this key information is essential to the care of diverse populations.

## Recommendations

Adapt current systems to better identify medical errors in LEP patients by collecting patients' REL data at registration, improving the capacity of patient safety systems to capture key root causes and risk factors for LEP patients, and linking these databases so that this information is readily accessible.

1. Collect REL data systematically at registration, early in the care process (see Figure 8). This process could be facilitated by:
  - Ensuring that when patients register by phone to schedule an appointment, or if experiencing an emergency, they can indicate language preference and whether an interpreter is needed.
  - Creating prompts in scheduling systems for frontline staff to ask about language preference and English proficiency to determine interpreter needs.

### Figure 8. Collecting Race, Ethnicity, and Language Data

The Health Research and Education Trust's (HRET) Disparities Toolkit ([www.hretdisparities.org/index.php](http://www.hretdisparities.org/index.php)) provides guidelines and resources for systematically collecting REL data from patients. The HRET Disparities Toolkit provides a rationale for the systematic collection of REL data, as well as resources for staff training on how to ask related questions that will assist hospitals in the data collection process.

2. REL data should be documented whenever possible in the electronic medical record to allow ongoing monitoring and easy integration with other reporting systems for quality of care monitoring purposes.
3. Patient safety systems should include data fields to track the role of language and culture in the patient safety events reported by staff (see Figure 9). To support this practice, we recommend that the standard formats for patient safety events be augmented by adding the following fields:
  - A field for patient preferred language and English proficiency.
  - A field for whether a hospital interpreter was present at the time of the adverse event or was used at any time during the visit.
  - A field to document if a hospital interpreter was called and did not show up at the time of the event or during a patient appointment.
  - A field to document the use of family or other nonqualified personnel for interpretation during the hospitalization or at the time of the adverse event.
  - An open text field that would allow information on the role of cultural values or beliefs to be documented.

We also recommend developing comprehensive data analysis systems and tools to facilitate a better understanding of the root causes of medical errors and adverse events among LEP and culturally diverse patients.

## Figure 9. Patient Safety Reporting: Collecting Data on Language and Culture

Only one of the hospitals interviewed as part of our study was systematically documenting language and culture as part of its patient safety reporting system. This hospital utilized a drop-down menu that included the option of “communication” as a factor contributing to the medical errors, and recently expanded the options to include “communication issues with LEP patients,” and “interpreter services” (e.g. interpreter did not show up to encounter). This system is just being rolled out and there is no evidence at this time on its effectiveness. It does, however, allow for discussion and feedback from multiple departments, especially if “interpreter services” is documented on the incident report. This allows for a response and negotiation of how to address such situations moving forward.

## Improve Reporting of Medical Errors for LEP Patients

### Background

The effectiveness of patient safety reporting systems is predicated on several key conditions. These include user-friendly tools that facilitate reporting, staff who are educated about the issue of safety and the reporting process, and, most important, organizational culture that makes staff members feel comfortable making reports when events arise. Absence of any of these conditions limits an organization’s ability to identify and subsequently prevent errors. A fair amount of effort has been spent on developing systems for reporting. The personal component, whether staff feel empowered and have the knowledge and ability to submit a report, has received less attention, particularly as it relates to issues that emerge in LEP patients.

### Findings

Our research revealed several key areas in need of improvement to ensure that staff are empowered and can identify and report medical errors that occur among LEP and culturally diverse patients:

- Interpreters and frontline staff worry that they will be perceived as spies or snitches if they report errors, making them reluctant to do so.
- Frontline staff and interpreters have limited knowledge about issues related to patient safety. They do not receive training on what constitutes an error or a near miss, or on how to report these when they occur.
- Current safety reporting systems are seen as complicated and burdensome, rather than user friendly.

The TeamSTEPPS LEP Module provides interprofessional care teams with structured communication tools to help dispel hierarchical challenges and build trust among care team members.

### Recommendations

Develop institutional strategies to empower frontline staff and interpreters to report medical errors, and provide them with the training and systems to do so effectively and efficiently.

1. Create a hospitalwide public relations campaign (e.g., National Patient Safety Foundation’s National Patient Safety Awareness Week) about the importance of safety reporting, with a particular focus on the issues that frontline staff and interpreters are concerned about (e.g., being viewed as snitches, losing trust of health care providers, being alienated from the care team).

The TeamSTEPPS  
LEP Module empowers  
interpreters to be cultural  
brokers by providing  
structured communication  
tools

The TeamSTEPPS  
LEP Module trains  
leaders to hold “Briefs”  
with interpreters prior to  
clinical situations.

2. Develop targeted messages so that frontline staff and interpreters are empowered to report any patient safety events they might encounter.
3. Train all staff, particularly frontline staff and interpreters, on the full spectrum of what constitutes a patient safety event (including near misses) and how to report them. Create educational sessions led by the quality and safety team (see Appendix A for recommendations for training).
4. Create or restructure reporting systems based on the “Just Culture” model. This model strikes a balance between blameless reporting and accountable care. It focuses on removing stigma associated with medical errors to allow an open environment of error reporting. Use medical error reporting as a learning tool for greater hospital staff understanding, and expand the array of punitive measures to include lesser penalties for more minor errors.<sup>60</sup>
5. Create or restructure reporting systems that are easy to use and efficient so that even interpreters who are not hospital staff members can complete an incident report quickly.
6. Consider developing other methods of identifying errors outside of standard reporting, such as audio-recorded systems, paper, routine focus groups, or conferences with frontline staff and interpreters, especially to capture near misses.

## Routinely Monitor Patient Safety for LEP Patients

### Background

To improve quality and safety continually, organizations must routinely generate reports or dashboards that document their performance in achieving quality objectives and reducing medical errors. This process provides opportunities for identifying problem areas and strategies for quality and safety improvement internally while responding to requirements for external reporting. The need for routine, systematic monitoring of quality and safety will only be magnified by the current push for public reporting and new approaches that result from payment reform. As it relates to safety in particular, it is essential that hospitals develop systems to routinely monitor adverse events, and analyze their root causes.

### Findings

Our research revealed a significant need for improvement in the area of monitoring safety among LEP and culturally diverse patients:

- Hospitals and health systems do not routinely monitor medical errors for LEP patients.
- Hospitals rarely analyze events that occur among culturally diverse and LEP patients.

### Recommendations

Develop systems to monitor patient safety among LEP patients routinely, as well as processes to analyze medical errors and near misses that occur among these populations.

1. Develop routine (e.g., quarterly, yearly), hospitalwide safety reports or dashboards that focus on patient safety among LEP patients. Link monitoring efforts to a quality committee or patient safety committee to create accountability and assistance with reporting mechanisms. Strategies from the section titled *Adapt Current Systems To Better Identify Medical Errors in LEP Patients* can provide guidance on how to populate these reports. For example, when one hospital analyzed their patient safety report database by keywords (e.g., language, interpreter, language barrier) and generated a monitoring report, they found the following key issues for LEP patients:
  - Care routinely provided without an interpreter.
  - Wrong language interpreter being sent.
  - Family member or untrained staff person used as interpreter.
  - Written translation errors.
2. Create routine forums (e.g., M&M-style conferences) to analyze medical errors and near misses among LEP and culturally diverse populations to better understand root causes and high-risk scenarios, and develop strategies for improvement and error prevention.

The TeamSTEPPS LEP Module provides additional resources on evaluation metrics for monitoring patient safety events, including participant reactions, learning, changes in behavior, and outcomes.

## Address Root Causes To Prevent Medical Errors Among LEP Patients

### Background

Medical errors among LEP patients can be prevented by addressing their root causes and by targeted prevention strategies. These strategies might include a focus on particular high-risk scenarios that build on a robust patient safety identification, reporting, and monitoring system.

### Findings

Our research revealed a need for significant improvement in the capacity of hospitals to prevent medical errors among LEP and culturally diverse patients:

- Dedicated interpreter services – ranging from trained, in-person interpreters to telephonic interpreting, as well as translated materials (e.g., informed consent forms, procedure preparation instructions) – are yet to be commonplace in all hospitals.
- If in-person interpreter services are available at hospitals, they are rarely effectively coordinated to ensure the timely provision of clinical services.
- Staff and clinicians lack awareness about the impact of LEP status on patient safety.
- Interpreters are often not treated as team members or with respect. Several incidents of doctors, nurses, and other staff displaying ignorance, condescension, impatience, and rudeness toward interpreters and LEP patients were reported.
- Limited training is provided to clinicians and staff members on team communication, interpreter use, cultural competence, and patient advocacy.
- A set of policies or protocols does not exist for how to manage high-risk scenarios to prevent medical errors among LEP patients.

## General Recommendations

Develop strategies and systems to prevent medical errors among LEP patients. These include strengthening interpreter services, improving coordination of clinical services, providing translated materials, and developing training for health care providers and staff on team communication, interpreter use, cultural competency, and advocacy.

1. Develop dedicated services for interpretation that include qualified medical interpreters, in person or telephonic (see Figure 10).
2. Provide patients with written materials, such as informed consent forms or procedure instructions, in their preferred written language.
3. Identify patients' language needs on boards on the inpatient floors that list current patients and responsibilities.
4. Create a mechanism to schedule an interpreter automatically at clinical points of service for LEP patients (see Figure 11).
5. Develop visual cues to remind hospital staff to attend to language and cultural needs (see Figure 12).
6. Train staff on team communication, interpreter use (Appendix A), cultural competency (Appendix A), and advocacy (see Chapter 3 focusing on TeamSTEPPS).
7. Consider other initiatives to improve safety for LEP and culturally diverse patients (see Figure 13).

### Figure 10. Improving Access to Interpreter Services

At Massachusetts General Hospital, in addition to having in-person trained medical interpreters, each inpatient care unit houses an Interpreter Phone On a Pole, which can be rolled into any patient's room and hooked up to a wall jack to provide telephonic interpretation on demand in any language.

Some hospitals provide patients with an "interpreter requested card" in their language and in English that can be used throughout the care process to notify clinicians and other staff that the patient requires an interpreter. This strategy visually reminds staff of the patient's LEP status and helps encourage patients to participate in their care.

### Figure 11. Mechanisms for Scheduling Interpreter

One hospital described a system that flags previously hospitalized LEP patients at admission and automatically links them to Interpreter Services. The patient is then placed in a queue to be checked on (regardless of whether interpreters conduct rounds to check on LEP patients).

### Figure 12. Visual Cues for Language and Cultural Needs

Hospitals often devise creative systems to assess and address patients' language needs. One hospital reported using orange bracelets to indicate LEP patients, marking the language on the bracelet so that every care team member would instantly know the patient's language of care. This solution was devised in consultation with the community, and the color orange was chosen because it was not offensive to any of the major language groups represented.

### Figure 13. Other Initiatives To Improve Safety for LEP and Culturally Diverse Patients

- Develop community advisory boards that can provide insight on key issues related to patient safety in diverse communities.
- Hire staff who reflect the linguistic and cultural diversity of the service area.
- Use a community health worker or patient navigator whose purpose is to bring together all necessary members of the care team to work on cases that are complicated by cultural and linguistic issues.
- Create “Language Champion” teams of trained nurses and social workers who try to increase and improve the use of interpreters for LEP patients and families. These can be the first line of communication for LEP patients and can coordinate with patients, families, and other staff.
- Have interpreters conduct regular rounds on inpatient units as a resource for both patients and providers. As part of regular rounds, interpreters would be checking in on LEP patients, even when clinicians do not page them, as an additional support network.
- Have interpreters included and present at medical rounds for LEP patients.

*“When [interpreters are] doing rounds members of the care team sometimes jump onto the bandwagon to communicate essential information about medications. They check in to see if anybody needs them; it’s made a big difference in making them available” (Leader, Nursing).*

*“Some way you build in having physicians, the nurses, the social worker, the case manager, and the interpreter all together in an organized way discussing a patient. I think that would be an improved communication strategy” (Leader, Nursing).*

### Specific Recommendations for High-Risk Scenarios

Our research suggests that certain high-risk clinical situations need immediate attention to prevent adverse events among LEP patients. Ensuring that resources are available to address these high-risk clinical situations should be a priority. These high-risk scenarios include: medication reconciliation, patient discharge, informed consent, emergency department care, and surgical care.

Below are three key recommendations to address these high-risk scenarios:

- Require presence of qualified interpreters.
- Provide translated materials in preferred language.
- Use “teach-back” to confirm patient understanding.

In brief, requiring the presence of qualified medical interpreters is necessary for all high-risk scenarios. Further, providing translated materials in plain language is critical, especially in the case of discharge instructions, informed consent, and surgical care (e.g., pre- and post-op instructions). Using “teach-back” is an effective strategy to confirm patients’ comprehension of care processes, particularly instructions for self-care.

## Chapter 3:

# Improving Team Communication To Foster Safety for LEP Patients: TeamSTEPPS® LEP Module

Providing safe and effective care for LEP patients requires that all members of the health care team, including physicians, nurses, interpreters, and frontline staff, work together effectively. Given that team functioning around the care of LEP patients may be suboptimal, one important part of improving care for this vulnerable population is to create a more effective team dynamic that fosters attention to the intersection between language barriers and patient safety.

While the previous chapter describes specific mechanisms to identify, report, monitor, and prevent patient safety issues for LEP patients, this chapter will focus more specifically on team performance and care delivery on the ground. **We will describe a new training module that is part of the TeamSTEPPS patient safety system. This tool centers on a set of team behaviors and structured communication tools to improve patient care and reduce medical errors for LEP and culturally diverse patients.** Figure 14 presents an overview of the LEP Module.

### Figure 14. TeamSTEPPS LEP Module Objectives and Teaching Methods

**The TeamSTEPPS LEP Module** trains interprofessional care teams working together in hospital units to acquire the knowledge, attitudes, and team behaviors needed to reduce the number and severity of patient safety events affecting LEP and culturally diverse patients in their unit.

#### Training Objectives:

Participants (doctors, nurses, technicians, front desk staff, and interpreters) will be able to:

1. Understand patient safety risks to LEP and culturally diverse patients.
2. Assemble the most appropriate and effective care team in their hospital.
3. Identify and raise patient communication issues.

#### Teaching Methods Include:

- “Train the trainer” module.
- Workshop materials, including slides, handouts, and exercises.
- Video vignettes to illustrate key concepts.
- Evaluation guide and metrics.

*TeamSTEPPS was developed initially by the Agency for Healthcare Research and Quality and the Department of Defense. More information is available at [teamstepps.ahrq.gov/](http://teamstepps.ahrq.gov/).*

TeamSTEPPS is presented here as *one* way a hospital can implement the key processes to improve safety for LEP patients (identify language needs, call for interpreter, empower interpreter to be a member of the care team, address interpreter shortages). However, it is just one tool, and we encourage hospitals to implement the recommendations in this guide any way they can, using any tools at their disposal.

Unlike other team-based trainings, TeamSTEPPS does have several advantages, including that it is evidence based and field tested, comprehensive, customizable, and publicly available at no cost. Most important, it provides easy-to-use teamwork tools and strategies.

## Background on TeamSTEPPS and the TeamSTEPPS LEP Module

In November 2006, AHRQ, in collaboration with the Department of Defense, released Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) as the national standard for team training in health care.<sup>20</sup> TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system. The approach is scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles.

TeamSTEPPS was originally successfully implemented through military health care and has recently been expanded nationally and implemented at hospitals across the country. There are currently five national implementation centers (Team Resource Centers) nationwide. These centers offer training to create a national network of master trainers, who in turn offer TeamSTEPPS training to frontline providers in hospitals and other health care settings throughout the country. Recent research has shown that TeamSTEPPS is effective in multiple settings at improving care outcomes, team communication, and team attitudes.<sup>21-24</sup>

TeamSTEPPS provides higher quality, safer patient care by:

- Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.
- Increasing team awareness and clarifying team roles and responsibilities.
- Resolving conflicts and improving information sharing.
- Eliminating barriers to quality and safety.

TeamSTEPPS has a three-phase process aimed at creating and sustaining a culture of safety (see Figure 15 for brief overview). This process includes:

- Pretraining assessment for site readiness.
- Planning, training, and implementation.
- Sustainability.



## **Figure 15. TeamSTEPPS Overview**

### **Main Phases of TeamSTEPPS**

#### **1. Pretraining assessment**

- a. Establish organizational-level change team
- b. Conduct site assessment
- c. Define challenge, opportunity, or improvement
- d. Define goal of your intervention

#### **2. Planning, training, and implementation**

- a. Define TeamSTEPPS intervention
- b. Develop plan for determining intervention effectiveness
- c. Develop implementation plan
- d. Gain leadership commitment to plan
- e. Develop communication plan
- f. Prepare institution
- g. Implement training

#### **3. Sustainability**

- a. Provide opportunities for practice
- b. Ensure that leaders emphasize new skills
- c. Provide regular feedback and coaching
- d. Celebrate wins
- e. Measure successes
- f. Update the plan

The three phases of TeamSTEPPS are based on lessons learned, existing master trainer or change agent experience, quality and patient safety literature, and culture change. A successful TeamSTEPPS initiative requires a thorough assessment of the organization and its processes and a carefully developed implementation and sustainability plan. A change team is expected to drive the process within each institution that implements the system.

The change team is typically composed of four to six “change agents” who are respected individuals with the motivation and skills to effect change. As part of the process, each institution sends individuals to a “master training.” Master trainers then return to their home institutions to train interprofessional care teams within one or more units of the hospital.

We have used the principles and structure of the TeamSTEPPS approach to develop a TeamSTEPPS LEP Module specifically focused on building a health care team’s capacity to improve safety for LEP patients.<sup>61</sup>

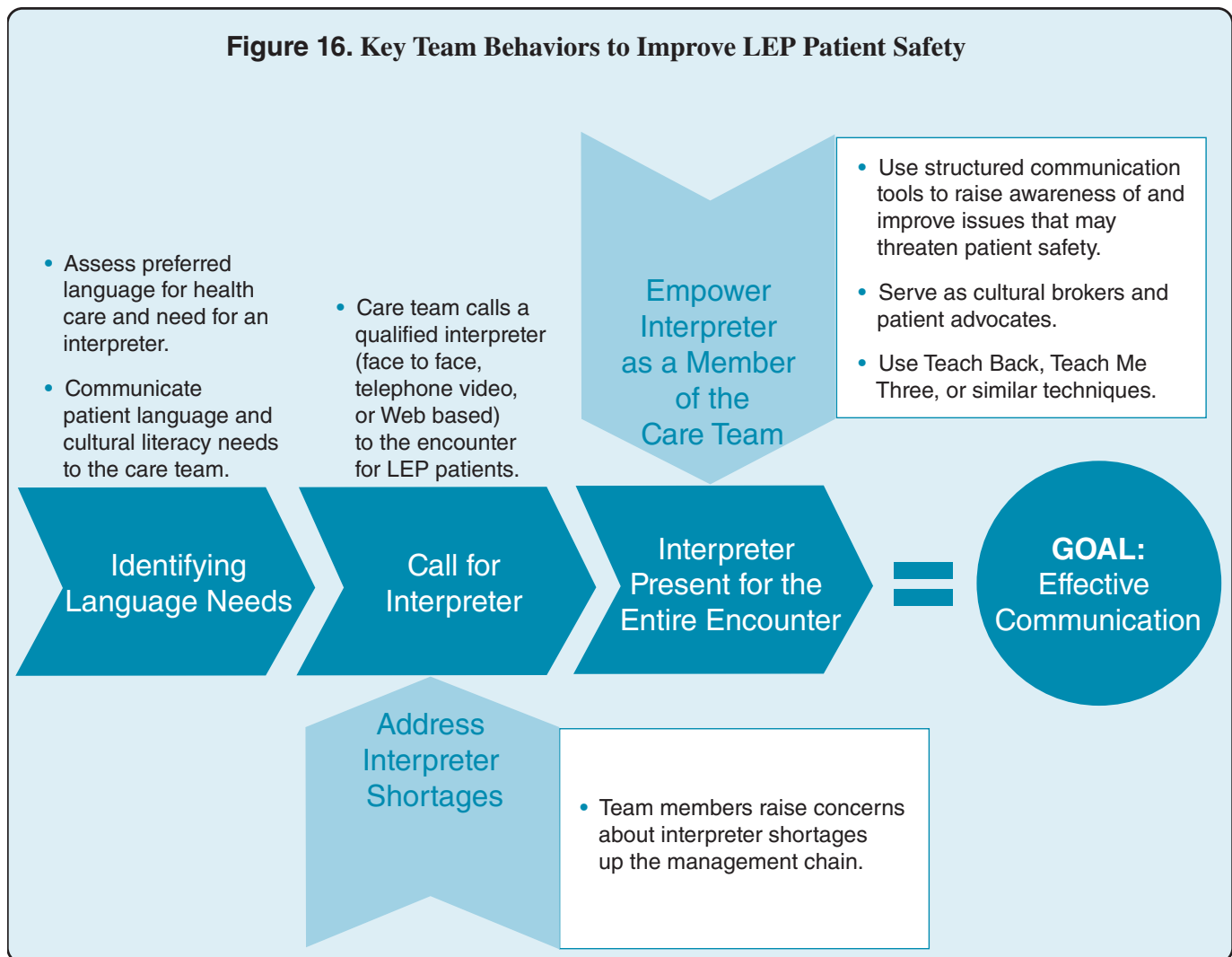
## TeamSTEPPS Module Content: Team Behaviors To Improve LEP Patient Safety

Improving team communication when caring for LEP patients is a complex process, but it can be broken down into some basic components. Based on a review of the literature and findings from our research, we identified several key team behaviors that are central to improving patient safety for LEP and culturally diverse patients (Figure 16). While these do not represent a complete list of issues, they are a useful framework from which to start and are at the core of the TeamSTEPPS LEP Module content. The case example, presented in Appendix B, provides a common miscommunication scenario due to language and highlights potential negative outcomes that would occur if the following steps below were not taken properly.

### Identifying Language Needs

Team behavior:

- Front desk staff effectively assess preferred language for health care and need for an interpreter. This may include an assessment of cultural and literacy needs.
- Front desk staff rapidly and effectively communicate patient language, cultural, and literacy needs to the care team.



## **Calling for Interpreter and Interpreter Present for the Entire Encounter**

Team behavior:

- The care team calls a qualified medical interpreter to the encounter for LEP patients. This may include face-to-face, telephone, video, or Web-based interpreters.
- An interpreter is present (either in person or by phone or video) from the beginning of the encounter to its end.

## **Empowering Interpreter To Be a Member of the Primary Care Team**

Team behavior:

- The interpreter uses TeamSTEPPS structured communication tools to bring to the providers' attention conditions that may threaten LEP patients' safety.
- The care team uses TeamSTEPPS structured communication tools to elicit, recognize, and act upon information provided by the interpreter to improve LEP patient safety.
- The care team works with the interpreter to assess patient understanding through the use of the Teach-Back, Teach Me Three (questions that guide Teach-Back ), or similar techniques.

Structured communication tools include:

- Briefs to designate team roles and responsibilities and establish psychological safety and goals for all team members.
- Check-backs to verify that all team members share the same understanding.
- Teach-backs to confirm patient understanding by having patients explain in their own words what they were told.
- CUS words: an agreed-upon communication tool that any team member can use to stop the action at any time when there is any concern for miscommunication or risk to patient safety. The CUS words are Concern (“I am concerned that...”), Uncomfortable (“I am feeling uncomfortable because...”), and Safety (“This is a safety issue.”).

These are described in more detail in Appendix B, *Bringing It To Life – A Case Study*, which is adapted from the TeamSTEPPS LEP Module.

## **Addressing Interpreter Shortages**

Team behavior:

- Team members raise concerns about interpreter shortages up the management chain.

## Summary of TeamSTEPPS LEP Module

The purpose of the TeamSTEPPS LEP Module is to train interprofessional care teams working together in hospital units on the knowledge, attitudes, and team behaviors needed to reduce the number and severity of patient safety events affecting LEP and culturally diverse patients in their unit. The intent is to train doctors, nurses, technicians, front desk staff, and interpreters together so that they will improve their team dynamics.

The module provides facts and statistics regarding the increased patient safety risk to LEP patients and encourages hospitals to provide local data on their LEP patient population and describe existing policies on interpreter services. Hospitals will highlight risks specific to their LEP population and work with unit staff to refine and reinforce their process, roles, and responsibilities in accessing language assistance. The module also provides structured communication tools, such as briefs, check-backs, and teach-backs, to make it easier for staff members and patients to identify and raise patient communication issues. Finally, trainees will learn how to prevent miscommunication by creating a psychologically safe environment for others to clarify misunderstandings.

The TeamSTEPPS LEP Module, which can be used to augment core TeamSTEPPS training or as a standalone training, is an easy-to-use comprehensive multimedia kit that contains:

- “Train the trainer” module.
- Workshop materials, including slides, handouts, and exercises.
- Video vignettes to illustrate key concepts.
- Evaluation guide and metrics.

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# Appendix A: Recommendations for Staff Training

## Patient Safety Training for Nurses, Interpreters, and Frontline Staff

Train all staff, particularly frontline staff and interpreters, on the full spectrum of what constitutes a patient safety event (including near misses) and how to report them. Below are recommendations for training and educational sessions in this area:

- Include a focus on the definition of a patient safety event or medical error, as many interpreters and nonclinical frontline staff had a difficult time providing definitions of patient safety events and medical errors.
- Emphasize potential differences between patient safety events and adverse events and distinguish between actual errors and near misses.
- Provide data and specific examples of the ways limited-English-proficient (LEP) and culturally diverse patients are at greater risk for medical errors and patient safety events due to language and cultural barriers.
- Clarify roles and responsibilities for all clinical and nonclinical staff pertaining to reporting safety events and emphasize that all staff are responsible for reporting. Our study revealed that nonclinical staff might not report a patient safety event since they believe it is the responsibility of the clinicians on the care team.
- Incorporate instructions on how to use reporting systems to document and record medical errors and near misses.
- Using the Hospital Survey on Patient Safety Culture, evaluate whether training has made staff more likely to report an error. Available at: [www.ahrq.gov/qual/patientsafetyculture/hospindex.htm](http://www.ahrq.gov/qual/patientsafetyculture/hospindex.htm).

### Train Staff in Cultural Competence

Cultural competence training attempts to provide health care professionals with the tools and skills to communicate effectively across cultures. Some hospitals currently incorporate aspects of cultural competence into other trainings for clinicians and other staff. However, rarely, if ever, do these trainings focus on how cross-cultural issues, misunderstandings, and lack of respect for cultural beliefs and traditions, may lead to patient safety events among diverse populations.

In the recommendations below, we link cultural competence with recommendations to improve team communication given its relevance to both patient-staff interactions and staff-to-staff interactions. It is critical that training in cultural competence incorporate information on how issues related to cultural diversity or LEP may contribute to medical errors.

- Outline the goals and principles for what constitutes culturally competent care. It is crucial that all staff be trained with the same goals and principles.
- Teach a set of cross-cultural skills that will enable health care providers and staff to understand the impact of sociocultural factors on health and health care and be able to manage them more effectively in the clinical encounter. These skills could be applied to the care of any patient, regardless of background.
- Include an overview of key cultural beliefs and traditions that are associated with the most commonly

“They will have to be trained in the key cross-cultural aspects of communication. For example, when patients nod, it doesn’t necessarily mean ‘I understand.’ It’s a nod that’s ‘pretending that I understand.’ So that would be a big factor for training”  
(Frontline, Interpreter).



served patient populations at the hospital. Ideally, these trainings could be co-led or led by members of interpreter services. Educating staff on common cultural and sociopolitical factors associated with the diverse populations served will provide a context in which to allow more open conversations between clinicians, staff, and patients.

- Include case examples of how cultural factors affect communication and medical errors.
- Include an overview of the diversity of staff and how this may relate to issues of power and hierarchy. Encourage appreciation, value, respect, understanding, and open communication.

### **Recommendations for Interpreter Training**

In addition to basic training on medical interpreting and meeting International Medical Interpreter Association and National Council on Interpreting in Health Care standards of practice,\* we recommend that training for interpreters include:

- Clearly outlined roles and responsibilities specifying when it is appropriate for interpreters to serve as cultural brokers or patient advocates. Consider using strategies to indicate a switching of roles (e.g., both hands up means interpreter moving from interpreter role to advocate role).
- Empowerment for interpreters to view themselves as critical members of the care team.
- Behavioral skills and communication tools to correct for errors related to clinician's level of fluency.
- Guidance on how to report and document errors related to cultural factors (if reporting systems will be incorporating fields for the role of cultural factors in patient safety situations).

For additional information on standards for interpreters, see the Robert Wood Johnson Foundation's *Speaking Together Toolkit*.

### **Train Staff on Using Interpreter Services**

All staff need training on how to use interpreter services. Below is a summary of key points that such training should cover.

- **Need for an interpreter:**
  - Provide education and awareness about increased risks for LEP patients and the dangers associated with using nonqualified interpreters or trying to get by with inadequate language skills. Provide examples of how using nonqualified interpreters can have adverse effects on patient care.
- **Hospital procedures related to language assistance:**
  - Instruct trainees on how to inform patients that interpreter services are provided free of cost and they have a legal right to language services. Let trainees know that under no circumstances should minor children be used to interpret.
- **Role of interpreters:**
  - Train staff to understand the expanded role of interpreters as patient advocates and cultural brokers, and familiarize them with the code of ethics under which interpreters operate.
  - Address issues related to power and hierarchy. Provide strategies to create environments in which the interpreter feels like a valued member of the care team (e.g., introducing interpreters as part of the care team to patients, which can set a tone of inclusiveness).

- **How to work with interpreters:**
  - Teach trainees how to call for interpreters and how to explain to patients why they do not use friends or family members to interpret.
  - Emphasize the importance of professionalism – showing courtesy and respect – when working with interpreters and caring for LEP patients.
  - Instruct trainees on how to use structured communication skills (e.g., TeamSTEPPS® tools).
  - Inform both staff and interpreters that it is appropriate for interpreters to correct false fluency errors.
  - Verify language proficiency of all staff who want to converse with patients in languages other than English.
- **Use of interpreter services:**
  - Train providers on how to use available resources if an interpreter is not available for face-to-face interpreting. Encourage use of alternative services (e.g., video and phone).
  - Teach trainees how to access interpreters, scheduling in advance and as needed.
- **Awareness of health literacy:**
  - Train providers to avoid medical jargon and to use clear communication techniques for all patients, especially for LEP patients where the language can be an added barrier.

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\*Certification programs for interpreters have recently been developed. For more information see: the Certification Commission for Healthcare Interpreters and the National Board of Certification for Medical Interpreters.

## Appendix B: Bringing It To Life: Case Study

The following case study is adapted from our TeamSTEPPS® LEP Module: Enhancing Safety for Patients With Limited English Proficiency. This case highlights a situation that could have occurred in any hospital around the country. It is important to focus on the processes of care that do or do not occur leading to poor communication, misunderstanding, and potential patient safety events that are readily preventable. A video will be available on CD and on the Web site at [www.ahrq.gov/teamsteppstools/](http://www.ahrq.gov/teamsteppstools/).

Mr. Rafael Hernandez, a 45-year-old Spanish-speaking man with type 2 diabetes and no other major medical issues, presents to the emergency department (ED) at a local hospital accompanied by his wife. His first encounter is with the registrar, who asks him in English why he came to the ED today. He tells her that he is having “fatiga” and that he needs to be seen. His English is difficult to understand but the symptom seems clear enough. The registrar takes down his information as best as possible and asks him to wait for the triage nurse.

After 20 minutes, Mr. Hernandez sees the nurse, who asks again in English what brings him to the hospital.

**Mr. Hernandez:** I have...fatiga...you know how you say in English...Fatiga.

**Nurse:** OK, how long have you been fatigued?

**Mr. Hernandez:** I have fatiga. Very much. It happen in the morning.

**Nurse:** OK, so you have been tired since this morning. Do you have any other symptoms? Any fevers or chills?

After several more questions, the nurse goes on to explain that the ED is very busy today and he may have to wait a while before seeing a physician, but he will be seen. She is surprised that he would come to the emergency room for a complaint like fatigue, which should be managed on an outpatient basis by his primary care provider.

After 60 minutes, Mr. Hernandez has not yet seen a physician, prompting him to ask if he can see someone soon. About 30 minutes later, he begins to develop some chest pressure, which he had not noticed before. Feeling that he is already bothering the ED staff, he avoids telling anyone about this.

The doctor arrives and begins asking a similar set of questions but in more detail. The doctor uses more complicated terms, and it becomes clear that Mr. Hernandez is not able to communicate well enough in English to provide an accurate medical history. The doctor calls for an interpreter, who arrives 20 minutes later.

After a few minutes of discussion, the interpreter realizes that there has been a misunderstanding, and the word “fatiga” was not referring to “fatigue” but rather to “shortness of breath.” Since shortness of breath is a much more concerning symptom than fatigue, the doctor immediately orders an EKG. This shows that in fact the patient is having a myocardial infarction.

The doctor returns and, through the interpreter, begins to explain the situation to Mr. Hernandez and his wife. He is going to need an angioplasty and possibly a stent to help save his heart muscle. After describing the risks and benefits of the procedure, she asks if Mr. Hernandez understands. He says he does, but the interpreter is skeptical. The discussion was very fast and complicated, and Mr. Hernandez may have felt uncomfortable voicing his concerns. However, the interpreter does not feel it is her role to intervene. The doctor asks if Mr. Hernandez has any allergies to IV contrast dye, and he says he does not, but again, it is not clear that he understands what this means.

Several hours after his initial presentation to the ED, Mr. Hernandez is taken to the cardiac catheterization lab to undergo what should be a routine balloon angioplasty and stenting of a blocked coronary artery. An hour later, the nurse appears again and finds Mrs. Hernandez in the waiting room anxious and concerned. The interpreter is no longer present, but the nurse proceeds to explain:

*Mrs. Hernandez, unfortunately your husband had a very bad allergic reaction to the intravenous contrast that we use for the cardiac catheterization. We were not able to complete the procedure and he had to be taken to the intensive care unit. He told us that he had no allergy to IV contrast dye, didn't he?*

As we have highlighted throughout this guide, patient safety events are generally not caused by one specific or well-defined error. They are the result of a breakdown in communication and gaps in systems of care on many levels. This case exemplifies that breakdown in a way that will most likely be familiar to most who work in a health care setting. We will walk through these step by step to understand what happened and how Mr. Hernandez's care was compromised.

- Registrar did not recognize that the patient was LEP and did not relay this information to the clinical team. This initial problem may have led to a delay in the triage process and to a long delay in obtaining a qualified medical interpreter. However, blame for this should not fall on the shoulders of one individual registrar. It is likely that she was never trained on how to identify a patient's language needs, how to record this information in the medical record, or how to communicate it to the clinical team either verbally or through a standard flagging system.

This problem highlights the ***need for systematic collection of racial and ethnic data, language preference, and English proficiency***, which is absolutely necessary to adapt current systems to better identify medical errors in LEP patients. It is doubtful a systematic process of calling for an interpreter existed that could be initiated by the registrar alone or in quick consultation with the care team. Registrars may be the first point of contact with an LEP patient. To ensure safe care for LEP patients, they must be included in a team-based approach to identifying and addressing language needs.

- Triage nurse did not recognize the need for a qualified medical interpreter. The next level of missed opportunity occurred at the level of the triage nurse. The situation here is similar to that of the registrar. However, in this case, the assumption that effective communication is occurring without an interpreter leads to the first major safety issue. By not recognizing that by "fatiga" the patient means "shortness of breath," the nurse triages Mr. Hernandez to a low-acuity section of the ED, causing a long delay in his care. If an interpreter had already been assigned to the patient, or if the nurse had called for an interpreter immediately, this situation may have been avoided or mitigated. Again, this requires a system in place, a set of processes and education around these processes so that it is not a voluntary decision by a clinician who is already pressed for time but rather, the standard of care. This problem highlights ***the importance addressing root causes to prevent medical errors among LEP patients by training staff on the use of interpreter services and cultural competency***.
- Physician does not work effectively with the interpreter. Although the physician eventually realizes that she is not able to obtain an accurate history from the patient and calls for an interpreter, she does not work effectively with the interpreter. This problem highlights the ***need to address root causes to prevent medical errors among LEP patients by training providers on interpreter use, cultural competency, and patient advocacy***. Again, the goal is not to blame the individual but to understand the processes needed to provide safe care for LEP patients.

The physician could have improved her interaction with the interpreter and the care team in at least two major ways:

- She could have created a safe environment for effective communication by starting out with a brief “huddle” with the interpreter and the nurse during which she summarized the clinical situation. This may have allowed the interpreter to feel empowered to speak up when she felt the patient did not understand the physician.
  - She could have learned certain skills for how to work effectively with an interpreter, such as speaking as clearly as possible, minimizing medical jargon, pausing after every sentence to allow for the interpretation, and checking patient understanding through a method such as teach-back (see resources in Appendix E).<sup>62,63</sup> Had she done this, she may have realized that the patient had no idea what a contrast dye allergy was and that he in fact had experienced a severe reaction to contrast after a CT scan many years ago.
- Interpreter does not speak up when she realizes that the patient does not understand.

The interpreter does a good job early in this interaction to identify the miscommunication around the word “fatiga.” In this context, she is acting as a patient safety advocate, not just an interpreter. However, she later allows the care team to proceed with the cardiac catheterization even though she suspects that the patient does not understand the procedure or the question about contrast dye allergy.

This problem highlights two areas: (1) *the need to foster a supportive culture for safety of diverse patient populations* and thus ensure that staff are comfortable identifying issues, and (2) the need to improve reporting of medical errors for LEP patients by training staff on when to report and how to report effectively, and ensuring that they are empowered to do so.

Since interpreters often feel intimidated by the clinical care team, they may hesitate to speak up when they see a potential safety issue. It is crucial for the entire care team to create a safe environment for the identification of miscommunication or misunderstanding with LEP patients, particularly for interpreters who may be considered lower in the medical hierarchy. At the same time, interpreters need to feel empowered as to their important role in this regard.

If Mr. Hernandez’s interpreter had spoken up in this case about the contrast allergy, a simple premedication regimen could have prevented the severe allergic reaction and allowed him to receive the angioplasty that could have prevented injury to his heart. The TeamSTEPPS LEP Module details more specific structured communication tools (e.g., SBAR and CUS words) to foster team communication and LEP patient safety.<sup>64,65</sup>

While this case may seem extreme, research shows that errors like these occur more frequently for LEP patients when interpreters are not involved in care.<sup>66,67</sup> Other examples may include patients taking medications incorrectly due to misunderstanding discharge instructions or refusing important procedures because of a lack of clear explanation. By resensitizing ourselves to the importance of effective communication with LEP patients, we can develop a culture of patient safety that will prevent errors like these from occurring. Ultimately, hospitals must *routinely monitor patient safety for LEP patients* so that they can track these situations and learn from errors that occur, with an eye toward prevention in the future.

## **Appendix C: Advisory Board Members**

Gregg S. Meyer, MD, MSc  
Senior Vice President for Quality and Patient Safety  
Massachusetts General Hospital

Lela Holden, RN, MS, MSN, PhD  
Patient Safety Officer for Quality and Patient Safety  
Massachusetts General Hospital

James Walton, DO, MBA  
Vice President and Chief Equity Officer  
Baylor Health Care System

Karen Frush, MD  
Chief Patient Safety Officer  
Duke University Health Center

## Appendix D: Methods

We used a robust mixed-methods approach to better understand the unique role of language barriers and cultural factors in patient safety events. Specifically, we aimed to answer two research questions:

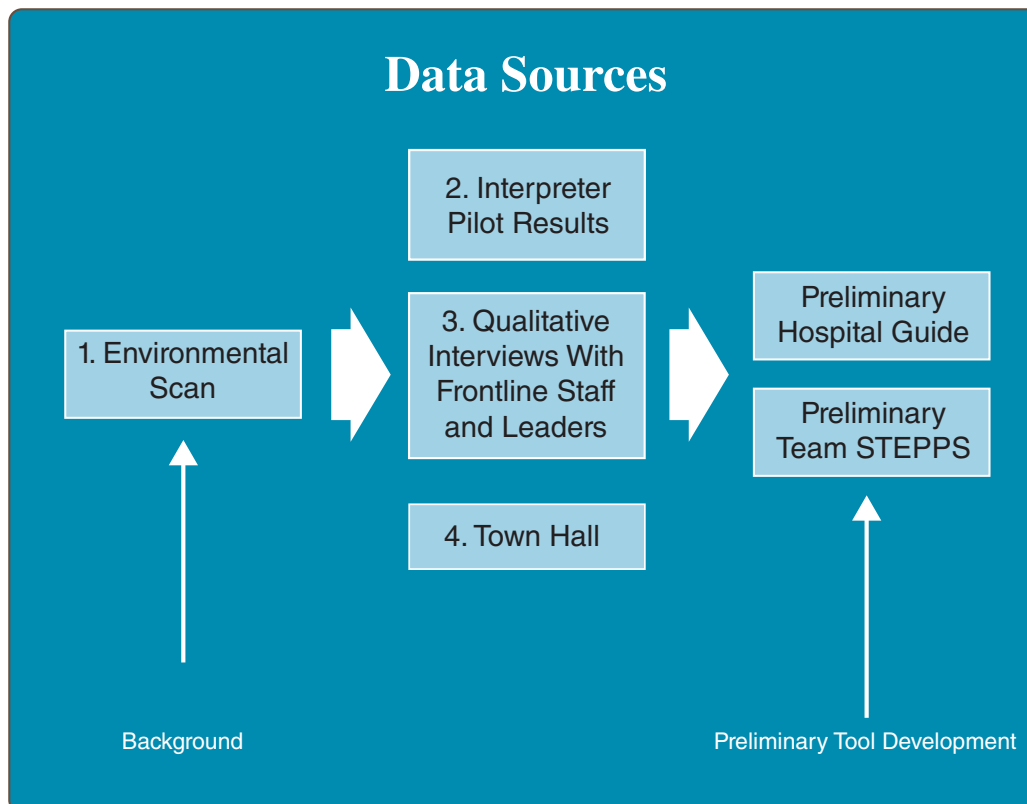
- What are the roles of language barriers and cultural factors in patient safety events?
- How are hospitals addressing linguistic and cultural sources of error for LEP patients?

Data were drawn from the following four sources: (1) environmental scan; (2) interpreter pilot database; (3) qualitative interviews; and (4) a town hall meeting.

The research was conducted by a diverse multidisciplinary team of researchers from the Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital and Abt Associates, a consulting firm in Cambridge, Massachusetts. General project oversight was provided by the Agency for Healthcare Research and Quality (AHRQ), which funded the project. All data were gathered and used in conformity with Institutional Review Board and Health Insurance Portability and Accountability Act requirements.

### Environmental Scan

We conducted a systematic review of the peer-reviewed and grey literature on LEP and patient safety, using English articles in PubMed between 1966 and 2009. Search terms related to limited English proficiency (LEP) and cultural diversity were combined with terms related to patient safety and teams (adverse event, medical error, patient safety). To identify grey literature in this area, we reviewed the Web sites of several key organizations and examined existing and proposed standards issued by accrediting bodies that related to health care for LEP patients. We extracted, summarized, and tabulated the design, research methods, and findings of each article. We summarized the implications of each article for policy and practice, with a specific focus on two types of policy and practice recommendations: trainable team behaviors and hospital-level change.



## **Interpreter Pilot Project**

We used a pilot project with interpreters to gather additional insight into the types of patient safety incidents commonly observed by interpreters but rarely recorded. We asked interpreters to document situations they thought negatively affected the health, health care, safety, and well-being of LEP patients. Prior to project start, interpreters received a brief training on patient safety terminology. Any significant quality and safety events were reported to hospital quality and safety leadership immediately; otherwise, incidents were reviewed by project staff and hospital leadership in Interpreter Services and Quality and Safety.

We collected information on 34 incidents between April 2009 and March 2010 (28 of which met the specific study criteria) and reviewed the cases for key themes and safety implications. For formal classification purposes, we applied the AHRQ patient safety classification Common Formats. We identified all incidents reported as Incidents since all events reached the patient. However, it was difficult to identify the emotional distress or other consequences the patient might have experienced, which made the application of the AHRQ Harm Scale inapplicable.

## **Qualitative Interviews**

We conducted indepth interviews with frontline staff and clinical and administrative leaders to obtain input on conditions affecting safety for LEP and culturally diverse patients. The goal of the interviews was to gather both “on the ground” and institutional perspectives on the role of language and cultural factors in patient safety events. We interviewed frontline staff (interpreters, nurses, and other bilingual frontline staff) and hospital leadership (directors/managers of interpreter services; patient safety officers; and clinical/administrative nurse managers).

We conducted the interviews at three hospitals in the Boston area. All interviewees received a formal letter of invitation and a study fact sheet summarizing their rights as participants and background information about the project. Frontline staff each received a \$50 cash incentive for their time.

Interviews lasted approximately 60 minutes. We conducted a total of 18 interviews both in person and by phone, with 9 interviews with frontline staff and 9 interviews with clinical and administrative leaders. All interviews were audio recorded and transcribed. Each interview was reviewed and coded for key themes, with a focus on the development of the two primary project deliverables, the Hospital Guide and TeamSTEPPS® Module. Quality assurance measures were taken to ensure that themes were identified in an unbiased and uniform process.

## **Town Hall Meeting**

We conducted a “town hall” meeting to help inform our understanding of how hospitals are addressing linguistic and cultural sources of error. The purpose of the meeting was to gather information from a diverse range of hospitals on best practices for preventing, reporting, and documenting medical errors for LEP patients. This interactive phone discussion lasted 1 hour and 15 minutes and included 19 participants from hospitals, hospital associations, and one health plan.

Key leaders from several hospital associations were represented, including the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the Joint Commission. The hospital associations and accrediting agencies helped to provide a broader perspective of common hospital practices and challenges.

Using the minutes from the town hall meeting, we developed a formal debriefing document that included key themes and implications for the content and development of the Module and Hospital Guide. This



meeting was held as part of ongoing activities of the Disparities Solutions Center's Disparities Leadership Program.

### **Field Testing of Hospital Guide**

In addition to consulting with our Executive Advisory Board, we field tested the Hospital Guide with a diverse range of hospitals across the country. We asked nine leaders in Quality and Safety at nine unique hospitals in the country to: (1) participate in an indepth 30-minute telephone interview to provide detailed feedback on the guide; and (2) share the guide with members of their implementation teams (e.g., representatives from Quality and Safety, Interpreter Services) to gather "real world" feedback on implementation. The goal of the field testing was to gather indepth and diverse perspectives from key decisionmakers in Quality and Safety and members of their implementation teams on the Hospital Guide's content, usability, ease of implementation, and overall design and structure.

Hospitals were specifically selected to represent diverse perspectives that included public, private, academic, and nonacademic hospitals in both rural and urban locations. We also selected two hospitals with experience implementing TeamSTEPPS. We developed a discussion guide that included 22 questions across three domains: (1) structure and design; (2) chapter-by-chapter content; and (3) usability, implementation, and impact. The interviews were transcribed and imported into Atlas.ti to identify key themes and a coding scheme.

To make sure the codes were applied correctly and systematically, a portion of the transcripts were double-coded by team members. Any coding inconsistencies were reviewed, discussed, and modified by consensus. Key themes and implications for the Hospital Guide were reviewed with the Executive Advisory Board and project staff, and revisions were made accordingly.

## Appendix E:

# Resources and Tools To Address Language and Cultural Barriers and Improve Patient Safety

## Language Access, Patient Safety, and Cultural Barriers Resources

Agency for Healthcare Research and Quality (AHRQ), [www.ahrq.gov](http://www.ahrq.gov)

### TeamSTEPPS®

- TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals.

[teamstepps.ahrq.gov/](http://teamstepps.ahrq.gov/)

### Hospital Language Services: Quality Improvement and Performance Measures

- This paper describes the use of a multistage process to develop quality performance measures for Speaking Together participants. Early experiences with the measures highlight challenges with collecting information on patient care that has not previously been collected and the importance of engaging staff, including registration staff and senior management.

[www.ahrq.gov/downloads/pub/advances2/vol2/Advances-Regenstein\\_54.pdf](http://www.ahrq.gov/downloads/pub/advances2/vol2/Advances-Regenstein_54.pdf)

### AHRQ Health Care: Innovations Exchange

- The AHRQ Health Care Innovations Exchange offers busy health professionals and researchers a variety of opportunities to share, learn about, and ultimately adopt evidence-based innovations and tools suitable for a range of health care settings and populations.

[www.innovations.ahrq.gov/](http://www.innovations.ahrq.gov/)

### American Medical Association, [www.ama-assn.org/](http://www.ama-assn.org/)

#### Collecting and Using Race, Ethnicity, and Language Data in Ambulatory Settings

- This white paper provides practical recommendations on the collection and use of race, ethnicity, and language data as they pertain to the quality of care in ambulatory settings.

[www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf](http://www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf)

### The California Endowment, [www.calendow.org/](http://www.calendow.org/)

#### Assessing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members

- This toolkit presents a systems approach to redesigning office practice to provide the highest quality care possible to patients who speak limited English.

[www.calendow.org/uploadedFiles/language\\_access\\_issues.pdf](http://www.calendow.org/uploadedFiles/language_access_issues.pdf)

#### How To Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish To Contract With Language Agencies

- How best to use a language agency? What can you expect from such a service? And how do you choose a good one? This publication is designed to assist health and human services administrators who are interested in contracting with a language agency and who are asking themselves these questions.

[www.calendow.org/uploadedFiles/how\\_to\\_choose\\_use\\_language\\_agency.pdf](http://www.calendow.org/uploadedFiles/how_to_choose_use_language_agency.pdf)

**The Commonwealth Fund, [www.commonwealthfund.org/](http://www.commonwealthfund.org/)**

**Promising Practices for Patient-Centered Communication With Vulnerable Populations: Examples From Eight Hospitals**

- As patient populations become increasingly diverse, health care organizations are looking for innovative ways to communicate effectively across cultures, languages, and health literacy levels. This study identified eight hospitals from across the country that have demonstrated a commitment to providing patient-centered communication with vulnerable patient populations.

*[www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia\\_promisingpracticespatientcentered\\_947%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Aug/Promising%20Practices%20for%20Patient%20Centered%20Communication%20with%20Vulnerable%20Populations%20%20Examples%20from%20Ei/Wynia_promisingpracticespatientcentered_947%20pdf.pdf)*

**Diversity Rx, [www.diversityrx.org/](http://www.diversityrx.org/)**

- The purpose of DiversityRx is to improve the accessibility and quality of health care for minority, immigrant, and indigenous communities. We support those who develop and provide health services that are responsive to the cultural and linguistic differences presented by diverse populations.

**Health Research and Educational Trust (HRET), [www.hret.org/](http://www.hret.org/)**

**Disparities Toolkit**

- This Web-based toolkit provides hospitals, health systems, clinics, and health plans with information and resources for systematically collecting race, ethnicity, and primary language data from patients.

*[www.hretdisparities.org/](http://www.hretdisparities.org/)*

**Improving Health Equity Through Data Collection and Use: A Guide for Hospital Leaders**

- This guide takes a deeper look at select hospitals and their use of patient race, ethnicity, and language data. Reflecting on their practices, the guide provides methods for hospital leaders to use these data effectively in care interventions.

*[www.hret.org/health-equity/resources/improving-health-equity.pdf](http://www.hret.org/health-equity/resources/improving-health-equity.pdf)*

**Health Resources and Services Administration (HRSA), [www.hrsa.gov/index.html](http://www.hrsa.gov/index.html)**

**United Health Communication Training: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency**

- This free online training can improve providers' communication skills with patients and help overcome barriers that can keep patients from taking their medications, seeking primary care instead of going to the emergency room, or otherwise getting the full benefit of the quality care provided.

*[www.hrsa.gov/publichealth/healthliteracy/index.html](http://www.hrsa.gov/publichealth/healthliteracy/index.html)*

**The Joint Commission, [www.jointcommission.org](http://www.jointcommission.org)**

**Hospitals, Language, and Culture: A Snapshot of the Nation**

- This is the first report released by the Hospitals, Language, and Culture study. It presents the challenges hospitals face when providing care and services to culturally and linguistically diverse populations and discusses the way hospitals are addressing those challenges.

*[www.jointcommission.org/assets/1/6/hlc\\_paper.pdf](http://www.jointcommission.org/assets/1/6/hlc_paper.pdf)*

### **What Did the Doctor Say?: Improving Health Literacy To Protect Patient Safety**

- This public policy white paper frames the existing communication gap between patients and caregivers as a series of challenges involving literacy, language, and culture. It suggests multiple steps that need to be taken to narrow or close this gap.

[www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving\\_health\\_literacy.pdf](http://www.jointcommission.org/NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health_literacy.pdf)

### **Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals**

- This guide provides recommendations to help hospitals address unique patient needs, meet the new Patient-Centered Communication standards, and comply with existing Joint Commission requirements.

[www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf](http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf)

### **National Center for Cultural Competence (NCCC), [nccc.georgetown.edu/](http://nccc.georgetown.edu/)**

- NCCC's mission is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity and persistent disparities. NCCC also promotes health and mental health equity.

### **The National Quality Forum (NQF), [www.qualityforum.org](http://www.qualityforum.org)**

#### **Endorsing a Framework and Preferred Practices for Measuring and Reporting Cultural Competency**

- This paper presents a framework and 45 practices to guide health care systems in providing care that is culturally appropriate and patient centered. The comprehensive framework for measuring and reporting cultural competency covers issues such as communication, community engagement, and workforce training. This report is intended to provide health care systems with the tools they need to help reduce persistent disparities in health care and create higher quality and more patient-centered care.

[www.qualityforum.org/projects/cultural\\_competency.aspx](http://www.qualityforum.org/projects/cultural_competency.aspx)

#### **Safe Practices for Better Healthcare - 2009 Update**

- The 2009 report includes a set of 34 NQF-endorsed safe practices updated with current evidence and expanded implementation approaches. The 2009 report also provides additional measures for assessing the implementation of the practices.

[www.qualityforum.org/Publications/2009/03/Safe\\_Practices\\_for\\_Better\\_Healthcare%E2%80%932009\\_Update.aspx](http://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%E2%80%932009_Update.aspx)

### **Robert Wood Johnson Foundation, [www.rwjf.org/](http://www.rwjf.org/)**

#### **National Health Plan Collaborative**

- The National Health Plan Collaborative has created this toolkit of resources, lessons, best practices, and case studies to help other health plans join the effort to reduce disparities. AHRQ was a cosponsor of the Collaborative.

[www.rwjf.org/pr/product.jsp?id=33960](http://www.rwjf.org/pr/product.jsp?id=33960)

#### **Speaking Together Toolkit**

- Ten hospitals with racially and ethnically diverse patient populations participated in RWJF's Speaking Together: National Language Services Network, a program aimed at improving the quality and availability of health care language services for patients with limited English proficiency (LEP).

[www.rwjf.org/pr/product.jsp?id=29653](http://www.rwjf.org/pr/product.jsp?id=29653)

## **Hablamos Juntos - Language Policy and Practice in Health Care**

- Hablamos Juntos (Spanish for “We Speak Together”) is a unique project designed to forge connections between health care providers and the rapidly growing Latino health market. They offer translation and interpreter services resources.

[www.hablamosjuntos.org/](http://www.hablamosjuntos.org/)

## **Medical Interpreting Specific Resources**

### **Certification Commission for Healthcare Interpreters (CCHI),**

[www.healthcareinterpretercertification.org](http://www.healthcareinterpretercertification.org)

- CCHI is the only certification body created by interpreters for interpreters and the public good. It will involve thousands of interpreters and users of interpreter services in defining their future and the credentials by which they will be known and respected.

### **California Healthcare Interpreting Association, [chiaonline.org/](http://chiaonline.org/)**

#### **Standards of Practice (only standard that includes ethical decisionmaking)**

- The goal of this document is to standardize health care interpreting practices by providing a set of ethical principles, interpreting protocols, and guidance on roles particular to the specialty of health care interpreting.

[www.chiaonline.org/resource/resmgr/docs/standards\\_chia.pdf](http://www.chiaonline.org/resource/resmgr/docs/standards_chia.pdf)

### **International Medical Interpreters Association, [www.imiaweb.org/](http://www.imiaweb.org/)**

#### **Medical Interpreting Standards of Practice (only standard that includes an assessment tool at the end)**

- The Medical Interpreting Standards of Practice document was the first set of standards to be developed in the field of spoken language interpreting in medical settings. It remains a vital evaluation and competency tool for professional interpreters all over the country, delineating core performance standards and competencies required of a competent interpreter.

[www.imiaweb.org/uploads/pages/102.pdf](http://www.imiaweb.org/uploads/pages/102.pdf)

#### **A Medical Interpreter’s Guide to Telephone Interpreting**

- Medical interpreters often have questions about telephone interpreting but often do not have access to general information about this area of interpreting. In July 2007, IMIA offered to respond to questions from its membership about this topic. This query, along with subsequent discussions with organizational members with extensive experience in providing telephone interpreting services, resulted in the compilation of questions and answers in this document.

[www.imiaweb.org/uploads/pages/380.pdf](http://www.imiaweb.org/uploads/pages/380.pdf)

#### **IMIA Guide on Medical Translation**

- The objective of this document is to provide an easy-to-use set of translation management and quality control guidelines for those in the medical field.

[www.imiaweb.org/uploads/pages/380\\_2.pdf](http://www.imiaweb.org/uploads/pages/380_2.pdf)

#### **National Interpreter Advocacy Forum**

- The National Interpreter Advocacy Forum is a coalition of organizations and individuals that engage in effective advocacy for equitable treatment of language minority individuals.

[www.imiaweb.org/advocacy/NatIntAdvForum.asp](http://www.imiaweb.org/advocacy/NatIntAdvForum.asp)

## Resources

- [www.imiaweb.org/resources/links.asp](http://www.imiaweb.org/resources/links.asp)

### **National Board of Certification of Medical Interpreters, [www.certifiedmedicalinterpreters.org](http://www.certifiedmedicalinterpreters.org)**

- The National Board aims to consolidate resources and avoid duplication in the field; coalesce existing efforts into a single national certification program; further the process and make certification available to the largest number of languages in the largest number of locations; model a multiorganizational collaboration that recognizes certification efforts and other testing organizations' efforts without compromising their intellectual property; and have a comprehensive project to ensure national accreditation.

### **The National Council for Interpreters in Health Care (NCIHC), [www.ncihc.org](http://www.ncihc.org)**

#### **National Standards of Practice for Interpreters in Health Care**

- These standards are intended to provide a common base of understanding of the profession, foster the consistency with which the profession is practiced, and improve the quality of interpreter services.

*[data.memberclicks.com/site/ncihc/NCIHC%20National%20Standards%20of%20Practice.pdf](http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Standards%20of%20Practice.pdf)*

#### **National Code of Ethics**

- The National Code of Ethics standardizes expectations that the health care industry and patients should have of interpreters. The document places the code in the context of ethical behavior in general and then discusses each principle in the context of specific issues and dilemmas often faced by health care interpreters.

*[data.memberclicks.com/site/ncihc/NCIHC%20National%20Code%20of%20Ethics.pdf](http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Code%20of%20Ethics.pdf)*

### **Registry of Interpreters for the Deaf, [www.rid.org](http://www.rid.org)**

#### **RID Standards Practice Papers**

- RID's Standards Practice Papers articulate the consensus of the membership in outlining standard practices and positions on various interpreting roles and issues.

*[www.rid.org/interpreting/Standard%20Practice%20Papers/index.cfm](http://www.rid.org/interpreting/Standard%20Practice%20Papers/index.cfm)*

## Other Resources

### Access Project

#### Community Access Monitoring Survey (CAMS) Project

- The national report (available in English and Spanish) presents national CAMS findings. It compares the perceptions and experiences of adults who needed and had ready access to an interpreter with those of adults who needed and did not have an interpreter readily available and those who did not need an interpreter.

[www.accessproject.org/new/pages/languageServices.php](http://www.accessproject.org/new/pages/languageServices.php)

### California Health Care Safety Net Institute

#### Straight Talk: Model Hospital Policies and Procedures on Language Access

- The adoption of hospital policies and procedures is the essential mechanism to making a significant change in the operational actions of the U.S. hospital industry. It has been used throughout the history of this industry as a mechanism to change practice and establish expectations on a challenging issue. This document is designed to offer American hospitals a set of tools to use in updating their own internal policy and procedure manuals.

[safetynetinstitute.org/content/upload/AssetMgmt/Site/StraightTalkFinal.pdf](http://safetynetinstitute.org/content/upload/AssetMgmt/Site/StraightTalkFinal.pdf)

### Institute for Diversity in Health Management's Institute Resource Center

- The Institute for Diversity in Health Management, a 501(c)(3) nonprofit organization, works closely with health services organizations and educators to expand leadership opportunities for ethnic minorities in health services management.

[www.diversityconnection.org/diversityconnection\\_app/membership/Institute-Resource-Center.jsp?fl=S13](http://www.diversityconnection.org/diversityconnection_app/membership/Institute-Resource-Center.jsp?fl=S13)

### Institute for Family-Centered Care

#### Creating Advisory Councils

- This guide discusses the purposes of an advisory council and explains all the necessary items that one may need to develop an advisory council (including council composition, structure, etc.).

[www.ipfcc.org/advance/Advisory\\_Councils.pdf](http://www.ipfcc.org/advance/Advisory_Councils.pdf)

### Kaiser Family Foundation

#### Minority Health: Access to Care

- This collection includes news updates, articles, and reports related to health and health care issues that affect underserved and racial and ethnic communities.

[www.kff.org/minorityhealth/access.cfm](http://www.kff.org/minorityhealth/access.cfm)

### National Health Law Program

#### Language Access

- Content includes Language Access Publications, External Research and Studies, Federal Administrative Activities, Federal and State Legislation, and more.

[www.healthlaw.org/index.php?option=com\\_content&view=article&id=239&Itemid=196](http://www.healthlaw.org/index.php?option=com_content&view=article&id=239&Itemid=196)

## **Health Disparities**

- Content includes Health Care as a Human Right; Collection of Race, Ethnicity, and Language Data; Working Group on Health Disparities and Health Reform; and more.

[www.healthlaw.org/index.php?option=com\\_content&view=article&id=247&Itemid=198](http://www.healthlaw.org/index.php?option=com_content&view=article&id=247&Itemid=198)

## **U.S. Department of Health and Human Services, Office of Civil Rights**

- Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons Summary

[www.health.state.nm.us/pdf/Appendices%20H-%20LEP%20From%20DHHS.pdf](http://www.health.state.nm.us/pdf/Appendices%20H-%20LEP%20From%20DHHS.pdf)

## **U.S. Department of Health and Human Services, Office of Minority Health**

### **A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations**

- The Office of Minority Health has sponsored the development of this guide to help health care organizations implement effective language access services to meet the needs of their LEP patients, thereby increasing their access to health care.

[minorityhealth.hhs.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107](http://minorityhealth.hhs.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107)

## **A Physician's Guide to Culturally Competent Care**

- This Web site offers continuing medical education and continuing education credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve.

<https://cccm.thinkculturalhealth.hhs.gov/>



# Appendix F:

## PowerPoint Presentation: Executive Summary



### Improving Patient Safety Systems for Patients With Limited English Proficiency

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#### A Guide for Hospitals



### Improving Patient Safety Systems for LEP Patients

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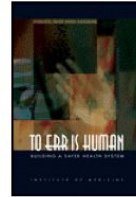
- Goal of the Guide:
  - Help hospital leaders better understand how to address the issue of patient safety for limited-English proficient (LEP) and culturally diverse patients
- The Guide provides guidance on how to:
  - Foster a Supportive **Culture** for Safety of Diverse Patient Populations
  - Adapt Current Systems to Better **Identify** Medical Errors Among LEP Patients
  - Improve **Reporting** of Medical Errors for LEP Patients
  - Routinely **Monitor** Patient Safety for LEP Patients
  - **Address** Root Causes to Prevent Medical Errors Among LEP Patients

## Improving Patient Safety Systems for LEP Patients

- This presentation will:
  - Highlight what we know about patient safety and LEP patients
  - Provide evidence for why we should focus on LEP patient safety
  - Identify common causes of adverse events for LEP and culturally diverse patients
  - Present five key strategies for how to improve detection of medical errors and prevent high-risk scenarios from becoming safety events

## What We Know About Patient Safety and LEP

- The Institute of Medicine Report **To Err is Human: Building a Safer Health System** states patients should not be harmed by care that is intended to help them
- The Institute of Medicine Report **Crossing the Quality Chasm** defined patient safety as one of the essential components of high quality health care
- Patient safety efforts are now a central component of strategies to improve quality of care for all patients



## What We Know about Patient Safety and LEP

- Research demonstrates that language barriers can have a significant impact on multiple aspects of health care and contribute to disparities in patient safety between English-speaking and LEP patients
- Communication problems are the most frequent root cause of serious patient safety events reported to the Joint Commission's Sentinel Event Database

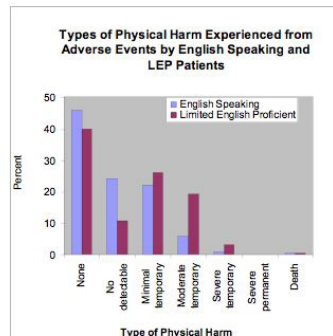


Chart illustrating results from Divi C, Koss RG, Schmalz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care*. Apr 2007;19(2):60-67. Epub 2007 Feb 2002.

## Why Focus on LEP and Patient Safety?

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- **A Large and Growing Population**
  - Minority groups are the Nation's fastest growing demographic group, accounting for one-third of U.S. population
  - Nearly 25 million (8.6%) of U.S. population are defined as LEP and therefore at risk for adverse events because of language barriers and culture

## Why Focus on LEP and Patient Safety?

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- **Patient Safety, Quality, and Cost Drivers**
  - Greater risk of line infections, surgical infections, falls, and pressure ulcers, due to LEP patients' longer hospital stays compared to English-speaking patients with the same clinical condition
  - Greater risk of surgical delays and readmission due to LEP patients' greater difficulty understanding instructions, including how to prepare for a procedure, manage their condition, take their medications, and know which symptoms should prompt a return to care or when to follow up

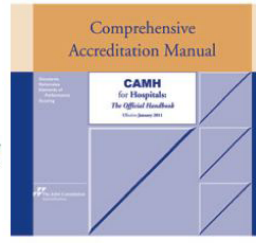
## Why Focus on LEP and Patient Safety?

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- **Risk Management**
  - Multiple liability exposures arise when providing care to LEP populations
  - These may include situations relating to:
    - Patient comprehension of medical condition
    - Treatment plan
    - Discharge instructions
    - Complications and followup
    - Inaccurate and incomplete medical history
    - Ineffective or improper use of medications or serious medication errors
    - Improper preparation for tests and procedures
    - Poor or inadequate informed consent

## Why Focus on LEP and Patient Safety?

- **Accreditation Standards**
  - In 2011, the Joint Commission published Patient-Centered Communication standards in the *Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook*
  - These standards emphasize the importance of effective communication, cultural competence, and patient-centered care as important elements of providing safe quality of care

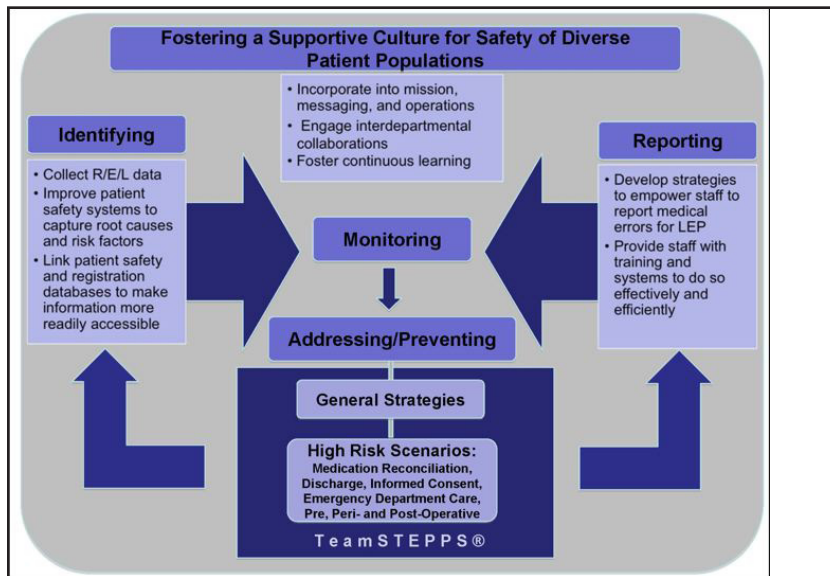


## Common Causes: Adverse Events for LEP Culturally Diverse Patients

- **Use of Family Members/Friends or Nonqualified Staff as Interpreters**
  - Family members and friends typically don't understand subtle nuances of language and culture that may influence the interaction, and will not question use of medical terminology
  - Research confirms that bilingual hospital staff often serve as ad hoc interpreters for LEP patients, despite evidence that they are more likely to make clinically significant mistakes than qualified medical interpreters
- **Use of Basic Language Skills to "Get By"**
  - Clinicians with basic or intermediate foreign language skills often attempt to "make do" or "get by" without the use of a competent interpreter, increasing patient risk
- **Cultural Beliefs and Traditions Affecting Patient Care**
  - Cultural beliefs and traditions, such as minimizing reports of pain, deferring to authority figures, and following specific gender roles, can influence the medical encounter and compound the risk for LEP patients

## Systems and Strategies to Improve Safety for LEP Patients

- Hospitals can engage in a systematic approach to better identify and prevent medical errors and adverse events that occur commonly among LEP patients
- We present **five** key recommendations that represent the "ideal system," but they can be implemented in different phases depending on existing hospital systems and structures
  - Foster a Supportive **Culture** for Safety of Diverse Patient Populations
  - Adapt Current Systems to Better **Identify** Medical Errors Among Patients With LEP
  - Improve **Reporting** of Medical Errors for LEP Patients
  - Routinely **Monitor** Patient Safety for LEP Patients
  - **Address** Root Causes to Prevent Medical Errors Among LEP Patients



## Systems and Strategies to Improve Safety for LEP Patients: *Culture*

### ○ Foster a Supportive Culture for Safety of Diverse Patient Populations

*Foster a supportive culture for safety of diverse patient populations, articulated clearly by leadership, operationalized in strategic planning for the organization, and supported by providing staff with key tools and resources to accomplish this successfully*

- Link the goal of overcoming language and cultural barriers into the overall message and mission of the culture of quality and safety, and frame this within existing operational policies and standards related to quality and safety for all patients
- Share lessons learned from patient safety events with all staff to: 1) help build an institutional culture sensitive to issues that affect LEP patients, and 2) ensure ongoing continuous learning and training in this area
- Involve patients in Family Advisory Councils or Cultural Advisory Groups to incorporate patient perspectives

## Systems and Strategies to Improve Safety for LEP Patients: *Identification*

### ○ Adapt Current Systems to Better Identify Medical Errors Among Patients with LEP

*Adapt current systems to better identify medical errors in patients, improve the capacity of patient safety systems to capture key root causes and risk factors, and link databases so information is readily accessible*

- Document data on race, ethnicity, and patient language and interpreter services needs in the electronic medical record to allow for ongoing monitoring and easy integration with other reporting systems for quality of care monitoring purposes
- Include these data fields in patient safety systems to track the role of language and culture in the patient safety events reported by staff

## Systems and Strategies to Improve Safety for LEP Patients: *Reporting*

### ○ **Improve Reporting of Medical Errors for LEP Patients**

*Develop institutional strategies to empower frontline staff and interpreters to report medical errors, and provide them with training and systems to do so effectively and efficiently*

- Develop targeted messages so that frontline staff and interpreters are empowered to report any patient safety events they might encounter
- Train all staff, particularly frontline and interpreters, on the full spectrum of what constitutes a patient safety event (including near misses) and how to report them, and consider other methods of identifying errors outside of standard reporting
- The term “frontline staff” includes all patient-facing staff such as registrars, medical technicians, medical assistants, and nurses.

## Systems and Strategies to Improve Safety for LEP Patients: *Monitor*

### ○ **Routinely Monitor Patient Safety for LEP Patients**

*Develop systems to routinely monitor patient safety among LEP patients, as well as processes to analyze medical errors and near misses that occur among these populations*

- Develop routine (quarterly, yearly) hospitalwide safety reports or dashboards that focus on patient safety among LEP patients
- Create routine forums for analyzing cases of medical errors and near misses that occur among LEP and culturally diverse populations so as to better understand root causes and high-risk scenarios, and develop strategies for improvement and error prevention

## Systems and Strategies to Improve Safety for LEP Patients: *Address*

### ○ **Address Root Causes to Prevent Medical Errors Among LEP Patients**

*Develop strategies and systems to prevent medical errors among LEP patients by strengthening interpreter services and improving coordination with the provision of clinical services, providing translated materials, and developing training for health care providers and staff on interpreter use, cultural competency, and advocacy*

- Develop dedicated services for medical interpretation that include either in-person or telephonic qualified medical interpreters, or both
- Provide patients with written materials — such as for informed consent, or procedure preparation — in their own preferred written language

## Systems and Strategies to Improve Safety for LEP Patients: *Address*

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- ***Address Root Causes to Prevent Medical Errors Among LEP Patients***
  - Create a mechanism to automatically schedule an interpreter at clinical points of service for patients who are identified as having LEP
  - Train staff on team communication, the use of interpreter services, cultural competency, and advocacy by using the new TeamSTEPPS® LEP training module
  - Fluent bilingual staff may be used as a form of language assistance, but should receive training in basic medical interpretation

## Specific Recommendations for High-Risk Scenarios

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- Certain high-risk clinical situations need immediate attention to prevent adverse events among LEP patients:
  - Medication reconciliation
  - Patient discharge
  - Informed consent
  - Emergency department care
  - Surgical care
- Ensuring that resources are available to address these high-risk scenarios should be a priority. Below are three recommendations to address high-risk scenarios:
  - Require presence of qualified interpreters
  - Provide translated materials in preferred language
  - Use “teach-back” to confirm patient understanding

## Improving Team Communication to Foster Safety for LEP Patients: **TeamSTEPPS®**

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- There are several activities that can be implemented to prevent errors in the short-term—primary among these is the use of **TeamSTEPPS**
- In November 2006, the Agency for Healthcare Research and Quality, in collaboration with the Department of Defense, released **Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS™)** as the national standard for team training in health care
- TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals

## Improving Team Communication to Foster Safety for LEP Patients: TeamSTEPS®

The **TeamSTEPS LEP module** trains inter-professional care teams working together in hospital units to **acquire the knowledge, attitudes, and team behaviors** needed to reduce the number and severity of patient safety events affecting LEP and culturally diverse patients

### TeamSTEPS® LEP Module Objectives

#### TeamSTEPS®: National Implementation

Participants in the **TeamSTEPS® LEP Module** will be able to:

- Identify high-risk situations for LEP and culturally diverse patients
- Assemble the most appropriate and effective care team for LEP patients
- Apply new TeamSTEPS strategies to enhance the safety of LEP and culturally diverse patients
- Utilize TeamSTEPS structured communication skills to identify and raise patient communication issues with the care team

<http://teamstepps.ahrq.gov/> - The module is free, publicly accessible, and customizable, and contains the following components: training module, video vignettes, workshop materials, training guide, and evaluation guide and metrics

## Summary

- Adverse events that affect LEP patients are more frequently caused by communication problems, and more likely to result in serious harm compared to English-speaking patients
- Failure to address the role of language and cultural factors in the provision of care for LEP patients has significant implications for quality of care, patient safety, and hospital costs
- Hospitals are beginning to engage in a systematic approach to better identify and prevent medical errors and adverse events that occur commonly among LEP patients
- There are a basic set of activities and strategies that can help hospital leaders initiate an agenda to address patient safety risks and inequities in care for LEP and culturally diverse patients

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