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How pediatric emergency department nurses initiate and provide care to children and families with limited English-proficiency

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HOW PEDIATRIC EMERGENCY DEPARTMENT NURSES INITIATE AND PROVIDE CARE TO CHILDREN AND FAMILIES WITH LIMITED-ENGLISH PROFICIENCY

BY

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APPROVAL FOR SUCCESSFUL DEFENSE

Caroline Meza has successfully defended and made the required modifications to the text of the doctoral dissertation for the Doctor of Philosophy in Nursing during this spring semester, 2023.

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ABSTRACT

Effective pediatric emergency care requires ongoing communication between the pediatric patient and their family. There may be additional challenges for pediatric emergency nurses (PENs) to consider in their efforts to provide safe quality nursing care to pediatric patients and families with limited English proficiency. The purpose of this study was to explore and describe the experience of PENs who are engaged in providing care to pediatric patients and families with limited-English proficiency (LEP) in a pediatric emergency department. Using an interpretive description method, semi-structured interviews conducted with 15 PENs and five certified professional medical interpreters (CPMIs) were analyzed. The study illustrates the PENs' descriptions of their experiences and challenges initiating care in triage, providing care while maintaining ongoing communication when informing, updating, and educating patients/families with LEP. Some PENs described feeling empathy for their patients/families when receiving critical news and wished they could clearly express their emotions directly to the patients/families. Although the CPMIs found their work rewarding in helping patients/families with LEP, they described their experiences as challenging, and unexpectedly traumatizing at times. This study revealed that safe, quality, and compassionate provision of care for patients/families with LEP not only requires the availability of appropriate interpretative services, but also the professional development and support to the PENs and CPMIs experiencing challenges in their efforts to meet the healthcare needs of patients/families with LEP, a population which continues to grow in the United States.

Keywords: pediatric emergency nursing, emergency services, pediatric nursing care, limited-English proficiency, certified professional medical interpreters

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I am truly blessed, thank you all.

DEDICATION

I dedicate this work to the nurses whose patient advocacy has made all the difference.

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CHAPTER I

INTRODUCTION

Purpose of Study

The purpose of this study was to explore and describe the experience of pediatric emergency nurses (PENs) who are engaged in providing care to pediatric patients and families with limited-English proficiency (LEP) in a pediatric emergency department (PED). PENs practicing in specialty PEDs are responsible for providing prompt, multifaceted health care to meet the unique needs of pediatric patients and their families, often in an overcrowded environment influenced by departmental time constraints and frequent workflow interruptions (Remick et al., 2018). Effective pediatric emergency care requires ongoing communication between the pediatric patient, their family, and the health care team (Emergency Nursing Association [ENA], 2017a). When pediatric patients and families with LEP are involved in a communication exchange, there may be additional challenges for PENs to consider in their efforts to provide safe quality nursing care.

Although research indicates that language barriers may negatively impact the safety and quality of health care received by patients with LEP (The Joint Commission, 2015), studies examining language barriers among the pediatric patient population and health care professionals have predominantly focused on the perspectives and experiences of professional interpreters, pediatric physicians, and patients/families with LEP (Abbe, et al., 2006; Enlow et al., 2014; Gil et al., 2016; Gutman et al., 2018; Miquel-Verges et al., 2011; Obregon et al., 2019; Thienprayoon, et al., 2016; Zamora et al., 2016; Zurca et al., 2017).

According to the United States Census Bureau, in 2015 there was an estimated 25.9 million people with LEP residing in the US (United States Census Bureau, 2015). While this number is slightly higher compared to the estimated 25.3 million people with LEP reported in 2020 (United States Census Bureau, 2020), the linguistic diversity and number of people that may potentially use the health care system remains high. They encounter nurses in all nursing specialties and medical settings, including emergency departments. Nurses caring for hospitalized adult patients with LEP expressed frustrations with the unique care complexities and poor communication that language barriers generated (Galinato et al., 2016).

Nursing care of pediatric patients involves the provision of age specific, developmentally appropriate, and family centered care, fostering collaboration and decision-making through effective communication between the nurse, pediatric patient and family or caregiver (Society of Pediatric Nurses, 2017). PENs often initiate emergency nursing care for children experiencing life-threatening illness, injury, or trauma; perform cardiopulmonary resuscitation; detect and report child abuse; or assist a family to cope with the death of a child (ENA, 2020). In the short amount of time PENs may spend with their patients, their scope of practice requires application of the nursing process to expedite emergency treatment of injuries and/or illness, evaluation of the patient's response to treatment and provision of education and appropriate referrals (ENA, 2017b).

A language barrier when encountering a child and family in a PED may lead to unforeseen challenges for PENs providing emergency nursing care. Evidence indicates that pediatric patients and families with LEP cared for in a PED reported poor access to professional interpreters and experienced problems understanding information regarding their child's illness (Arthur et al., 2015). Little is known about the experience of PENs caring for pediatric patients and their families with LEP. The aim of this study was to explore and describe the experience of PENs who are engaged in providing care to pediatric patients and families with LEP in a PED.

To better understand this phenomenon of interest, the qualitative methodology of interpretive description was selected to seek understanding of the participants' subjective experiences (Thorne, 2016; Thorne et al., 2004). The results from this study, exploring the individual accounts of the PENs' experiences caring for pediatric patients and families with LEP, generated disciplinary knowledge, with the potential to influence the practice of nurses providing emergency care to pediatric patients and families with LEP. Additional data were collected through interviews with certified professional medical interpreters, to gain their perspectives related to working with pediatric emergency nurses.

Definitions

A variety of definitions are used by researchers to identify those persons who do not understand or speak English. Non-English speaking, having a language barrier or having limited-English proficiency are terms often used interchangeably in the literature. In this study, the term limited-English proficiency means that the pediatric patient (aged 5 years or older) and/or the family member attending the child has a primary language that is not English and has a limited ability to read, speak, or understand English (U. S. Department of Health and Human Services [HHS], Office of Civil Rights, 2013a).

Family is identified as the person(s) accompanying the pediatric patient, be it an individual or group of individuals, with a continuing legal, genetic, and/or emotional relationship to the patient (American Academy of Family Physicians, 2014). Identifying the person responsible for the pediatric patient's health care may represent an additional challenge to the PEN while overcoming language barriers and attempting to provide emergency care.

Pediatric Emergency Nursing

Pediatric emergency nursing is a relatively new nursing specialty, developed approximately twenty years after the establishment of the broader emergency care system (Institute of Medicine of the National Academies, 2007). In the 1970s and 1980s efforts were made to include the care of children in emergency departments; however, a seminal study by Seidel et al. (1984) indicated that children experienced worse outcomes and more deaths than adults with similar traumatic injuries when treated in emergency departments with no pediatric specialty. Furthermore, Seidel (1986) conducted a study in the United States that revealed emergency medical services lacked appropriate equipment and training to treat children with emergency-related injuries.

Emergency departments dedicated to the care of children of all ages, from neonates to adolescents, were developed in the 1980's and resulted in the formation of a pediatric emergency medicine subspecialty within emergency medicine and pediatrics implemented by the American Academy of Pediatrics (AAP) and the American Board of Pediatrics (Schenk & Edgerton, 2015). Dedicated pediatric emergency departments are now designed exclusively for children with the incorporation of colorful and comforting décor and distraction techniques such as TVs, toys and video games to occupy children and alleviate anxiety (Zwaigenbaum, et al., 2016).

By the late 1980s, the Emergency Nurses Association (ENA) established a pediatric emergency nursing specialty dedicated to offering nurses training in the care of pediatric patients (ENA, 2023). In the early 1990s the ENA developed a standardized Emergency Nursing Pediatric Program to promote the education of PENs in the treatment of pediatric illnesses, injuries, and trauma.

Phenomenon of Interest

The PENs' effective delivery of emergency care is often dependent on their ability to communicate effectively, and it is essential for PENs to establish partnerships with the pediatric patient and family. The Joint Commission (2010) defines effective communication as an exchange and negotiation of information between a patient and health care professional so both parties understand the information correctly and the patient can participate in their decision making through the care continuum. In 2000, guidelines were established by the U.S Department of Health and Human Services Office of Civil Rights to ensure patients with LEP receive equitable health services (HHS, 2018), including the opportunity for families to communicate, without difficulty, the health care needs of their children.

Prioritizing, multi-tasking, and making prompt decisions that influence the provision of patient-family-centered care (PFCC) interventions in the pediatric emergency department may be delayed due to communication difficulties. PFCC involves planning, intervening and evaluating health care in a mutually beneficial partnership among patients, families and health care professionals (American Academy of Pediatrics [AAP], 2012; Institute for Patient-and-Family Centered Care, 2016). Patients and families are encouraged to actively participate in decision making which potentially may affect the type of care a child receives as well as the eventual outcome of such treatment(s). Effective communication is essential in supporting the pediatric patient's and family's participation and collaboration in their emergency care (Dudley et al., 2015). Furthermore, the Joint Commission and the AAP provided recommendations for hospitals to implement PFCC and effective communication in caring for patients and families with LEP (The Joint Commission, 2010; AAP, 2012).

According to a study by Pytel et al., (2009) emergency department patients identified the importance of nurses communicating with them with respect, care and compassion; however, nurses preferred informing their patients of tests and treatments over inquiring about patients' cultural needs or appropriate use of eye contact when speaking with patients. Considering the limited availability of research addressing how PENs initiate and provide care for patients and families with limited-English proficiency, the purpose of this study was to explore how PEN's engage with patients and families with LEP during an encounter in the PED in their efforts to provide emergency care.

Legal Basis for Language Rights

In support of Title VI of the Civil Rights Act of 1964 which bans discrimination based on race, color, or natural origin, in 2000 President Clinton signed executive order 13166 requiring that all federally funded facilities afford persons with LEP accessibility to programs and activities that offers them opportunities to participate in their health care (U. S. Department of HHS, Office of Civil Rights, 2013b). Subsequently, in 2000, The Office of Minority Health issued the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, comprised of guidelines to lead healthcare organizations in eliminating health disparities (U.S. Department of HHS, Office of Minority Health, 2018). The significance of these legal guidelines and mandates cannot be overlooked in the delivery of health care to persons with LEP.

In the case of Castillo-Monterroso v. Rhode Island Hospital (Sup. Ct. R.I. 2009) legal case documents indicate that two pediatric emergency physicians and two pediatric emergency nurses failed to obtain the proper medical history of an 11-day old infant from her mother and uncle with limited-English proficiency. Using gestures and limited English vocabulary, the infant's uncle attempted to explain to the triage nurse that the infant stopped breathing at home. The infant was in no distress on arrival to the pediatric emergency department and subsequently discharged home. The infant was returned to the pediatric emergency department that same day after she stopped breathing for a second time at home. The events led the parents to make the difficult decision to take their infant off life support, ultimately resulting in the death of the child. A complaint of medical negligence was presented against the pediatric emergency department staff involved in the care of the infant for not obtaining an accurate history from the infant's mother and uncle, not determining the family's need for an interpreter and not using translation services as mandated by federal standards.

In 2007, the Institute of Medicine of The National Academies published the report *Emergency Care for Children: Growing Pains,* supporting the importance of PFCC since parents and guardians are recognized as the primary source of strength and information for the pediatric patient. The report concluded that failure to incorporate PFCC into emergency care practice may result in difficulties with informed consents, miscommunication, inadequate understanding of diagnosis and treatment by families, unnecessary child abuse evaluations, and lower quality care (Dudley et al., 2015). PENs may encounter challenges when attempting to provide PFCC for children and their families in the PED due to the acute nature of situations which may not provide the time to form an effective partnership with the child and family. Similarly, pediatric patients and families with LEP may not be aware of the significance of their role in PFCC, presenting concerns with communicating critical information and patient education (Dudley et al., 2015).

Research Question

How do pediatric emergency department nurses initiate and provide emergency care to children and families with limited-English proficiency?

Sub-Questions for Pediatric Emergency Nurses

1. How do PENs initiate emergency care for a pediatric patient and family with LEP?

2. What do PENs experience when encountering a pediatric patient and family with LEP?
3. What concerns do PENs identify in the provision of care for pediatric patients and families with LEP?
4. How do PENs relay critical medical information to pediatric patients and families with LEP?
5. How do PENs provide discharge, follow up and medication instructions to pediatric patients and families with LEP?

Sub-Questions for Certified Professional Medical Interpreters

1. What is your experience working with pediatric emergency nurses?
2. What is your experience working with pediatric patients and families with LEP?
3. What issues have you encountered working as a certified professional medical interpreter?

Justification for Studying the Phenomenon

The demographic profile of the United States is steadily becoming increasingly multicultural and multilinguistic. The U. S. Census Bureau (2015) reports that at least 350 different languages are spoken in various U. S. homes. The top five languages spoken by native and foreign born individuals with LEP in 2013 were: (1) Spanish (16.2 million), (2) Chinese (1.6 million), (3) Vietnamese (847,000), (4) Korean (599,000), and (5) Tagalog (509,000), (Zong & Batalova, 2015). Furthermore, of the 51.3 million children ages 5 to 7 in the U.S., 2.3 million had LEP and 77 percent had at least one immigrant parent (Zong & Batalova, 2015).

Children younger than 18 years accounted for 25.5 million emergency department (ED) visits in 2010 (U.S Department of HHS, Agency for Healthcare Research & Quality [AHRQ], 2013). This number increased to 30 million ED visits in 2015 (U.S Department of HHS, AHRQ, 2015). Levas et al. (2014) conducted a secondary analysis of a prospective, cross-sectional, multicenter study of children aged 3-18 years presenting to ten tertiary care pediatric emergency departments in the United States. Data were obtained from the electronic medical records and concluded that Hispanic children with LEP are less likely than English speaking children to have computed tomography scans or ultrasounds when presenting to pediatric emergency departments with abdominal pain which led to higher rates of appendiceal perforations among Hispanic children with LEP, highlighting the importance of LEP as a factor associated with healthcare quality and outcomes.

Patients and families with a limited ability to communicate in English face challenges navigating the health care system in the U.S. (U.S Department of HHS, Office of Minority Health, 2015). Healthcare disparities associated with patients who have LEP include: (a) decreased access to health care (Eneriz-Wiemer et al., 2014; Watts et al., 2011), (b) decreased quality of health care (de Moissac & Bowen, 2019; Fields et al., 2016), (c) increased rates of medication errors (Samuels-Kalow et al., 2013) (d) increased rates of post-operative infections (Tang, et al. 2016), (e) longer lengths of hospital stays (Levas et al., 2011; Lion et al., 2013; Tang, et al., 2016), and (f) minimal patient-provider communication (Zamora et al., 2016). Parents with LEP were less likely than English speaking parents to understand their child’s health information discussed during interprofessional rounds in a pediatric intensive care unit (Zurca et al., 2017). Parental participation during rounds with an interdisciplinary team, including physicians, nurse practitioners and registered nurses, is considered an important facet of patient family centered care; however, an interdisciplinary team reported that parents with limited English speaking ability chose not to participate in pediatric cardiac intensive care unit rounding with the health care team due to a language barrier (Blankenship et al., 2015).

Home health care referrals for long- term antibiotics were significantly decreased for children with LEP parents in comparison to patients with English speaking parents (Levas et al., 2011). A grounded theory study by Davies et al. (2010) indicated that parents with LEP reported feelings of frustration, anger, helplessness and guilt for not being able to verbally express themselves and share information about their child with the pediatric palliative health care team. Similarly, Steinberg et al., (2016) reported mothers with LEP experienced frustration managing a language barrier when they sought out primary pediatric health care for their children. As these findings represented families in other pediatric specialties, there was a need to focus on the emergency nursing care provided to pediatric patients and families with LEP in the PED.

Jimenez et al., (2014) used a retrospective matched cohort design to evaluate the association between English proficiency, use of interpretive services, pain assessment, and analgesic treatment among pediatric surgical patients. Children 0-18 years admitted for a surgical procedure in a Seattle Children’s Hospital were included in the study. Electronic medical records were examined for nurse’s documentation of pain medication administration, pain scale used and pain scores after each assessment. Among the parents with LEP, there was diversity in languages spoken (e.g., Spanish, Vietnamese, Somali, Ukrainian, Russian, Arabic, Japanese, and Mandarin). Children of parents with LEP received less pre-analgesic and post- analgesic administration assessments per day when compared to children with English proficient parents. The use of the non-verbal Faces pain scale was higher among children from parents with LEP than with children of English proficiency parents; however, it was not clear if those patients being evaluated understood how to interpret the pain scale. The researchers also concluded that children and families with LEP assisted by professional medical interpreters had similar positive pain management outcomes as English proficient patients.

Parents are a significant factor in the medical care of their child, and it is important that every attempt be made to initiate effective communication with them and to ensure they are kept informed of their child’s medical status. Steinberg et al. (2016) using a qualitative methodology, discovered mothers with LEP reported “getting by” by using an English proficient child or family member to interpret for them (Steinberg et al., 2016, p. 1321). The mothers feared being a burden and hesitated to ask questions about their child’s care. Moreover, the mothers reported negative experiences overcoming language barriers and not being offered language services in an emergency department. This highlights the importance of initiating and maintaining effective communication with pediatric patients and families with LEP, in order to address parental concerns and provide appropriate medical information.

Children often lack the vocabulary, knowledge and/or maturity to interpret the information given by healthcare providers and this may lead to misinterpretation of pertinent and complex health care information (Free et al., 2003; Giordano, 2007; Russell et al., 2015). It is important to consider that children (non-patients/family members) and pediatric patients were often used as ad hoc interpreters in healthcare settings by surgeons to obtain preoperative consents (Patel et al., 2016); and by health care providers in times of emergencies or when interpreters were not available (Balakrishnan et al., 2016; Jones, 2008; Russell et al., 2015). Children of parents with LEP represent a significant portion of informal interpreters in health care settings. Inaccurate interpretations result in poor communication between the patient/family with LEP and the health care provider, which may contribute to the likelihood of medical errors

(Samuels-Kalow et al., 2013).

Social workers, nurses, and physicians agreed that they were not able to provide adequate support and counseling for families that had difficulty speaking/understanding English, and at times they have requested the children of families to interpret (Russell et al., 2015). Similarly, in a multi-site mixed methods study by Tate et al., (2016), emergency medical services (EMS) field providers reported frustration with the time delay in accessing a medical interpreter and approximately six of the 27 EMS providers interviewed described using bystander children as interpreters.

Most hospital emergency departments have some form of interpretive services available; however, studies indicate that these services are often underutilized due to patients' lack of awareness regarding the availability of interpreter services, patient privacy concerns in using family as interpreters, or the health care provider's desire to save time (Balakrishnan et al., 2016; Parsons et al., 2014; Perez et al., 2016). Researchers also suggest that ED staff are associated with under-utilization and improper usage of language interpretive services (Gutman et al., 2018; Garrett et al., 2008; Ramirez, Engel & Tang, 2008). Despite the benefits of using professional medical interpreters, health care providers infrequently used the interpretative services in offering discharge education to patients (Lee et al., 2018), further hindering the communication process with patients and families with LEP and influencing follow-up compliance with discharge instructions.

In summary, there is supporting evidence that health disparities among pediatric patients and families with LEP are associated with language barriers (Fields et al., 2016). Families with LEP face challenges navigating the health care system and often decline to actively participate in inter-professional discussions regarding their child's medical information. Furthermore, health care professionals often underutilize professional medical interpretive resources, due to lack of time or training and instead use ad-hoc interpreters, including children. It is for these reasons and in consideration of the estimated future changes in the demographic profile of population in the United States that it was fitting to explore how PENs provide emergency care to patients and families with LEP in the dynamic and fast-paced setting of a PED.

Relevance to Nursing

The American Nurses Association (ANA) promotes the importance of providing safe and effective nursing care to an increasingly diverse patient population in the United States (American Nurses Association, 2018). Furthermore, the Nursing Code of Ethics for Emergency Nurses (Emergency Nurses Association [ENA], 2017a) underscores the importance of the ED nurse's commitment to providing education and information to each patient with professionalism, compassion, and respect, without bias or prejudice. To provide safe quality health care to patients with LEP in high-risk and complex environments, such as the pediatric emergency department, the Joint Commission (2015) recommends health care providers collect accurate language information at the point of entry and document all language services used during the patient and health care provider encounters. In 2012, the United States Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) reported that the ED is a high-risk, hectic and hurried environment where adverse effects and medical errors are more likely to occur among patients with LEP than among English speaking patients. Obtaining reliable data on the patient's medical history, allergies, past surgeries, medications, and current health condition is imperative in providing quality patient care when important life-saving decisions must be made without delay (U.S. Department of Health & Human Services

AHRQ, 2012).

Hildegard Peplau's middle-range nursing theory of interpersonal relations defines nursing as an interpersonal, therapeutic three-phase process that takes place when nurses engage with people who need health care services (Peplau, 1988). The importance of a nurse establishing a trusting interaction with the patient is emphasized in the first phase, orientation. Unfortunately, a language barrier may impede the transition of the nurse and patient to a successful working phase (2nd phase) or the resolution phase (3rd phase) where the nurse provides care, education, resources and collaborates with the patient to meet their health care need. Senn (2013) explains the essential responsibility of the emergency nurse to communicate proactively with the patient presenting to an ED to interact purposefully and promptly with the patient and family.

The increasing number of people with LEP seeking healthcare in the United States requires nurses to direct their efforts towards addressing linguistic differences with appropriate methods to ensure that all patients, receive equitable health care. When faced with challenges communicating with patients with LEP, critical cardiac care, medical-surgical, pediatric and maternal care nurses used limited verbal and non-verbal attempts to communicate with their patients as well as face-to-face interpreters and interpreter phones (Coleman & Angosta, 2016). Nurses report using "gestures" and "charades" when teaching patients with LEP the importance of using the call bell system to ensure fall prevention and effective pain management (Galinato et al., 2016, p. 4). Differences in language comprehension between nurses and patients affected the delivery of quality nursing care, health care outcomes, patient satisfaction and nurse job satisfaction (Montie et al., 2016; Lee et al., 2018; Olivarez et al., 2017) and may threaten patient safety during routine nursing responsibilities such as medication administration and pain management for hospitalized patients (van Rosse et al., 2016).

In summary, studies indicated that nurses in acute care areas experienced both positive and negative reactions to managing the care for patients with LEP including the coordination and use of professional medical interpreters. Research studies are limited in describing the experience of PENS when caring for pediatric patients and families with LEP in the often hurried, unpredictable environment of the PED. Therefore, the aim of this research was to examine the experience of PENs when caring for pediatric patients and families with LEP.

Researcher's Perspective

On June 2013, my father telephoned me on a Sunday evening requesting that I contact his primary doctor who had just attempted to explain to him, over the telephone and in English, the results of his recent thyroid biopsy. Without hesitation I phoned my father's physician who immediately revealed to me my father's malignant results. How did my father give his physician permission to reveal information of this nature to me if he does not understand English medical terminology very well and how did the physician, through her conversation with my father, determine that it was legally permissible to divulge her patient's private medical information to a family member? I remember thinking, at the time, how unreasonable it is to ask a family member, albeit a nurse, to translate this devastating news to her own parent. As the eldest daughter of immigrants from Peru, at a very young age, I became the official family translator for my parents who only spoke Spanish. So, I learned first-hand about the difficult process my parents and other people with LEP faced when navigating the health care system in the US.

I became interested in how nurses care for patients with limited English proficiency through my professional experiences as a nurse. My 24-year experience as a registered nurse has included medical-surgical, telemetry, emergency, home care, as a nursing instructor and as a nursing professional development specialist for medical-surgical, labor & delivery, mother/baby and critical care nurses.

In my role as an ED nurse, I had witnessed parents with LEP bring in their young children for treatment and due to the parents' language barrier, the child would be the one to describe their own signs and symptoms in English to the ED staff. Very little interaction occurred between the nurse and the parents with LEP other than signing informed consents and discharge papers, at times with the assistance of translators and myself. Through my interactions with Spanish speaking patients, I often witnessed their concerns, frustrations and/or helplessness in their efforts to help their child.

My observations of how other nurses in the ED managed the care of patients with LEP left me disappointed with the less than optimal interactions between nurses and patients with LEP. In emergency life-threatening situations, ED nurses would search for anyone (e.g., environmental services, security, visitors, including children, another nurse) who could translate for a patient or family with LEP and often disregard the professional interpretive resources available to ED staff. In emergent cases, nurses would rely on their skilled assessment techniques and without any verbal interaction, a patient would be triaged and medically treated based on their medical evaluation. I felt that there should have been a more efficient way to provide the care and communication that all patients deserve.

I chose to focus on pediatric emergency nurses because they have the additional responsibility in caring not only for children but also for the child's family. Children of parents with LEP are most vulnerable since they cannot express themselves and thus participate in the care their child receives. The ED environment is often fast-paced and chaotic, and nurses are pressured to provide emergency care to all patients despite the high acuity and high patient volume. Health care disparities are reported in patients with LEP that present to emergency departments, and these disparities have been clearly associated with language barriers.

For this study, I made every effort to maintain an unbiased approach and considered the nurses' experience with objectivity taking the necessary steps to maintain the trustworthiness of this study. I am interested in and committed to the discovery of new knowledge about the experience of PENs initiating and providing care for pediatric patients and families with LEP.

CHAPTER II

LITERATURE REVIEW

Introduction

Pediatric emergency nurses (PENs) are expected to gather accurate health related information in a time sensitive and often high acuity, high volume environment to provide safe and efficient patient-family centered care to the pediatric patient and family (Byczkowski et al., 2016; Dudley et al., 2015). A language barrier may present additional challenges to the PEN performing unique age appropriate assessments and providing emergency nursing care necessary to treat a range of illnesses and injuries in children. Furthermore, effective communication is essential to the delivery of quality healthcare for pediatric patients during emergency situations. Despite significant evidence supporting health disparities existing among pediatric patients and families with limited-English proficiency (LEP); and federal guidelines and various modalities of professional interpreter resources available to safeguard these patients, there is little research describing the experience of pediatric nurses caring for this population, specifically, the experience of PENs' encounters with children and families with LEP.

Literature Search

A literature search was performed from the year 2000 to the present year. This publication range was determined based on the release date of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) by the U.S. Department of Health and Human Services, Office of Minority Health (2001) in December 2000. The National CLAS Standards offer guidelines intended for organizations to improve the quality of health care delivery by eliminating health care disparities (U. S. Department of HHS, Office of Minority Health, 2018). International studies were excluded from this review since the American nursing standards of practice and health care system infrastructure differ from other countries. Research studies focusing on adult or general emergency departments were also excluded from this review due to the specific focus of this study on pediatric emergency nurses who practice in dedicated pediatric emergency departments. Publications in English were reviewed from four online databases: CINAHL, MEDLINE, PsychINFO, and ERIC using singular and combinations of the search terms: *pediatric emergency nursing*, *emergency services*, *pediatric nursing care*, *nurs**, *limited-English proficiency*, and *limited-English*, with additional articles reviewed from the reference lists of identified studies.

The scarcity of research examining the experience of PENs caring for patients and families with LEP led to a decision to include studies describing the experience and perspectives of parents with LEP whose children received care from nurses, health care professionals and medical interpreters associated with other pediatric nursing specialties. Certified professional medical interpreters are identified as trained specialists that assist in bridging the communication gap between a health care professional and a patient and family with LEP (Perez et al., 2016). Authors in these studies refer to interpreters as professional medical interpreters, professional interpreters or certified interpreters.

As described earlier in this study, the term limited-English proficiency defines that the pediatric patient (aged 5 years or older) and/or the family member attending the child, has a primary language that is not English and has a limited ability to read, speak, or understand English (U. S. Department of HHS, Office of Civil Rights, 2013a). In addition to use of the term LEP, some authors in studies referred to the patients' inability to speak English as non-English speaking or as a language barrier.

Studies in the neonatal intensive care unit (NICU), pediatric intensive care unit (PICU) pediatric oncology and pediatric hospice care are initially discussed, followed by studies specifically related to PENs.

The Perspectives of Parents, Healthcare Providers and Medical Interpreters

Pediatric Hospice Care

Thienprayoon et al. (2015) used a qualitative design to interview 34 bereaved caregivers (English speaking interviews n=12, Spanish speaking interviews n=8) of children who died of cancer between 2006-2010 while receiving pediatric hospice services and being cared for by primary oncologists at Children's Medical Center in Dallas. Participants were interviewed as a mother-father dyad, a family unit (including siblings), individually and as an extended family including 1 uncle and 2 cousins. Interview questions for this pilot study were translated by a bilingual research assistant and reviewed by the University of Texas Languages & Validation Services. Receiving honest and truthful information about their child's prognosis was important to both English and Spanish speaking caregivers; however, Spanish speaking families reported their "culture-related frustrations" with the emergency department (ED) staffs' poor decision to deliver bad news to them in the presence of their child. One Spanish speaking family reported that their child told them, "I heard the doctor told dad that I was going to die" (Thienprayoon et al., 2015, p.33). Another Spanish speaking family explained how "crude" the ED staff was with delivering critical news to them about their child's prognosis (Thienprayoon et al., 2015, p.33). Some families would have preferred to protect their children from learning about their poor prognosis and if given the option would have chosen to hear the bad news initially instead of learning of the bad news together with their child. Similarly, the English-speaking families agreed on the poor quality of communication in the ED, primarily due to long wait times without updates from the staff. During the child's hospitalization, Spanish speaking parents reported the unreliable use of and difficulty accessing professional interpreters daily when the child or siblings spoke English. However, the Spanish speaking parents reported satisfaction with professional interpreters, when they were made accessible, to facilitate the communication of direct diagnosis information between them and the health care staff. In contrast, English speaking parents reported that they would have liked to receive direct honest information initially and not need to rely on a second medical opinion to learn and understand their child's poor prognosis. Due to the language barrier, Spanish-speaking parents expressed feelings of inadequacy and apprehension as their child's caregiver. Spanish speaking parents often hesitated to be honest with their child about their disease progression; however, family dynamics were at times affected if the patient was a bilingual teenager and allowed to discuss his or her own prognosis with health care providers in English when their parents only spoke Spanish. Spanish speaking parents believed their teenaged child had protected them from learning of their poor prognosis. Overall, most of the Spanish speaking families reported a positive interaction and experience with the hospice nurses despite the language barrier they encountered on a day-to-day basis; however, they had difficulty in accessing professional interpreters and expressed concerns regarding their experience communicating with staff in the ED.

Spanish speaking parents perceived that trust, discretion and protection of their children were important in their communication with healthcare providers and professional interpreters. Findings from this study highlight the experiences and challenges that parents with LEP face in anticipating the death of their child. Although this was a pilot study conducted in one institution with a small number of participants, further research is warranted in areas involving the communication exchange between nurses and parents with LEP particularly in the pediatric emergency department (PED). This is especially true where the delivery of bad news deserves careful insight and a communication approach that meets the needs of the family and pediatric patient.

Pediatric Intensive Care Unit

A cross-sectional study was conducted by Zurca, et al. (2017) examining communication experiences and preferences among families with LEP (n=52) and English proficiency (EP) (n=109) in a pediatric intensive care unit (PICU) located in an urban hospital in the United States. Spanish speaking families were invited to participate in this study, because the hospital demographics demonstrated that 20 % of the patients were Spanish speaking, 70% English speaking and 10% spoke a different language. The three primary communication settings evaluated in this PICU were: (a) planned family conferences which were conducted twice a day; (b) family centered rounds, and (c) unplanned bedside conferences by physicians and nurses. The authors also examined the experiences of families with LEP using professional medical interpreters while their child was hospitalized in the PICU. Families with LEP (58%) and EP (50%) preferred communication with health care professionals at their child's bedside, followed by participating in family centered rounds. Least preferred were family conferences. Few families with LEP and EP reported participating in family conferences; however, those families who attended these conferences reported a better understanding of their child's plan of care. Families with LEP were less likely to report being invited by the staff to participate in family centered rounds (P=.004) and less likely to report they understood their child's plan of care after rounds (P<.001). Families with LEP suggested that using a professional medical interpreter during rounds would have helped them understand their child's plan of care better. Families with LEP also reported that they were less likely to be at the bedside when their child was evaluated by a health care provider. There were no significant differences in the families with LEP when compared to families with EP in their satisfaction with the amount of time physicians spent at the bedside. Families with LEP reported being less satisfied with the amount of time their child's nurse spent communicating with them and that they were less likely to rely on the nurses to explain their child's plan of care to them. During admission to the PICU 73% of the families with LEP reported using an interpreter, of which 49% used an in-person interpreter, 44% used a phone interpreter and 7% used a family member or friend for help with translation. During their stay in the PICU, 53% of families with LEP reported that the medical team used a professional medical interpreter to communicate with them "Most of the time", "Sometimes" (33%), and "Rarely" or "Never" (14%). In contrast, the families with LEP reported that during their admission to the PICU their nurses used an interpreter to communicate with them "Often (41%)", "Sometimes (30%)" and "Rarely or Never (28%)".

Results of this study demonstrate the underuse of interpretive services by nurses in the PICU when compared to other members of the medical team. Although parents preferred communication with healthcare professionals at their child's bedside, the parents with LEP were not satisfied with the amount of time the nurses spent communicating with them and consequently that they did not rely on the nurses for information regarding their child's care. Evidence from this study also supports the importance of offering interpretive services to parents with LEP so that they may actively participate in the decision-making process of their child's healthcare (e.g., during family centered rounds). A need for further research examining the experience of nurses communicating with parents with LEP is justified based on the reports of parents not understanding their child's plan of care and indicating a poor quality of communication and trust with nurses. It is important to note that the responses from the Spanish speaking parents are based on a survey tool that was not previously validated and the

Spanish-speaking parent participants were recruited from one single medical center.

Neonatal Intensive Care Unit

Using a descriptive design, Miguel-Verges et al., (2011) studied the experience of parents of newborns transitioning from receiving care in a neonatal intensive care unit (NICU) to being discharged and following-up with community pediatric care in the mid-Atlantic United States, between 2007 and 2009. The NICU staff identified the Spanish-speaking parents who was asked to participate in this study. Parents with LEP were interviewed with the assistance of an interpreter 48 hours prior to discharge from the NICU and one-month post discharge. The patients' personal pediatricians were also interviewed one month after the infant was discharged from the NICU. Interviews with pediatricians focused on the availability of interpreter services, their experience of communication with the family, their perception of the family's preparation for transitioning from the NICU to home, and recommendations for improving this transition. Due to the low number (n=9) of father participants, only mothers (n=36) were included in the study. A control group was not available, so the authors compared a subset of the results from the Spanish-speaking parents to previously collected data of English-speaking mothers who had their newborns in the NICU between 2004 and 2006. In comparison to the English-speaking mothers, the Spanish speaking mothers were less educated, less likely to be employed and had a lower income. When compared to English speaking mothers the Spanish speaking mothers were more likely to report that the hospital staff was friendly and available; however, the Spanish speaking parents reported feeling uneasy asking the nurses questions, uncomfortable participating in the care of their newborn and in making decisions for their newborn in the NICU. Seventy-eight percent of the Spanish-speaking mothers used a professional medical interpreter to communicate with the NICU staff. Interestingly, two Spanish-speaking families reported that they were refused entry into the hospital because they could not communicate in English with the security guard at the main hospital entrance. The mothers with LEP did not report any significant differences in their pre and post discharge responses, which revealed their satisfaction with the discharge information received. Forty-seven percent of the mothers reported being prepared for discharge during both interviews. Although the mothers with LEP reported their satisfaction with discharge preparation, 53% worried about their baby's future. In the follow-up interview one-month post NICU discharge 50% of the mothers with LEP reported experiencing ongoing medical problems with their babies (e.g., breathing problems, feeding problems, constipation, cardiac arrhythmias, inguinal hernias). One third of the mothers reported taking their infant to the ED. Results from this study indicate that language barriers interfered with the mothers' ability to follow discharge instructions. For example, a mother whose infant was discharged with a lower extremity orthopedic cast had difficulty contacting the orthopedist, so she removed the baby's cast herself. Another mother's infant was seen at an outpatient cardiology office and placed on a Holter monitoring system. The mother's interpretation was that the monitor wires were supposed to stay on the infant's chest for 6 weeks without bathing instead of the 72 hours that were recommended by the cardiologist. The pediatricians with which the patients followed up after discharge from the NICU suggested that the communication problems with the NICU staff and the presence of low literacy among the parents with LEP impacted their transitions to community care and resources.

Recommendations were made by the pediatricians that the NICU staff provide parents with LEP information that was simple for them to understand so they could navigate the medical system better. Findings indicate that interpretation services only amend part of the language barrier issue as indicated by the pediatricians. Low literacy and a language barrier have a long-term effect on the home medical care of an infant with parents with LEP.

Obregon et al., (2019) conducted a retrospective analysis of secondary data comparing the neonatal intensive care unit (NICU) technical and emotional discharge preparedness of families with and without LEP whose newborns' length of stay in the hospital was greater than 10 days. The authors studied 1307 families discharged from the NICU at a teaching hospital in Massachusetts between 2011 and 2016, of whom 90 (7%) were families with LEP. The most common languages found in families with LEP were Chinese (38%) and Spanish (21%). Each family in the NICU participated in an individualized discharge planning to meet their child's medical needs initiated soon after the admission process was completed. Parents were taught technical infant care skills which included, feeding, bathing, safe sleep, assessing temperature, identifying signs of illness, normal and abnormal preterm infant behavior, and infant cardiopulmonary resuscitation. Emotional preparedness was comprised of the family's confidence in their ability to assume care of their baby at home and their readiness to be discharged home. Data indicated that families with LEP were assisted by a professional interpreter during discharge planning sessions and when completing the 9-point Likert scale survey. Development and validation data of the survey instrument were not provided in this article. The authors highlight that the tool was not validated for use with parents with LEP and certified interpreters read the surveys to the parents. The corresponding nurses independently completed an assessment of the families' technical and emotional preparedness for discharge. Results of a logistic regression indicated that all the families with LEP considered themselves prepared for discharge. Nurses indicated 94% of the families with LEP and 97% of the English proficient (EP) families were emotionally prepared for discharge ($p= 0.012$). Similarly, the nurses determined that 94% of families with LEP were technically prepared for discharge compared to 98% of families with English proficiency. Families with LEP considered themselves technically prepared for discharge and scored significantly less than the families with English proficiency on their emotional self-assessment (LEP 8.6 ± 2.7 and EP 9.1 ± 2.2, $p = 0.048$). Overall, families with LEP were less likely to be technically and emotionally prepared for discharge based on the nurses' assessment in comparison to the family's self-assessment. The results of this study are based on a secondary data analysis; thus, the authors were unable to further explore the parents' responses. Further research is indicated to examine the reasons why nurses assessed the parents with LEP as less likely to be technically and emotionally prepared for discharge from the NICU.

Using a prospective cohort study design in a NICU located in Northern California, Enlow et al.,(2014) surveyed parents (N=79) at discharge and 2 weeks after discharge (n=49). The 33-item discharge tool and 27-item post-discharge tool were written in English and translated in Spanish by certified translators. The tool validation data was not provided; although, the researchers report the survey content was validated for readability by a focus group of bilingual NICU parents. Survey items focused on the experience of the NICU and discharge teaching needs. The post discharge survey focused on identification of barriers to care and use of health care resources after discharge and was conducted over the phone by a bilingual research assistant. Parents that filled out the Spanish surveys (n= 18) reported being less satisfied with their experience in searching for answers from a physician ($p = 0.05$) or a nurse ($p= 0.001$); however, both Spanish and English speaking parents (n=61) were satisfied with the overall experience of the way they were treated as a partner in the care of their newborn in the NICU. Over 90% of parents participating in the study strongly agreed that the NICU staff provided them with enough information on topics such as car seat instructions, feeding patterns, CPR, sleep patterns, when to call a physician and when to go to an emergency department. Both Spanish and English-speaking parent agreed that the NICU provided them with adequate information on community resources. In the follow-up phone survey 2 weeks after discharge, both English (n=36) and Spanish (n=13) speaking parents identified infant developmental issues (52%), understanding infant moods and behaviors (29%); and how to talk to their family members about having a special needs baby (24%). Parents that filled out the Spanish survey reported difficulty speaking to follow-up referrals in their primary language. Thirty-five percent of the parents reportedly took their infant to a pediatrician, urgent care or emergency department. Pediatricians reported that approximately 50% or more of NICU parents experienced challenges contacting the clinic, filling their prescriptions and arranging transportation to the clinic. It was also reported that Spanish speaking parents had lower education levels than the English-speaking parents.

In summary, parents with LEP with newborns admitted to a NICU face challenges communicating with physicians, nurses and following up with healthcare providers due to an existing language barrier. Although parents with LEP reported satisfaction with the overall NICU experience, evidence indicated they are less satisfied with their interactions with nurses. Parents with LEP hesitated to ask nurses questions and participate in their infant's care and were reluctant in seeking out nurses for answers about their child's healthcare due to their limited ability to speak and/or understand English. Furthermore, nurses suggested that parents with LEP are less likely to be prepared to manage the home care of their newborn discharged from a NICU.

Although these 3 studies (Enlow et al., 2014; Miquel-Verges et al., 2010; Obregon et al., 2018) offer evidence that parents with LEP may experience communication issues with nurses due to a language barrier, the results are limited to individual medical centers and a focus on

Spanish-speaking parents. Further research is indicated to examine the experience of nurses providing care to families with LEP through a qualitative inquiry to further explore the nurses' voices in this healthcare disparity.

Pediatric Oncology Care

Zamora et al. (2016) conducted a cross sectional study exploring communication barriers, perceptions of healthcare quality and care experience among English (n=310) and Spanish (n=56) speaking parents in a children's hospital located in Salt Lake City, Utah. Parents were invited to participate in the study if they were the caregiver of a child that was diagnosed with cancer at least 3 months prior to completing the survey during 2010 and 2013. Data regarding the reliability and validity of the 49- item survey was not provided by the authors. The survey was offered in both English and Spanish languages, with the Spanish survey consisting of an additional 23 questions inquiring about the parent's: (a) country of origin, (b) language proficiency, (c) communication barriers, and (d) immigration status. One additional question regarding clinical trial enrollment included in both the English and Spanish surveys revealed 73% of Spanish-speaking parents believed their child was enrolled in a clinical trial when in fact only 56% of those children were participating in a clinical trial. Twenty-five percent of Spanish speaking parents reported difficulty in communicating with physicians and 31% reported difficulty communicating with nurses. Most of the Spanish speaking parents reported feeling uncomfortable requesting a professional interpreter and 21% of Spanish speaking parents admitted to falsely understanding health care professionals because they were embarrassed that they did not speak English. Eleven percent of Spanish-speaking parents who self-reported an undocumented immigration status reported avoiding seeking medical care for their child and 9% reported their hesitation to call the on-call physician at night or weekends because of concerns the physician would not speak Spanish. Furthermore, Spanish speaking parents reported higher levels of satisfaction with the care their child was receiving and with the communication regarding the side effects of chemotherapy in comparison with English speaking parents; however, 32% reported that their child would have received better quality medical care if they spoke English. In conclusion, the Spanish speaking parents reported having a difficult time communicating with the health care staff while their child was undergoing oncology treatments; inversely, these same parents reported high levels of satisfaction with the care their child received in comparison to English speaking parents. The authors suggested that a possible explanation for the high levels of satisfaction reported on the questionnaires by the Spanish speaking parents are associated with a "cultural" demonstration of respect and gratitude for healthcare providers (Zamora at el., 2016, p. 2177).

Abbe et al., (2006) used a mixed- method study to explore how pediatric oncologists (n=37), parents with LEP (n=17) of pediatric patients with blood specific cancers and pediatric-based professional interpreters (n=17) perceived their experience communicating with a language barrier. Twelve interpreters reported having received college level interpretive training, and four interpreters reported having no formal interpretive training. Three separate mixed-method surveys with common themes were developed by the authors and validated through a pilot study with a separate group of pediatric oncologists, professional interpreters and parents. Spanish surveys were translated and independently validated for accuracy. Although pediatric oncologists were concerned over not being able to control the accuracy of translations provided through a professional interpreter, they preferred the benefits of using an interpreter as compared to enduring the difficult process of communicating on their own with the parents with LEP. Professional interpreters expressed their concerns over physicians who were not experienced in working with interpreters. For example, physicians not taking into consideration sentence length, information overload and word complexity when communicating with a parent through a professional interpreter. Furthermore, professional interpreters described the misconceptions they believed physicians had about Spanish-speaking patients. Often physicians did not understand the limited medical knowledge and understanding of Western medicine that patients and parents with LEP had, making hospital visits and physical examinations intimidating for the parents with LEP. Parents with LEP expressed their fears and concerns in not understanding an English-speaking physician and not being aware that they could request the assistance of an interpreter. At times, the use of professional interpreters led to comprehension difficulties due to interpreters not being able to clarify or simplify complex medical information for the parents. Parents who understood little English expressed their frustrations at knowing that the interpreter omitted details of the physician's information regarding their child's chemotherapy. Fourteen of the parents reported feeling safe and confident when having an interpreter present. Parents suggested that interpreters be made available for all encounters with clinicians and patients with LEP and that they arrive in a timely manner. Other parents mentioned the importance of clinicians and interpreters working well together for the benefit of the patients. Interpreters also suggested that clinicians learn how to work more effectively with them by avoiding medical jargon and limiting the length of sentences that need translations in order to improve communication with patients. Moreover, the pediatric-based professional interpreters recommended that they receive additional training to better understand pediatric oncology medicine and better serve patients with LEP.

The researchers concluded that professional interpreters demonstrated understanding of their role mediating communication between health care providers and parents with LEP. Their concerns over working collectively with clinicians was also highlighted in this study.

Recommendations were offered by the parents with LEP for clinicians to receive training on working efficiently with professional interpreters. Although parents with LEP reported difficulty communicating with physicians and nurses, they also reported their hesitation in requesting a professional interpreter, despite feeling safe and confident in the presence of one. Parents with LEP at times were embarrassed to admit they did not understand English and subsequently perceived their child's healthcare information incorrectly. For example, mistakenly thinking their child was included in a clinical trial, which is significant due to the informed consent process that is involved with participating in clinical trials.

Using a mixed methods design Gil et al., (2016) studied the experiences of parents with LEP (n=12) whose child was receiving cancer treatment and health care providers (n=15) working at a pediatric cancer center in a children's hospital in Minnesota who used the LEP Patient and Family Advocate (PFA) as a resource. Parents with children receiving treatments for acute lymphoblastic leukemia, melanoma and medulloblastoma participated in the study by completing surveys and interviews. The surveys were created by the authors and reviewed by pediatric nurse practitioners for face validity and content. The survey intended for the Spanish speaking parents included one additional open-ended question asking the parents to share stories of their experience with the LEP PFA. Health care provider participants included medical doctors, pediatric nurse practitioners and registered nurses. To better meet the needs of Spanish speaking families the role of the LEP PFA evolved from the role of the professional medical interpreter. Unlike the role of a trained medical interpreter that is bound by a code of ethics and standards of practice to remain objective at all times and not engage in conversation with patients outside of the interpretive sessions, the LEP PFAs are described as reliable long-term advocates for the patients with LEP. The patient family advocate was considered a member of the health care team and was consistently present with the Spanish speaking families from the moment their child was admitted through the discharge process and follow-up care. The continuity of the LEP PFA was appreciated by both the parents and staff because the need to repeat the pediatric patient's status each time a new interpreter was used for translation was eliminated. Spanish speaking families were provided with medical interpretation and appropriate resources through the assistance of the LEP PFA whose collaboration with the health care team (e.g., nurses, advanced practice nurses, physicians, social workers, psychologists, child life specialists, and physical therapists) improved the hospital experience of the families with LEP. Responses from parents with LEP and staff revealed their concerns with language barriers and appreciation of the use of the LEP PFA. Staff recognized the potential risk of families with LEP having received fragmented care prior to implementing the role of the LEP PFA. The presence and interactions between the families with LEP, health care providers and LEP PFA helped address this risk. For example, a parent with LEP expressed how he had to repeat his child's history every time a new interpreter was designated to help with translations. Families with LEP expressed their satisfaction and trust of the LEP PFA and credited it with improving their ability to communicate with the staff about their child's medical condition. The introduction of the LEP PFA provided Spanish-speaking families with reassurance that they would have the same interpreter work with them every time their child came in for treatments. Likewise, the staff felt comfortable with the quality of interpretation when using the LEP PFA to teach families about cancer treatments their child was receiving. Furthermore, the staff reported satisfaction in using the LEP PFA to engage families with LEP in social conversation and they felt at ease knowing that families with LEP were receiving the same quality of care as that other patients who spoke English. In addition to serving as a patient/family advocate, the LEP PFA also coordinated necessary resources outside of the clinical setting to address the challenges parents with LEP faced with follow up care. The role of the LEP Patient Family Advocate was accepted by the staff and parents with LEP.

The new enhanced role of the previous professional interpreter on the nursing unit improved the connection between nurses and patients. Nurses reported their satisfaction with the care children of parents with LEP were receiving with the assistance and continuity of the LEP PFA. Likewise, parents with LEP reported their appreciation for the LEP PFA and credited it with improving their communication with the health care team. There is a possibility that the LEP PFA may have developed a rapport with the pediatric patient and family with LEP due to repeated visits for oncology medical evaluations and treatments. Since nurses reported satisfaction with the patient outcomes of working with LEP PFAs, further research is necessary to explore the experience of nurses working with LEP PFAs.

Pediatric Emergency Department

Pediatric emergency nurses (PENs) provide care to children presenting with conditions from minor illnesses to traumatic life-threatening injuries in a fast-paced and often hectic environment. A visit to an ED can be a source of anxiety and distress for the patient and the family (Fletcher et al., 2011; Ramsdell et al., 2016; Salmela et al., 2009). It is critical for PENs to initiate age-appropriate and family-centered care (Brown et al., 2008; Byczkowski et al., 2016; Gillespie et al., 2012), which requires the ability to communicate effectively with patients and families. How PENs address the needs of the patient and family during their initial ED encounter and/or potential return visits may impact the quality of care received and ultimately affect patient outcomes. Family satisfaction with pediatric emergency care correlates with the quality of provider-patient interaction and the adequacy of information received (Margaret et al., 2002).

Gutman et al., (2018) used a regression analysis to examine an association between professional interpreter use, discharge education and caregiver comprehension during video recorded pediatric ED visits of Spanish-speaking LEP families at a medical center in Seattle, WA. Results were obtained from a larger randomized clinical trial comparing professional telephone and video interpretation services at a children's hospital. Parents with LEP in the ED were randomly assigned to an interpreter modality based on the choice of the ED provider. For example, nurses, medical residents and attending physicians all interacted with a patient in the PED and each interaction required the provider to choose the method of interpretation they considered best to communicate with the patient. Video recordings were reviewed for the type of provider interacting with the patient, primary language used during communication and mode of interpretation. Primary languages used for interpretations were either English or Spanish. Modes of either in-person, telephone, or video interpretations to choose from included: (a) no interpretation, (b) use of family members or (c) professional interpreters. Each video interaction was examined for four essential components of a child's discharge from the pediatric emergency department: (a) information on the child's diagnosis or review of presenting signs and symptoms, (b) discharge instructions for home management of injury or illness, (c) follow up appointments, and (d) instructions on when to return to the pediatric emergency department (PED). If the discharge instructions included medication prescriptions, two additional components were evaluated in the discharge video: (a) did the parent receive instructions on medication dosing including frequency in which to give the medication and, (b) did the patient receive instructions administering the medication correctly. Discharge education was considered complete if the patient-provider encounter met 3 of the four components. Forty-seven pediatric emergency department visits with Spanish speaking families were recorded. Forty-seven percent of the discharge communication interactions recorded involved a medical resident or nurse practitioner in the PED, 21% of interactions with physicians and 11% with nurses. A professional interpreter was used in 66% of the interactions and a bilingual provider provided discharge communication in 3% of the video recorded interactions. Therefore, 31% of the interactions involving discharge instructions did not occur with an interpreter, despite the providers being aware that they were being video recorded. In evaluating the four essential components of a child's discharge, all caregivers were provided with a summary regarding their child's injury or illness. However, only 55% were given instructions on when to return to the PED for reevaluation and no more than 70% received complete discharge instructions. The study did not indicate if the discharge instructions were provided in a language other than English. Analysis of the medication discharge instructions revealed only 65% of the patients were given medication dosing instructions; furthermore, the patients were not taught how to administer the medication. Evidence from this study indicates parents with LEP are most likely not receiving safe and efficient discharge instructions in the PED rendering them at risk for medication errors and poor quality health care.

The results of this study are limited to a single institution in Washington and may not be transferable to other PEDs or emergency health care providers. Although the findings support prior studies on the underuse of professional interpreters in emergency departments the sample of nurses in the study was small. Moreover, the findings are based on an observer's evaluation of the interaction between a PED healthcare provider and the patient and family with LEP. Therefore, a qualitative study utilizing interpretive descriptive methods will provide further in-depth investigation of the experience of the PEN initiating and providing emergency care to pediatric patients and families with LEP through the nurses' voice.

Pediatric emergency nurses form partnerships with patients and families to initiate emergency care and patient teaching. Patients and/or their families who are not proficient in the English language present challenges to PENs. Ian et al., (2016) examined the experiences of registered nurses caring for non-English speaking patients and how those experiences influenced their clinical practice by means of an internet open-ended questionnaire. The study focused on 17 female participants employed mainly in the ED of a large pediatric hospital located in the Pacific Northwest of the United States involved in the care of non-English speaking patients. Open-ended questions included such topics as description of the nurses' experience in caring for non-English speaking patients, issues that came up during the provision of care, and the education and resources necessary to care for non-English speaking patients. The nurses reported the "unavailability" of interpretive resources when caring for non-English speaking patients; although, many of the participants reported that the institution provided them with various in-person, phone and video interpretive resources. The nurse encounters with non-English speaking patients were reported as being "difficult" and "frustrating" when having to wait for every word to be interpreted, thereby increasing the length of stay in the emergency department (Ian et al., 2016, p. 259). The nurses indicated that they used non-verbal skills and required additional time to teach non-English speaking patients who required interpreters. One nurse reported a positive experience of professional growth and self-reflection, explaining how through taking the time to understand the patients' situation she came to see herself "a better nurse" and by putting herself in "their shoes" she was able to achieve a "mutual understanding" with the patients before continuing with the plan of care (Ian et al., 2016, p. 259).

The researchers described the experiences of nurses in an ED in a pediatric hospital; however, due to the limited sample of nurses, the transferability of the findings may not be applicable to nurses outside the Pacific Northwest. This study described the beliefs and attitudes of the nurses caring for non-English patients but did not provide details of how the nurses initiated and provided emergency care to children and families who did not speak or understand English. In addition, the growing population of people with LEP in the northeast US (Migration Policy Institute, 2011) warrants investigation of the nurses' experience of providing care to children and families with LEP seeking health care in pediatric emergency departments in this geographical area.

Conclusion

Ten relevant research studies**,** including five surveys, two mixed-method, one qualitative, one video recording evaluation and one internet-based survey, investigating the perspectives of healthcare providers, professional interpreters and parents with LEP in the NICU, PICU, pediatric hospice, pediatric oncology and PEDs were selected for this literature review. Studies reviewed in this chapter conclude that parents with LEP experienced frustration, difficulty, hesitation, shame, uncertainty and low levels of confidence in caring for their child due their inability to speak or understand English.

Although parents with LEP acknowledged the benefits of using professional interpreters in their interactions with health care providers, they worried that interpreters were not always accessible and often hesitated to make a request for one. Furthermore, parents with LEP reported their concern over the underuse of professional medical interpreters among health care providers and that interpreters and clinicians should be trained to collaborate efficiently during interactions with patients and families. Parents with LEP reported their dissatisfaction with the quality of communication nurses had with them during the hospitalization of their child. Moreover, parents with LEP reported hesitation in asking questions of nurses regarding their child's healthcare and at times were embarrassed to admit that they did not understand information due to the language barrier. Based on the findings, it is reasonable to suspect that parents with LEP regard trust as important in their communication with health care providers and interpreters. However, parents with LEP reported difficulty in communicating with nurses, hesitation in asking them questions and apprehension with the approach the ED staff used to deliver difficult news regarding their child's poor prognosis.

Similarly, professional interpreters perceived that health care providers did not fully understand how to approach Spanish speaking patients when communicating with them. Training was suggested for health care providers to learn how to use interpretive resources to better serve patients and families with LEP. Professional interpreters also suggested that they receive training to understand specific oncology treatments so they can improve services to patients with LEP.

Despite the small number of nurse participants in these studies, the evidence is significant in that nurses are not consistently using interpretive resources when communicating with parents with LEP and that parents with LEP hesitate to ask nurses questions and often do not rely on nurses for information regarding the care of their child. Although research is scarce as to why nurses do not consistently use interpretive resources, one study indicated that nurses were satisfied with the LEP Family Patient Advocate role as a reliable link between them and the parents with LEP. Evidence on how nurses are providing care to pediatric patients and families is not evident from the studies in this literature review.

Although the internet-based qualitative study explored the experiences of emergency nurses caring for non-English patients in a pediatric hospital, the nurses' responses focused on their attitudes in caring for patients with LEP and the study was limited to nurses in one hospital. While there is limited literature that describes the experience of pediatric nurses caring for patients with LEP, the description of the PEN's experience initiating care for children and families with LEP has not been studied previously. Based on the scarcity of research on PENs' experiences in caring for patients and families with LEP and with a rapidly growing population of families with LEP in the United States, it is evident that further research exploring nurse-patient encounters with LEP patients and families is needed. Examining the PEN's experience caring for patients with LEP may lead to improvements in the safety and efficiency of emergency care offered to children and families with LEP.

An increasing number of children and families with LEP are expected to become significant healthcare consumers as the population of limited-English-proficiency people grows in the United States. However, much remains unknown about how nurses initiate and provide emergency care for children and families with LEP. An exploration of how nurses navigate these processes will generate a greater understanding of ways to better meet the needs of pediatric patients and families with LEP who seek ED assistance.

CHAPTER III

METHODS

Research Approach

Interpretive description (ID) is the qualitative methodology that was employed to study pediatric emergency nurses'(PENs) experience when initiating and providing care to children and families with limited-English-proficiency (LEP) in a pediatric emergency department (PED). My purpose of using ID as a research method was to generate meaningful, credible, and defensible findings, which may potentially contribute applicable knowledge to emergency pediatric nursing and other nursing specialties. The research design, the selection of participants, and method of collecting and analyzing the data are explained in this chapter.

Qualitative research design offers flexibility in adapting to ongoing data collection, tends to be holistic, involves combining various data sources, requires researchers to become personally involved and data collection is determined and completed through strategies of ongoing data analysis (Polit & Beck, 2017). The ID method provides a "coherent methodological framework within a fairly wide range of options for design decisions" (Thorne, 2008, p. 75). Choices were made in the design of this study to facilitate the exploration of how PENs initiate and provide care to pediatric patients and families with LEP.

Thorne (2016) suggests that not all qualitative nursing research lends itself to the conventional social scientific analytical methods (e.g., anthropology, philosophy and sociology) which may not readily answer inquiries involving clinical context in the manner that the nursing discipline requires. Therefore, a method such as ID is better for studies of the subjective experiences that nurses encounter and may generate new knowledge to advance future nursing science.

Interpretive description, a methodology examining clinically based phenomena was developed by Thorne et al., (1997) as a “noncategorical qualitative research approach aligned with a constructivist and naturalistic orientation to inquiry” drawing from principles of the conventional qualitative designs of grounded theory, ethnography and phenomenology (Thorne, 2008).

Thorne (2008, 2016) proposed that the foundational underpinnings of ID are bound by a common set of assumptions about human experience in its relationship to the health care professions. Interpretive descriptive studies are conducted in a naturalistic context and are focused on the value of subjective and experiential knowledge, acknowledging human commonalties, recognizing that realities may sometimes be contradictory and considering the inseparable interaction between the researcher and the research outcomes (Thorne, 2016). Furthermore, ID methodology is not based on “a priori” underpinnings; it is based on the researcher recognizing that a theory “about a clinical phenomenon must emerge from or be grounded in that phenomenon” (Thorne, 2008, p. 74).

Using an ID research method, the personal accounts of the PENs’ experiences caring for pediatric patients and families with LEP, as well as interviews with professional medical interpreters were analyzed and synthesized. The study results have the potential to influence future research and/or change current standards of care.

Protection of Human Subjects

Research advances the knowledge and understanding of science and promotes human health (U.S. Department of HHS, Guiding Principles for Ethical Research, 2016). Federal and national mandates safeguard the physical, psychological, social and economic protection of volunteer participants. The researcher must take ethical precautions when inviting participants to join a research study. An application was approved through the Seton Hall University Institutional Research Board (IRB) on May 1, 2020 (see Appendix I). An IRB application was also approved through WCG IRB for The Valley Hospital, on May 10, 2021 (see Appendix J). For the purpose of this study, participants interested in participating were invited with a Letter of Solicitation (see Appendix C & Appendix D) and an informed consent (see Appendix E & Appendix F) was provided and obtained from each participant. The informed consent document included information relating to (U.S. Department of HHS, Office for Human Research Protection, 2018):

- the purpose and method of the research study;
- expected duration of the participant's participation in the study;
- description of interview procedure;
- description of minimal risk expected from participating in research interview;
- description of benefits that may be reasonably expected for nurses and patients from the research;
- description of how their data will be maintained in confidence;
- an explanation of how to contact me, the researcher, for questions related to the study and participants' rights;
- a statement that their participation is voluntary, and refusal to participate or desire to withdraw at any time during the study will involve no penalty;
- along with the expected duration of their participation.

Participants invited to participate in this study were afforded adequate time to review the informed consent prior to choosing to take part in the study. Pediatric emergency nurses and certified professional medical interpreters who agreed to participate in this study were given a copy of their signed informed consent. As this qualitative study required personal interviews, in order to safeguard the participants' privacy and identity, only general descriptions or pseudonyms of the participants were used throughout this study. This was important in order to avoid identification that can occur with detailed description of participants (Polit & Beck, 2017).

Participants

Thorne (2008, 2016) does not provide an objective justification of what constitutes a specific sample size for a study. The sample size was evaluated by me on an ongoing basis and was determined by how the responses of the participants were meeting the purpose of the study and allowing for the collection of rich data which made a meaningful contribution to the field of nursing (Thorne, 2008). A sample size of 15 PENs working in specialty PEDs were recruited for this research study (see Appendix A). The number of participants was adjusted based on the ongoing data collection and interpretive analysis.

To examine the experiences of certified professional medical interpreters (CPMIs) related to their work with PENs caring for pediatric patients and families with LEP I also interviewed 5 CPMIs (see Appendix B). Triangulating multiple data sources within the study added credibility to the study and provided context for a greater understanding of the data collected from the interviews. Thorne (2016) conveyed that confirming data through multiple lenses will give the researcher confidence in the trustworthiness of the findings and conclusions of the data analysis.

Participants were recruited through diverse professional contacts utilizing a snowball sampling technique. No participants with whom I have a personal relationship were included. Relying on extensive professional contacts of 24 plus years, I was able to include participants of varying ages, work experience and demographics. Inclusion criteria for this study included registered nurses with at least one-year experience in a PED, currently working full-time, part-time or per-diem and providing direct patient care. The inclusion criteria for the CPMIs included currently working as a certified professional medical interpreter serving pediatric patients and families with LEP in a PED.

Participants were invited to participate in the study with a letter of solicitation containing my contact information, the dissertation Chairperson, and the SHU IRB in case the participants had any questions regarding their role. Participants were encouraged to keep this letter of solicitation should they have any questions or concerns following participation in the study.

Furthermore, theoretical sampling is recommended by Thorne (2016) for "maximal variation" in a study (p.100). As themes and patterns began to emerge with ongoing data analysis, I searched for participants who provided useful information or clarification on aspects that remained underdeveloped on the phenomenon being studied.

Setting

Participants were interviewed at a specific mutually agreed to date, time and location that was conducive to a private conversation free from potential disruptions.

The Question of Bias

The objective of conducting qualitative research is to understand the meaning of experience and reality through the voice and articulation of other people (Munhall, 2012). Munhall (2012) emphasizes the importance of a researcher adopting "a perspective of unknowing" and regarding the participants as "the knowers, the knowledge holders, the holders of meaning to their experience" (p. 23). To fully understand another's personal experience without pre-conceived ideas or biases Munhall (2012) highlights the importance of a researcher acknowledging their "preconceptions, beliefs, intuitions, motives, biases and knowledge base" to be fully open to a new perspective of another and of themselves (p. 26). My interest in this research phenomenon stems from my own experience as a child of immigrant parents with LEP and as an emergency nurse faced with challenging moments in which I felt empathetic and frustrated at my own inability to speak their language at such a vulnerable point in their healthcare experience. My personal and professional experiences as an ED nurse having cared for pediatric patients and families with LEP have led me to acknowledge and reveal my personal views on this research topic in order to place myself in a position to approach the participants' experiences "honestly and openly" (Streubert & Carpenter, 2011, p. 26). I cannot avoid or ignore my past experiences or views regarding the research phenomenon; instead, I did articulate my perspectives through reflexive journaling throughout the data collection, data analysis and data interpretation processes.

Data Collection

Data was collected through semi-structured interviews with the participants and researcher meeting in a mutually agreed location. Using a semi-structured interview format encouraged the participants to speak freely about their experiences related to the research phenomenon (Polit & Beck, 2017). To explore the main research question, interview guides for PENs and CPMIs were created using the research sub-questions as a guide.

Interviews were conducted by me using an interview guide of open-ended questions (see Appendix G & Appendix H) and were kept to a minimum of 60 to 90 minutes. Data collection concluded when I achieved data saturation (repeating responses and descriptions from participants), relevant to an understanding of the research questions posed. It is also important to note that Thorne (2016) implies that setting data collection limits in interpretive description is justified in smaller studies as long as the researcher recognizes that there will always be more to study in the context of all clinical phenomena. Interviews were audio-recorded and transcribed verbatim. All audio-recordings and transcribed text were stored in the researcher's home in a locked cabinet. Only I have access to the locked cabinet.

Data Analysis Specific to the Qualitative Approach

Data analysis occurred concurrent to the data collection to expand on the concepts that began to form as soon as I entered the field of study. As the analysis progressed, I considered theoretical sampling and theoretical scaffolding to further develop an understanding of the data (Thorne, 2016). To maintain the trustworthiness and integrity of this study I approached the interviewing and data collection with an active awareness of any personal biases, making every effort to maintain the rigor of this study.

Establishing & Maintaining Rigor

It is important that a qualitative study be conducted in a rigorous, continuous and systematic method to produce meaningful and applicable results, and be accepted as trustworthy research (Nowell et al., 2017). Lincoln and Guba (1985) suggested achieving trustworthiness of a naturalistic inquiry through four criteria: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.

Credibility refers to the techniques used in a research study that make it more likely that the findings provided by the participants and the interpretations considered by the researcher are credible. Two techniques that were used in this study to establish credibility were triangulation and member-checking. Triangulation involves obtaining data from multiple sources or using different data collection methods to produce rich data and a deeper understanding from the findings. For this study, I interviewed pediatric emergency nurses, as primary participants, to examine their experiences in caring for pediatric patients and families with limited English proficiency. A secondary source of data was generated from interviewing certified professional medical interpreters. Hospital policies and procedures describing the care standards for communicating and interactions with persons who have limited English proficiency were considered for review. Member checking is a second technique that was used to establish credibility at the end of each interview by summarizing for each participant the “major points” of the interview to elucidate clarifications or additional data (Lincoln & Guba, 1985, p. 271).

A rich detailed description of the data is necessary to establish transferability of the study (Lincoln and Guba, 1985). For this study, the phenomenon of pediatric emergency nurses caring for pediatric patients and families with LEP was described in detail as appropriate, including verbatim statements from participants. Transferability is established when interpretations drawn from the findings may be viewed by readers to be transferable to similar settings, situations and participants.

Dependability of a study depends on an audit trail of the research process that is transparent, well documented, logical and reproducible (Tobin &Begley, 2004). Audit trails provide the reader with details regarding the methodological choices and decisions that I made through the process of the study, including the rationales for decisions made on any issues that surfaced during the collection and analysis of data. Thorne et al., (1997) recommend maintaining a reflexive journal to help guide the research process. I logged my reactions, experiences, insights, hunches, issues encountered, and decisions made associated with this study. Preconceptions that I brought to the study (as an ED nurse and bilingual nurse) were carefully noted and regularly examined to be sure that they were not influencing what I saw and heard in ways that I did not intend.

To establish confirmability, I demonstrated how interpretation and conclusion of the data were reached. Documented records describing the reasons for why I made analytical decisions were clearly delineated throughout the data collection and analysis process of the study to create an audit trail. Lincoln and Guba (1985) posit that achieving credibility, transferability and dependability establishes conformability in a research study.

Summary

This chapter presented an introduction to the ID design, sampling, data collection, data analysis and the actions to maintain the integrity of this research study. I anticipate the findings of this study will provide important perspectives on how pediatric emergency nurses initiated and provided care to patients and families with LEP, thereby contributing a greater understanding to how the quality of care delivered to this population may best be addressed. The use of such findings may be used to amend current practice and/or policy, as well as or to elicit further research in pediatric emergency care delivery.

CHAPTER IV

FINDINGS: INITIATING CARE FOR PATIENTS/FAMILIES WITH LIMITED-ENGLISH PROFICIENCY

Introduction

Fifteen, pediatric emergency nurses (PENs) were interviewed to gain a better understanding of how they initiate and provide care for patients and families with limited-English proficiency (LEP). These PENs described their frustrations, challenges, and individual victories experienced while caring for pediatric patients and families with limited-English proficiency (LEP). At the time of interview, the nurses worked in specialized pediatric emergency departments (PEDs) in medical centers, university affiliated hospitals, a specialized children's hospital, and a community hospital. A secondary source of data with relevance to how these PENs provide care to this population was obtained from interviewing five certified professional medical interpreters (CPMI) on their perspective of working with PENs.

These PEDs varied in bed capacity, patient flow and differences in LEP demographics. A typical patient visit to the pediatric emergency department (PED) involved a structured workflow: triage, medical evaluation, and determination of hospital admission or discharge (Emergency Nurses Association [ENA], 2020). Presented in this chapter are the participants' descriptions of their experiences initiating and providing care for pediatric patients and families with LEP where every step of their nursing interventions involved continuous communication with the patient and family.

Initiating Care in Triage

To appreciate the experience of the participants' caring for pediatric patients and families with LEP, it is important to first understand the routine workflow in a PED, which, for the purposes of this study, begins in triage. The role of the triage nurse was to identify the subtle signs of illness or distress in the pediatric patient, to prioritize emergency care and assign an acuity level without delay and to continuously monitor each patient in the waiting area for a change in their acuity status (ENA, 2020). The triage nurse's responsibilities included obtaining the child's chief complaint, most often from the parents, medical history, a list of prescribed medications, height, weight, and vital signs.

The nurse participants in this study referred to triage as an area located by the waiting room and registration desk, which at times also included a security guard and a registration clerk. The pediatric patient and family were greeted by a registration clerk who asked for the child's name, birthday, and reason for coming to the PED. Often times, if the patient arrived via ambulance, police and/or paramedics, patients bypassed the triage area, which resulted in the nurse initiating triage and emergency care directly at the bedside in the PED treatment area or in a trauma room.

The nurse participants that were assigned to work in the triage area often worked independently and were frequently the first healthcare team members that a patient/family with LEP encountered when arriving to the PED.

> You can usually see people running in, they are scared and nervous. With pediatric patients, a lot of times unless there is an obvious injury to the child, you know the parent is the first one at the window, you don't always see the child right away, depending on how small they are. Usually, I am lucky enough that the security guard that sits right by the registration desk most of the time speaks Spanish and I will try to get an understanding of what is going on with the child through them and also by looking at the child and intervening immediately if I have to (Nurse Ryder).

The nurses stressed the importance of completing the triage process in a timely manner. Nurse Sawyer emphasized the importance of the workflow metric where each patient encounter was time stamped, she added:

> You are supposed to have the patient triaged in 15 minutes…and if there is a serious condition, a live translator (means in-person interpreter) has come right away. It could be a nurse from another floor, someone else would have to cover her patients while she came down to help us. Unless a translator (means interpreter) was available immediately, getting one would back up the direct bedding process that we have in place in the pediatric emergency department (Nurse Sawyer).

The nurse participants underscored the importance of maintaining brevity and expediency throughout the triage process as time was the driving factor for the nurses when the PED waiting room was full and the influx of patients seeking emergency treatment was non-stop. To expedite the triage process, some of the nurses reported using the patients' electronic medical record (EMR) to search for the patient's pertinent medical information, such as the patient's prior PED visits, medical history, medication history and known allergies.

In triage, the nurses initially assessed the pediatric patients' for immediate signs of distress (i.e., difficulty breathing, facial swelling, hemorrhaging, or obvious orthopedic deformities) while obtaining other pertinent information from the patient/family. In cases where a child was in obvious distress the nurses reported immediately notifying the charge nurse and/or the PED physician and then rushing the child into the treatment area for an immediate medical evaluation and further emergency intervention. If the patient/family did not speak English, the nurses did not delay emergency treatment or life-saving measures, to access interpretive services (IS).

In these emergency situations verbal understanding by the patient/family with LEP was preempted by immediate medical emergency intervention. The participants relied on their assessment skills and followed standardized emergency treatment protocols to stabilize a child in distress with fast-acting medications and treatments. According to the Emergency Nurses Association (2020), respiratory emergencies are one of the most common emergencies that children present with to the PED, along with febrile seizures that are most common in children between the ages of 6 months and 5 years of age. Children who presented with these conditions to the PEDs were treated immediately, as reported by Nurse Hayes:

> If the patient looks like they are in distress. You know there are a lot of asthmatics. I will go ahead and quickly assess the patient and then grab the doctor and go ahead and start the treatment, while we wait for someone (the interpreter). The iPads© are pretty quick though, we have one in every hallway. You could always pull that in while you are trying to assess the patient, but we have had febrile seizures come in and you don't have time to bring anything in, so you just really treat the medical emergency and go from there (Nurse Hayes).

The nurses referred to various emergency treatment protocols and how they were trained to respond appropriately to an emergency; however, most nurses worried about the pediatric patient's known allergies if the parent did not speak English and the child was in severe distress. A nurse explained that it was rare for a child to be allergic to fast-acting rescue medications, such as "Solumedrol," "Albuterol" or "Epinephrine":

> It depends on the level of distress obviously, of the patient. And if there are basic things that I can start, like if there is respiratory issues, then I can start oxygen without having to worry about if there is any contraindications for that. I know how to ask if they have any allergies and things like that. That, I can get right away, because I can speak that Spanish, but if the patient is not in any distress and it seems like it is a confusing story, I am okay with sort of waiting a little bit to get the full whole story and see why exactly the patient is there. But, if the patient is in distress, I think that is the right thing to do to start treatment (Nurse Wilder).

Identifying the acuity of the patients in triage was considered to be a priority responsibility for the nurses. Their keen identification of the pediatric patient in distress guided the nurses to intervene appropriately without delay. If needed, during the stabilization of the patient the nurses delegated to other staff members to obtain the interpretive services and resources needed to meet the communication needs of the patient/family.

Determining Communication Needs

Communication with a patient/family was essential for the nurses to gather pertinent information to make clinical decisions based on the patient's presentation and chief complaint.

The nurses described their experiences using a number of resources in their efforts to determine the patient/family's preferred language and communication needs and added how environmental factors, such as the location of the nurse's triage area, the "loud" noise level in the waiting area due to "overcrowding" of people impacted the quality of privacy and care offered to a patient/family with LEP in triage.

The nurses described how they recognized they were encountering a language barrier when they identified the patient/family had difficulty responding to their questions. Patient/families with LEP would respond "yes, yes, yes" to the nurses' questions or they struggled to find the words to answer the nurses' questions. When in triage some nurse participants used visual aides to assist the patients/families in identifying their primary language by using language identification cards and gesturing for the patient/families to read and point to their written language on the card (a language identification card displayed short phrases, on requesting an interpreter, in multiple languages, that the patient/family read and pointed out to their primary language). The language identification card was helpful only if the "patient could read".

With a preferred language identified, if time allowed, the nurses offered the patient/family an interpretive service option in triage to facilitate communication. At times, parents refused an interpreter and preferred a family member, who was accompanying them, or their child to interpret or chose to "get by" with their limited understanding of English. Many of the nurse participants honored the parents' request for a family member to serve as an interpreter as an exception to securing a hospital specific interpretive service.

To expedite the triage process, nurse participants explained that they preferred to allow family members to interpret for the parents and saved time in "putting in an access code for a translator and sometimes waiting for 5-10 minutes for someone to come on the phone line." Whereas some of the nurses participants reported that they did not "feel comfortable" allowing family members to interpret; however, to prevent a delay in the triage process, they used a family interpreter to identify the chief complaint and then notified the PED charge nurse to arrange for access to IS for the remainder of the patient/family PED visit.

Spanish was reported as the most common foreign language encountered by the participants in this study. Several nurses relied on their "Spanglish" (a blend of English and Spanish) (Merriam-Webster Dictionary, 2022) to facilitate communication with patients/families with LEP in triage by asking them simple or close ended questions. With years of experience working in a PED, these nurses reported learning basic words necessary to introduce themselves to patients/families with LEP and to ask their patients/families simple medical questions, such as if they were experiencing *"dolor (pain),"* if the child had all their *"vaccunas (vaccines),"* if their child had *"allergias (allergies)"* and if their child was taking *"medicinas (medications)."* Usually, these words elicited one-word responses, either "*si (yes)*" or "*no (no)*;" however, if the answer was "*si*" to "*allergias*," the nurses then accessed an interpreter service to further investigate the nature of the allergy. Nurse Wilder illustrated the overall sentiment of the nurses who learned basic Spanish terms and phrases on the job:

> I do not speak Spanish fluently, but I know just enough where I can sort of communicate with my patients and I can get a basic understanding of why they are there and get a medical history from the parents. So, if my basic Spanish is not enough, and I have to wait for a phone or iPad©, as a last resort, I would ask one of the bilingual staff to help me translate (means interpreter) for my patient, obviously it is not what they are supposed to do, but it is the last resort, if I have no other option (Nurse Wilder).

The nurses realized they could not just "get by," with their limited Spanish speaking skills, when the patient/family responded with more than one-word responses; in those cases, the nurses determined the need for an interpreter and sought out a more effective method to communicate with their Spanish speaking patients. In recognizing the importance of obtaining accurate details about the patient's medical history, including any allergies to medications, most of the nurses opted to quickly access a bilingual patient care technician (PCT) on staff to help them interpret the patient/family responses.

Patient Privacy

Safeguarding the patient/family privacy is an ethical component proposed in the standards of emergency nursing practice (Emergency Nurses Association [ENA], 2017a). Several nurses explained how they preferred not to compromise their patients' privacy by opting to ask a PCT or a registration clerk to interpret instead of using an interpretive device when triaging patients with LEP because people in the waiting area could overhear the conversation between her, the parent, and the interpreter accessed via a speaker device. The noise factor in the waiting area, sometimes, made it difficult to hear the interpreter on the speaker device, compelling one nurse to ask the people in the waiting area to keep the noise down:

> In triage I am really frustrated because there's usually, a line behind them (The patient/family with LEP) and there's a privacy issue with the video translator and it is really difficult to hear them (the interpreter on the device) because I can say there have been times where I have had to say to the people in the waiting room to please keep it down, I'm trying to speak with this family. It's hard because there are kids playing in the waiting area. You don't have that area where you can just close the door and talk with them. I need to know if this is an emergency, do they need to go in right away or is this something that can wait. I need the story and it is not optimal to get it in a waiting room full of people when the patient's parent does not speak English (Nurse Harper).

Often the excessive number of patients/families waiting in the triage waiting area contributed to a noisy overcrowded environment. Most of the interpretive service devices that the nurses used functioned with an audible speaker which was increased so that the patient/family and nurse could listen to the interpreter. Nurse Ryan described her experience:

> Sometimes it may take a little bit of time to get the translator (means interpreter) on the phone…Some problems with the translator (means interpreter) hearing us properly and then there are also things that we cannot control, which is the background noise. Our translator phones are all speaker phones. There is no way to take it off speaker phone for the translation aspect and we try to limit the noise around us, but that sometimes, you cannot change that, overhead speakers, other nurses, or other people working speaking loudly that don't realize that you need quiet and that can further prolong a triage process or prolong getting across information to what they need or where they need to be (Nurse Ryan).

Knowledge of Polices

The nurse participants acknowledged the existence of hospital policies that guided the best practices for facilitating effective communication by providing interpretive services for the care of patients/families with LEP; however, the nurses could not give complete details about the practices in the specific policies. Fifty percent of the nurses understood they were: (1) "supposed to deliver care in the patient's preferred language", (2) reported they were required to offer the patient a "certified interpreter", (3) "not supposed to use family or staff" to assist with interpretations, and (4) indicated a documentation requirement was expected when using an interpretive service. The other half of the nurse participants expressed they had never seen or heard of a policy for the care of patients/families with LEP.

If the patient/family with LEP refused an interpreter, the nurses asked the patient/family to fill out a "declination form". A nurse participant described how the staff could be held liable for not "providing proper care to them (patients/families with LEP)."

> Sometimes it is annoying and frustrating to get an interpreter, sometimes every patient you have needs an interpreter and you know on those days it's hard to get someone on the language line and then to dial up and then it's hard for them to hear, so some of us speak Spanglish a lot or we use our techs. Some of these techs say no a lot. Unless it is something really small, like a small question. If it came to it, I know we could be disciplined for not doing it properly. But I can see it from both sides, you just have to do what you feel comfortable with (Nurse Hayes).

Communicating with the Use of Interpretive Services

Due to the locations of the facilities reported in this study and the surrounding communities served by the PEDs, using interpretive services to communicate with patients/families became a “normal part” of the nurses’ workday and workflow.

When describing how they initiated the care of patients/families with LEP, the PENs described their experiences and challenges using various interpretive service devices in triage. The interpretive service devices accessible to the nurses included electronic tablets with audio accessibility only, electronic tablets with video and audio options, dual handset language line phones, small voice activated devices that attached to their hospital identification badges, in-person interpreters and an interpreter phone application accessible on work assigned smartphones.

The availability of certified professional medical interpreters either in-person or as accessible through interpretive service devices varied between hospitals. Certified Spanish speaking interpreters were accessible through the dual handset language-line phones and electronic devices around the clock at some hospitals. Other languages, such as Arabic, Bengali, Mandarin, or unique dialects did not offer the same availability. Nurses encountered challenges while making multiple attempts to secure an interpreter in a different language other than Spanish with the primary obstacle being the amount of time to acquire their services.

Interpretive Service Devices. Interpretive service device accessibility, timeliness, accuracy, and patient privacy were factors considered by the nurses when describing their preferred method of interpretive service. Where possible, the nurse chose the interpretive service they considered offered a more “personal” impact to their interaction with the patient/family with LEP. Some of the nurses reported having accessibility to dual handset language line phones. The nurses appreciated how they and the patient/family were able to speak directly into an individual handheld phone receiver and listen to an interpreter simultaneously, allowing for a private conversation. Nurse Hunter described why she preferred the language-line phone over the electronic tablet with video accessibility which was considered a “distraction”, because everyone in the room could hear the conversation over the electronic tablet device speaker.

> I personally prefer the telephones, I just find that there are not as many glitches. Sometimes they (the parents) are trying to talk to the computer screen, and it freezes. I usually face it so that the patient and the family can see the interpreter. I do not get to see the interpreter, so the communication loses something for me. I prefer the phone. (Nurse Hunter).

Nurse Beckett reported that the dual handset phone was the only interpretating service available in the PED where she worked at the time. She preferred a face-to-face option, and when given the opportunity, she sought out bilingual staff to assist her in communicating to her patients/families, even though she was aware of the limitations in using non-certified interpreters.

> We, luckily have staff that speak more than one language, but we can’t actually document that we utilize them as a quick reference, even though they tend to be more thorough. I don’t know if it’s because they are face to face with these patients that they kind of interpret a little better, especially because they are able to read their body l language. I don’t know if it’s a hearing thing because the phones can be a little difficult to hear sometimes. But legally they (staff) are not supposed to be used because they are not certified translators (means interpreters). I just can’t feel like I can get the best information across to the patient using a phone to translate (Nurse Beckett).

A few of the nurse participants had access to a “user-friendly, audio” and “convenient walkie-talkie” device that was worn on their name badge. They could access a Spanish interpreter directly or request an interpreter for a different language, which usually took “about 2 to 5 minutes” to get on this device. Disadvantages of using this device were that “sometimes the reception was not the best, similar to a cell phone”.

For a few of the nurses, a medical interpretation service smartphone application was available on a facility provided smartphone which nurses would sign out at the beginning of their shift, and they would return them to a charging dock at the end of their shift. Benefits of using this smartphone application were the easy accessibility and availability of the interpretive service application for the nurses to use when communicating with patients/families with LEP; however, the inconsistent availability of the interpreters available through the smart phone application made this an unreliable option for the nurses.

Challenges When Using Interpretive Service Devices. The nurses frequently referred to the amount of time it took to access and use an interpretive service, and was not always feasible, particularly when the patient census was high in the PED and the triage waiting area "was full." They "worried" about missing a "true emergency" and helping all the patients by getting them into the PED safely without delay. Nurse Carter's description of her experience caring for patients/families with LEP in triage when there was a "full waiting area":

> There is a sense of dread (sighs) when you have someone that truly does not speak English at all, and they don't know what to do and I don't know what to do. And if they don't understand the interpreter, or they can't hear them or it's a bad connection. You know, time is of an essence, in the emergency room and you feel like, what if the next patient is really sick, I'm here all by myself. It's like you are racing the clock and that's not what you're supposed to be doing when you are translating (means interpreting) for someone (Nurse Carter).

Nurses expressed their "frustration" when realizing a language barrier existed between them and the patient/family and having to take additional time to access and use the interpretive service device, so they could understand why the patient was visiting the PED. Nurses described the length of time it took to access an interpreter through the electronic tablet would take from "a matter of seconds" to waiting several minutes, and this was often due to the limited "wi-fi services in the hospital". Nurse Harper described her experience using an interpretative service video device:

> What I don't love is that it takes so long. The video translator is like cellular reception, you have to move the iPad© around. Sometimes the reception in a certain room is choppy and they (the interpreter) say they cannot hear or sometimes it takes a while to get an interpreter on the line if it's a language line (dual handset phones) (Nurse Harper).

In-Person Interpretive Services. A quarter of the nurse participants worked in PEDs which served communities in which "Spanish was the primary language" and employed Spanish speaking in-person certified interpreters that were available on the day and evening shifts from Monday through Friday. The in-person certified interpreters also served as patient liaisons and when not interpreting for patients/families with LEP, they were visiting with other patients in both the adult ED and PED. Additionally, the nurses also had available electronic audio interpretive service tablets and several dual handset language line phones available to use as interpretive services when the in-person certified interpreters were not immediately available to interpret for Spanish speaking patients.

An interpretive service option, that was regarded as a last resort for the nurses who did not have immediate access to an interpretive service, was an organizational database storing the names of employees who were certified interpreters. Checking the availability of a certified interpreter bilingual in a particular language required calling the nursing supervisor on duty and often waiting for the available certified interpreter to be free to leave their unit and help the PEN in the PED. Some nurses reported how when they were pressed for time, they preferred to ask a bilingual patient care technician (PCT) or registration clerk to help as an interpreter for both her and the patient/family.

Challenges When Using In-Person Interpreters. A challenge, for the nurses working with in-person professional certified medical interpreters was that there was only one in-person interpreter per shift, leaving the staff without an accessible in-person interpreter if the interpreter called out sick or was off on scheduled vacation time. It was these circumstances that the nurses expressed they would use other interpretive services available to them or request the assistance of bilingual patient care technicians, registration clerks or other medical bilingual staff to interpret for them and the patients/families.

Nurse Carter expressed her gratitude that some patient care technicians were willing, “to help” even though it was a “legal risk” for the PCT, because they were not certified interpreters. She continued to elaborate upon several situations involving a bilingual PCT that agreed to help interpret for patients/families with the concession that their name not be included in the patients’ charts identifying them as the interpreter. Despite the PCT’s request, several nurses had included their name in patient electronic medical records; subsequently, the PCT made the decision to no longer assist patients/families and nurses with interpretation because of this. Several other nurses reported that some staff have declined to assist them with interpretation requests because they were either too busy, were not compensated for the additional interpretive service or they were advised not to serve as non-certified interpreters for legal reasons.

Staff as Interpreters

The nurse participants referred to the “easy” process of calling a unit clerk, a registration clerk, a PCT or a security guard to help interpret for the patient/family. The PENs reported Spanish as the most common language amongst bilingual staff but depending on the geographical location of the PED, other languages staff were bilingual in were Italian, French, Creole, Arabic, and Polish. In most cases staff members were used as interpreters to ask brief questions, expedite the triage process or to verify an interpreted message that the nurses believed the patient/family did not understand.

Family Members as Interpreters

The nurses described their experiences with family members who additionally accompanied the parents to the PED to serve as interpreters. Ultimately, the nurses made the determination if the family members were suitable to interpret. Nurse Wilder described how she allowed family members to interpret and, she paid close attention to the reactions and responses of the patients/families to ensure that the family member was interpreting her message as close to accurate as possible.

> It depends on the age of the family member and how much I trust their judgement in what they are interpreting, even though I don't understand exactly what they are saying, if I am saying something and they don't automatically interpret what I am saying. Say there is a lot of paraphrasing and a lot of omitting things that I say, and at that point I don't really trust that person anymore. So, at that point I would rather get a professional service to do it. It depends on the family member (Nurse Wilder).

Some of the nurses believed they were not "supposed to" let the patient/family's family member interpret; however, the nurses accepted the interpretive services offered by the family since they believed the family members knew the background situation "better."

Children as Interpreters

Patients from newborn up to the age of 23 years of age were accepted and treated in the reported PEDs. For patients eighteen years and older, the nurses initiated and maintained direct communication with the patient and included the parent upon request of either the patient or the parent. The nurse participants agreed that if the pediatric patient was a teenager, and spoke fluent English, they could help by telling the triage nurse their chief complaint. Similarly, the nurses considered a pediatric patient above the age of fourteen years-old mature enough to understand what was happening to them and with the permission of the parent(s), capable of interpreting for their parents. If the child interpreted and the nurse believed that the child was not interpreting correctly, she would access an interpreter.

Although, teenagers, who were patients, served as interpreters for the nurse and parents, some of the nurses mentioned how they were cautious when asking the teenager sensitive questions in front of their parents (i.e., regarding their sexuality, drug use or body piercings) and being careful in considering the privacy of their pediatric teenaged patient.

> In the case of a teenager, I would talk to them more than to their parents, especially if they are older like 14 or 15, because they may also be having an issue that they don't want the parent to know of. I ask them if they want me to get an interpreter so that their mom understands better or do they want to explain to her. You know, because at a certain age they are pretty autonomous about themselves and their health information (Nurse Logan).

If the teenaged patient required medication administration or preparation for medical procedures, the nurses would access an interpreter service to teach the patient/family the treatment instructions. These situations were used as teaching opportunities for the teenaged patients. If the teenagers were not aware of their allergy information or did not know the details of their medical history, Nurse Hayes explained how she would access an interpreter to help the parents, but then taught the teenagers the importance of knowing their personal health information.

Nurse Carter remembered instances when she observed other PENs ask children to help interpret for their parents and she felt this was "inappropriate." She felt the child may have been too young, did not understand medical terms, and was not capable of interpreting the meaning of the words to their parents. She recalls how "sometimes when they [the child] were interpreting for their parents, she heard them say 'I don't know how to say that word,' to their parents. She described a situation when the child acted as the primary source of information:

> It depends on the child's age. Even as young as school-age, they know their name and their birthdate, that's enough information to get them signed into triage. But the teenagers usually speak for themselves, especially in triage. Sometimes for the younger kids I get an interpreter for their parent, but many times the child automatically starts translating (means interpreting) for their parents. It's kind of sad. In triage I just had a mom who

> came in with her 7-year-old child. I started talking to mom and she elbowed the child to answer in English and the child stepped into the role to help their parent (Nurse Carter).

Unexpected Communication Circumstances

There were other less-common languages which created unexpected challenges for the nurses leading them to accept suboptimal communication alternatives to meet the communication needs of their patients/families. The nurses reported encountering the following foreign languages while caring for patients/families with LEP: (a) Spanish, (b) Korean, (c) Chinese/Mandarin, (d) Japanese, (e) Arabic, (f) Polish, (g) Tagalog, (h) French Creole, (i) Dialects of Hindi, (j) Ukrainian, (k) Sign-Language, (l) Bengali, (m) Cantonese, (n) African languages, (o) Russian.

Unique Language Dialects

The unfamiliarity of being confronted with a specific "Spanish dialect" found Nurse Logan searching the internet for a specific dialect from Central America. Two young children arrived at the PED with their mother, none spoke English. The nurse immediately noticed that both children were in no respiratory distress, "They had airways, nobody was bleeding, and I knew it wasn't life or death and I just had to get my facts straightened out." The nurse realized that the mother did not speak "regular Spanish" when the Spanish interpreter on the electronic tablet device notified the nurse that he could not understand the language the parent was speaking. The mother provided the nurse with a "community resource card' which displayed the mother's primary language. The nurse connected with the Spanish interpreter through the electronic device once again and was notified that it would take "about 4-5 days to find an interpreter that spoke that specific dialect."

> But eventually the husband came, and he spoke regular Spanish and this dialect, he did not speak English. So, the interpreter would speak to him in Spanish, then the interpreter would tell me what he said in English and the husband would have to translate

> for the mom. It was like a chain of people, but the fact that is was 4 to 5 days to find someone that spoke the dialect, you know, was a problem. I even looked online for the embassy to see if they had any resources there. And I started looking up the dialect, once I knew what it was, for resources. They had no resources available. We sometimes get other dialects and run into the same issue occasionally (Nurse Logan).

Nurse Mason detailed her experience caring for a patient/family that spoke a specific Chinese dialect which she had a challenging time finding an interpreter to help the family. She contacted the interpretive service via an electronic tablet and was offered the closest dialect to the one she was requesting for the family, with a disclaimer provided by the interpretive service representative, that the dialect offered was not the exact dialect that the family needed. Nurse Mason accepted the interpreter, with hesitation and concern about the quality of the translation, aware this was the only means of communication she had with the patient/family. In other situations, patients/families that spoke a unique language dialect were offered a similar dialect to their spoken dialect but were unable to understand the interpreter preferred that their child or family member translate for them.

Not all patients/families with LEP that arrived at the PED were able to tell the nurse what their primary language was. Nurse Harper recalled when a grandfather and his young grandson were transported to the PED by police officers when the child had been injured by a moving vehicle while they were out for a walk. The police officer reported that they were not able to identify the grandfather's primary language or the child's home address and left it up to the nurse to get further information from the grandfather. The language identification card available for a patient to read and identity their primary language was not helpful to the grandfather. Nurse Harper sighed as she explained how she pulled up a picture of a world map on the internet and using hand gestures she gestured for the grandfather to point to the country he was from, and he was still unable to understand her.

> It was just so difficult, what ended up happening was one of our doctors spoke the same language. Which was like crazy! I don't know what I would have done, because we tried everything, and he was just not able to help us learn what language he spoke. I showed him a whole list of languages and asked him to point to his language. It was so difficult. It just so happened that the doctor spoke the same language. They were both from the same village. I was like 'wow' (Nurse Harper).

Bengali was described by several nurses as "one of the most difficult" languages they have encountered. Nurse Wilder recalled a situation with a Bengali dialect in which she made two attempts to access this particular dialect on the electronic table and neither the interpreter nor the patient/family could understand each other.

> Luckily for me, that day there was a resident that spoke that specific dialect and it just worked out. It was just frustrating in the beginning because no one understood what each other was saying (Nurse Wilder).

Sign-Language Accessibility

When asked to recall the primary languages they have encountered while working in the PED, one nurse included sign language on their list. This nurse described the moment she discovered that sign language was not a universal language, and that each nation has a specific sign language. She explained how a particular non-verbal patient used sign-language to communicate in Spanish. In order to facilitate communication with this patient's preference of using sign language to respond to the nurse's questions, both an English sign language interpreter and a Spanish sign language interpreter were accessed through the electronic tablet devices to communicate with the patient and family. Although the situation was managed with a great deal of resources and time spent, the nurse desired to know how to be prepared to best manage this type of situation in the future.

Internet-Based Language Translation Services

The internet offers free translator services with real-time results which several nurse participants reported using when the languages they searched for were not available on the interpretive service devices in the PED. Some parents used this service to attempt to initiate a dialog with the triage nurse. The nurses expressed their hesitation in using this “unofficial” service and used it only as a last resort. For example, some of the nurses used the translation service to search for language specific medications when the patient/family could not provide the nurse with information on the medications. Sometimes the medication bottles had labels displaying distinctive language characters that the nurse could not search on the internet.

> I have no clue how many times a day they are supposed to take it (the medications), what the dosage is. I have no idea and I feel like sometimes that can hinder medical care especially with kids, because you know medications can affect kids a lot more and if it’s coming from another country and they are not necessarily prescribed that medication it makes it really hard (Nurse Sawyer).

The nurses were not the only ones searching for different methods to communicate with the patients/families. Medical residents were observed by nurses, using the internet-based translation service as well. Nurse Mason described how she often noticed medical residents using the internet-based language translation services and frequently intervened by bringing in the available interpretive service video tablet and encouraged them to use it, however; she conveyed that most of the medical residents just continued to use their personal mobile phones to attempt communication with the patient/family.

Summary

This chapter illustrates the PEN participants’ descriptions of their experiences and challenges initiating and providing care for pediatric patients and families with LEP during the triage process in the PED where communication with the patient and family was necessary for the successful provision of quality nursing care.

The nurse participants began their interviews with a description of their experiences initiating care for the patient/family in triage, in various acute care facilities housing a PED. The nurse participants were required to determine the patient's acuity level based upon their presentation while identifying the patient/family's preferred spoken language. Due to limited resources, interpretive services were not always readily accessible to the nurses in the triage area. For this reason, many of the nurse participants relied on their limited Spanish speaking skills they had acquired from their time working in the PED, as well as on other bilingual staff, to help them communicate with the patient/family with LEP. In the event that a patient in triage was in obvious distress, the nurses did not stop to search for interpretive services, instead they relied on their specialty training and assessment skills to implement immediate life-saving measures to the patient. Based on the nurses' description of the importance of stabilizing a patient, it is reasonable to imply that although it was imperative for the PEN to facilitate communication with the patient/family, medical stabilization of the patient took precedence over initiating interpretive services.

The nurse participants reported on the different interpretive services available for their use at their respective facilities. Audio and video electronic tablets, dual handset language line phones, internet-based interpreter applications and in-person certified interpreters represented the majority of IS incorporated. Spanish was reported by the nurse participants as the most common foreign language encountered and accessed in the PED (due to the large Hispanic communities surrounding most of the PEDs reported in this study). Certified professional medical in-person interpreters who also served as patient representatives were available at two of the reported PEDs. Although these nurses preferred the in-person interpreters they were not always available on request due to the staffing of one in-person certified interpreter per shift.

The nurse participants reported having limited knowledge of the policies regarding the care of patients with LEP, with the majority of them reporting they were aware that they were not to use non-certified interpreters; however, to save time, the nurse participants made exceptions to use co-workers, including patient care technicians, registration clerks and security guards, and with permission of the parents, patients' family members for interpretations.

Some challenges when using the available electronic interpretive services included: (a) additional time to search for a device and then accessing a language through that device, (b) confusion over the accuracy of the interpretation when patients/families had a difficult time understanding the interpreter, (c) limited access to selected languages on electronic interpretive devices during the night shift, and (d) environmental factors in the PED which impacted the quality of privacy offered to the patient/family when using a speaker-based interpreter.

Another obstacle some nurse participants faced included encountering unique languages or dialects which were not represented through the available interpretive services. In these situations, the nurses were challenged to accept compromises in the accuracy of the interpretation in order to facilitate some form of communication with their patient/family to initiate their care in the PED. Acquiring English sign language services was similar across facilities; however, acquiring sign language interpretive services for hearing impaired patients/families with LEP required additional resources and support.

Despite existing language barriers and challenges in using interpretive services to facilitate and maintain ongoing communication with the patients/families with LEP in triage, each nurse participant expressed the importance of gathering pertinent information to manage emergency care while concurrently navigating the communication needs of their patient/families with LEP.

CHAPTER V

FINDINGS: MAINTAINING ONGOING COMMUNICATION WITH PATIENTS/FAMILIES WITH LEP IN THE TREATMENT AREA

Introduction

Every aspect of care provided in the pediatric emergency department (PED), from triage through discharge, involves ongoing communication between the pediatric emergency nurse (PEN) and the patient/family. After a patient/family is assessed in the triage area, they are seen in the treatment area of the PED. The PED treatment area was described by the nurse participants as busy, often with high patient volumes and with unexpected situations. The care of patients/families with LEP in the treatment area required additional staff, resources, and extra time to acquire facility specific interpretive services (IS). The nurses were responsible for incorporating the language needs of the patient/family into the decision-making process of the patient’s care plan in the treatment area. In this chapter the nurse participants described their experiences communicating and caring for patients/families with limited-English proficiency (LEP) in the PED treatment area, including the delivery of critical news and providing discharge instructions.

Almost all the nurse participants in this study were assigned to either the triage area or to the main PED treatment area to care for pediatric emergency patients. The distinction being that the same nurse that triaged the patient was no longer their nurse in the treatment area. A few nurse participants reported being assigned to both triage and the treatment area for a given patient/family. They said that their facility believed this would add to the continuity of care for patients/families.

Initiating Communication in the Treatment Area with Patients/Families with LEP

The treatment areas in the reported PEDs varied in the number of treatment rooms and the availability of IS. The nurses described similarities within their organizational approaches, time management strategies, and communication challenges when providing nursing care to patients/families with LEP in the treatment area. They recognized the necessity for maintaining continuous communication to inform and include the patient/family in their ongoing treatment plan.

As previously described in Chapter 4, the triage nurse initially assessed the communication needs of the patient/family with LEP and documented the patient/family's preferred spoken language and their need for IS, or the use of IS, in the patient's electronic medical record. Several nurse participants reported their responsibility in collecting, verifying, and documenting this important language data from their patients/families with LEP in order to communicate more effectively with them and to facilitate appropriate emergency care in the treatment area.

Nurses again offered IS to the patients/families once they were in their PED treatment area rooms; however, at times, they were informed through family members present that the parent preferred to have the family member interpret instead of requesting an interpretive service. Although some nurses felt "uncomfortable" with this arrangement they honored the parent's request to not make them uncomfortable or add to the stress they already appeared to be in. Nurse Wilder described her experience observing family member interpreters for an inconsistency in the interpretation:

> There are some family members that will say word for word, sort of interpret exactly what I am saying. And they are very good about it and there's some family members who will sort of nod their heads and nod their heads. Like I will say like three sentences, and they will say like two words to the person. At that point I really don't trust that person anymore to interpret for that person. I try to find another way, if they have to wait longer then that's when I have to get somebody, maybe another co-worker that can help me out (Nurse Wilder).

Several nurse participants described how they preferred to use established "standing orders" when available, to facilitate the initiation of emergency care for patients/families with LEP. Standing orders are symptom specific physician prescriptions pre-authorized for the staff , including nurses, to implement clinical treatments or procedures without having to wait to obtain a physician's order to initiate patient care in the treatment area. Using these standing orders and with the use of IS, nurse participants provided the patient/family with as much information about their care upfront as they could, collected all pertinent lab specimens, as well as prepared the patient for pending diagnostic tests.

Standing orders were not available for all patient cases. At times, the nurses waited for the physician's initial evaluation of the patient/family with LEP to determine treatments. Nurse Sullivan explained her approach in organizing her use of interpretive services upfront to maintain communication with the patient/family:

> Well, we try to get as much information at once using the translator (means interpreter), so we are not piecemealing it, and also if you give them information, you let them sit with it for a few minutes, if they have any questions. If you are using the translator (means interpreter), that already uses a few minutes. And the person on the language line, you want to make sure that there is adequate time to talk. So, you try to use the translator (means interpreter) and try to maybe just give them as much information as you can at once. And circle back afterwards, I have realized that giving one result at a time is not always the best (Nurse Sullivan).

Collaboration with Bilingual Physicians

Several nurses worked with bilingual PED physicians in Spanish, Arabic and Egyptian languages, who assisted the nurses by interpreting for the patients/families with LEP. While the PED physicians were not certified medical interpreters, the nurses still preferred having the PED physicians interpret for them to save time searching and accessing an interpretive service device. Nurse Delaney described her positive experience working with bilingual physicians as they were helpful in interpreting for patients/families with LEP during procedures or as she administered medications to them. Furthermore, several other nurses described how helpful bilingual emergency physicians were in times when they needed a quick interpretation for the patient/family and their relief in knowing that the ED physician did not need IS to communicate with the patient/family with LEP.

Maintaining Communication with Patients/Families with LEP

Within the treatment area, the nurse participants used IS to complete the initial patient/family interview, assessment, provide a timeline of provision of care in the treatment area and then only once again at discharge. Nurse Becket explained how before beginning treatments on the patient, she would access an interpretive service to explain to the patient/family the treatments and diagnostic tests (i.e., IV fluids, labs) and approximately how long each would take. “So, I give them time frames. Blood work is going to take about 45 minutes to one hour, imaging, depending on the image, will take an hour, CT scans, X rays will only take about 30 minutes (Nurse Beckett).” Several nurse participants provided these timeframes allowing the patient/family to understand what to expect during their PED visit; and, unless a critical event occurred, the nurses’ plan was to use the interpretive service once and then again upon discharge.

Treatments in the PED occasionally involved invasive procedures. Nurse Hunter described a situation in which the pediatric patient required the insertion of a urinary catheter to retrieve a urine sample. Even though the parent expressed understanding some English, the nurse wanted to ascertain that the parent understood the details of the procedure.

> She understood enough English, but with something that is so invasive, we just had to make sure we had the interpreter, and they were able to tell her exactly what we were going to do. Why we needed this way as opposed to just putting a urine bag on her. And in the end having the interpreter ask if she had any questions, so they feel like they are being heard too (Nurse Hunter).

The nurses were responsible for communicating treatment updates and changes to the patient/family throughout their stay in the PED. They described their experiences of informing patients/families with LEP of their treatment plans using creative methods of communication, without using interpretive services, to get their message across. For example, using “body language” to “ask for a temperature, listen to their lungs” or using medical equipment as props, such as a urine specimen cup to signal the collection of a urine sample, in lieu of contacting an interpretive service. “We use a lot of body language and gesturing, and Spanglish (laughs), sometimes you just have to use what you have at the very moment, right?”(Nurse Carter)

One nurse described her attempts to check in with her patient/family during their stay involved her “popping” her head in to “see” if the patient/family needed anything:

> I just kind of go in there and try to read the room a little bit, just to re-check the patient, make sure they are doing ok. We do a lot of charades type work (laughing), like showing things that they need something to try to get them to understand a little bit like for short things like that. We don’t utilize the translator (means interpreter) phone again until it’s like test results involved or a poor prognosis or any discharge education instructions, that is the only time, like throughout the entire stay, it is usually in the beginning and at the end, whether they are admitted or going home” (Nurse Beckett).

Another nurse explained how she updated her patient/family:

> I don’t want them to ever feel forgotten, even though sometimes I personally don’t have the time to go back on the (interpretive) phone. So, I’ll just poke my head in, even if I just ask something like “Ok?”, or I’ll bring a pillow and be like ‘You need?’. Just to show them something, just to let them know ‘I see you’, ‘I didn’t forget that you are here’, even though I can’t interpret that to you right now.” I will try to use a visual prompt just so they don’t feel forgotten especially if I don’t have the time to go back in. It gives them a chance to ask questions. If they have questions, I will get the interpreter device. You know, I will make the time (Nurse Hunter).

Exceptions were made to allow teenaged patients to interpret updates to their parents as long as the nurses felt “comfortable” with the teenager’s level of understanding medical terminology. “I typically will use the patient as the interpreter. You know if the doctor is giving results to tests or explaining something a little more complicated over the child’s basic knowledge of medical terminology, we will get an interpreter (Nurse Hayes).” Maintaining ongoing communication with families was also important in order to understand the parents’ concerns. Nurse Ryder described a situation where she learned the importance of encouraging parents with LEP to provide comfort to their child. Through the interpreter application on her work assigned phone, she discovered the parents were "hesitant to hold the baby" because he had cardiac monitor leads on his chest and the father was "afraid" to interfere with the care his son was receiving. Using the interpreter, the nurse explained to the parents the need for the cardiac monitor and how holding their baby would "soothe the baby", which subsequently decreased his high heart rate and he fell asleep in his father's arms.

Challenges with Communication in the Treatment Area

While planning the continuing care of patients/families with LEP the PENs described situations that proved to be challenging. The nurse' continual revaluation of the patients' treatment plan often involved multiple steps: (1) analyzing blood and urine test results, (2) updating vital signs, (3) re-assessments, (4) preparing the patient for diagnostic tests and (5) notifying the PED physician if the "patient finished their popsicle, had their IV fluids and how they were doing".

> It is really hard to get an interpreter to ask them (patient/family) one more question. Because with a normal patient who speaks English, you can go in real quick and just ask them and you're done in 15 seconds. I would like to get the answer real quick, but you just can't pop your head in real quick. If you call the interpreter, you have to wait for them. Then that prevents you from going into your other rooms because you want to be available when the interpreter comes in. It's a delay. I wouldn't say it is necessarily a delay in care, but sometimes it is, because if the doctor is ordering something else based on their answer. You have to wait to get the answer (Nurse Hayes).

Nurse Beckett recalled a challenging situation when caring for a patient/family with LEP. While trying to get more information on their medical history using a dual handset language line phone, the patient/family appeared confused and were having difficulty comprehending the phone interpreter's questions. The registration clerk offered to help the nurse by asking the patient about their medical history. The patient/family responded to the registration clerk without difficulty. The nurse expressed her confusion as to why the patient/family comprehended the one interpretation versus the other and explained having experienced this situation “many times”. Furthermore, she recalled rewording her questions and using “simpler words” while speaking to an interpretive service provider. She referred to this as a “medical barrier, sometimes they (interpreters) don’t know the medical terminology (Nurse Beckett).” This phenomenon is further explained in chapter 6 from the interpreters’ perspective.

The patient/family’s request to have a designated family member interpreter would be honored; however, if a nurse noticed that the interpreter was “paraphrasing” or “omitting” words, she would not “trust” the interpreter and would search for a bilingual staff member or had the family wait for an interpretive device to become available. “They (patient/family) would have to wait longer then, that’s when I have to get somebody, maybe another co-worker who can help me out” (Nurse Wilder).

In a different situation, a nurse participant illustrated how planning the care of a patient/family with LEP was challenging and treatment was “delayed” when the parents were not forthcoming with the facts of why their child was presenting to the PED with specific symptoms. She recalled a case involving a young child brought to the PED by her parents with a stomachache and vomiting.

> The family did not speak English and they brought their child that was vomiting a lot. The mother told us that her stomach started hurting, then started vomiting and wouldn’t stop vomiting. We could not get a real story of why the child was vomiting. So, it took a while, but eventually the father told us in Spanish that the child took the marijuana that comes like a candy, so that is why she is vomiting a lot. And it proved positive in a urine test for the child. This is terrible because they were probably trying to avoid trouble (Nurse Cooper).

She stressed how specific patient care was difficult to plan and how the time needed to access the interpretive service also factored into the time that she had to wait to plan the appropriate treatment for the child once the exact details were acquired.

Pediatric patients arriving via ambulance and were received directly into the PED treatment area. This scenario was complicated when a language barrier was identified, and the parent of the child was not present. Nurse Wilder explained her challenge with coordinating the care of a developmentally disabled school-aged pediatric patient that was transferred via ambulance from school and the mother with LEP was contacted to come to the PED. Upon arrival the mother was visibly distraught about her child and was not calm enough to give the nurse any information on the child's medical history. The nurse explained how she planned the care of the child based solely on the child's clinical presentation, allowing the mother time to compose herself enough to speak with an interpreter.

Conveying Critical News

When asked to describe their experience delivering critical news to patients/families with LEP, the nurse participants described their role exclusively as a "support system" because the PED physician were responsible for conveying all critical news to the families. The use of interpretive services, whether in-person or an electronic device, for these sensitive conversations was imperative for the family to make decisions regarding an emergency surgery, an admission, an informed consent or being interviewed for a child protective services case. "Those are things they really have to understand, they have to make decisions" (Nurse Madison).

The nurse participants recalled situations when they were involved in the care of a child that required the delivery of critical news to their families. The following excerpts are events that that individual nurses shared with me.

Nurse Beckett recalled a situation when the parents with LEP did not comprehend how critically ill their 3-year child was. They declined permission to have their child transferred to a specialized children’s hospital for higher level medical treatment. The nurse collaborated with the PED physician, a second nurse and an interpreter using the dual handset phone interpretive device to explain to the parents the seriousness of their child’s medical condition. According to the nurse, “trying to find different ways to explain what was going on” took a “few hours”. Ultimately, the parents consented to the transfer and medical treatment of their child.

> The challenging part about it is the fact that I can’t speak their language, I can’t comprehend their feelings or understand what they are trying to say to me about why they don’t think their child needs to be in the hospital. And I think if maybe I could have understood them a little bit I could have relayed a little bit more to kind of push, let them know the severity of this child’s illness. I couldn’t understand why they thought he was doing better. The gap in language made it really hard for me to relate with the parents (Nurse Beckett).

Nurse Carter recounted receiving a 3-year-old child in the treatment area with symptomology consistent with new onset diabetes mellitus Type I. Using an electronic video interpretive service device, she and the medical resident instructed the parents on the diagnosis, and treatment required, including a hospital admission. This particular case occurred when the PED was under strict isolation guidelines due to the Covid-19 pandemic. The patient’s father understood and spoke some English; however, the mother did not speak English, and she declined IS as she preferred to have her husband interpret for her. Although, the nurse felt comfortable allowing the father to interpret for his wife, she wanted to make sure that they understood their child’s diagnosis and the mother had an opportunity to ask questions of her own through the electronic video tablet interpretive service. Using this interpretive service device involved challenges not only inherent to device used. Due to the multiple layers of personal protective equipment that both her and the medical resident were wearing, communication was more difficult.

> I am wearing my N-95 mask and a surgical mask and he is wearing his N-95, his surgical mask, and a face mask. So recently, it has been even more difficult to really get a clear

> translation for them to be able to hear us, one and then they cannot even read our lips (Nurse Carter).

In a case of a teenaged pediatric patient and family with LEP, Nurse Harper explained the teenager was present with their parents when the physician delivered the news of a cancer diagnosis to them through IS. The nurse expressed her sentiments, “It is sad because it seems a little impersonal (using IS), there’s nothing that we can do about that, because we want to relay that information accurately” (Nurse Harper).

Trauma

When the nurse participants were asked to describe an experience where they cared for a patient/family with LEP in the PED, several nurses recalled their experience with a trauma case involving a child. Upon receipt of a trauma patient, the staff followed time-sensitive life-saving protocols and interventions which limited opportunity to facilitate communication with the patient or family. Nurse Harper remarked, “There is no proper explanation (during a trauma evaluation). We do not have the time to give a good explanation about what is going on.”

Nurse Logan recalled when a child was struck by a vehicle and died. She was brought in as a trauma case. Her mother with LEP had to be located and instructed to come to the hospital. The nurse described being present with the attending physician, a social worker, and an in-person interpreter to deliver the tragic news to the mother that her daughter had died. The nurse emphasized her concern with the lack of empathy in the delivery of the sensitive news.

> I don’t want to say, but you want them to be factual, but you are hoping that they are not being so factual that they are being cold or unsympathetic or you know just the non-verbal things and the niceties, but just the tone, you might not even necessarily know the tone that they are giving the information in (Nurse Logan).

Nurse Wilder described a situation when a pediatric patient in cardiac arrest could not be resuscitated. The PED physician delivered the news of the death of the child to the mother in the presence of an in-person interpreter and “a child life specialist” available to offer the mother emotional support. The nurse explained how these situations were emotionally intensified with a language barrier.

> The communication barrier probably frustrated her (the mother) even more and made her more anxious and probably led her to feel out of control. It worsened the situation. Using the interpreter was pivotal. There's no way you can communicate with someone if they don't understand the language. It definitely helped that the doctor did it with an interpreter (Nurse Wilder).

Nurse Logan detailed her experience in a trauma situation when finding an in-person interpreter just in time to help a family who only spoke Mandarin. The family, including grandparents, parents, and children with LEP were involved in a motor vehicle crash on their way to an airport. The grandparents both died. The other family members, including the children were transported to the hospital. Challenged to find an interpreter of a Mandarin/Chinese dialect, the nurse recalled "It was just pure luck that that nurse (Mandarin bilingual PEN) was working that day and she was able to speak to the kids (Nurse Logan)."

Nurse Madison described the challenge of both resuscitating a pediatric patient in cardiac arrest while also trying to obtain pertinent medical information from the child's Korean-speaking family. An in-person Korean interpreter was located in the hospital to help the staff and the family. The nurse recalls how the interpreter stayed with the family in the PED, offering them interpretive services and emotional support. The pediatric patient was resuscitated and transferred to a pediatric critical care unit for further care.

Several of the nurses referred to a "child life specialist" as an essential staff responding to pediatric traumas. These specialty trained social workers immediately responded to the PED for pediatric traumas and coordinated the resources needed by the parents with LEP, including interpretive services, such as "multi-lingual chaplains." These specialists, using IS, assisted the nurses by explaining to the parents the life-saving interventions being implemented to their child by the PED medical and nursing staff. The nurses regarded these staff members as valuable resources during these difficult situations for the family with LEP, allowing the nurses to focus their efforts assisting in the care of the trauma pediatric patient.

> There have been times that I have had traumas or like a resus (resuscitation) patient and that is awful when they do not speak English, because it is very scary to be in that room and they (parents) don't know what is going on, they might think you are hurting the patient like when you are doing CPR, that is just the worst. It really is. We have social work with them (parents), and they console them, offering tissues, a chair or giving them water. (Nurse Harper)

Providing Discharge Instructions

After progressing through their individual PED course, the patient/family would either be prepared for discharged or be registered for a hospital admission. Several nurses reported that computer-generated discharge instructions were only available in select languages and expressed the need of these discharge documents in all the other languages they encountered. One of these nurses explained that ED physicians could also use other internet-based resources to generate PED discharge instructions in the patient/family's preferred language and then they could access an interpretive service to assist in the delivery of those discharge instructions by the physician and/or nurse.

When the nurse participants provided the discharge instructions to the patient/family, some preferred to accompany the PED physicians and jointly use interpretive services to answer any questions the patient/family had, especially regarding their prescribed medications. Several nurses emphasized how they were meticulous in writing out the medication details, times and providing the reason for taking the prescribed medication and side effects.

> I will just go in there and say "Tu tienes preguntas?" and if they say "no", I say ok. If they say yes and start asking questions, I will just call the interpreter back. Because when I say that they just assume I speak better Spanish (laughing) than I do, and they just start rattling off stuff and I just can't go that fast and I don't want to say something incorrect, but sometimes people will try to say something in English and then between the two of us we can kind of figure it out, you know when they take their medicine, how many hours

> apart. I can usually communicate with them to get the basic stuff answered
> (Nurse Hayes).

Patient/family return demonstrations were sometimes necessary for dressing changes, wound care, arm sling application and crutch walking instructions. The nurses demonstrated the task as the interpreter on the electronic IS device assisted by interpreting the nurses' instructions to the patient/family. The nurses would request the patient/family demonstrate the specific task to them as a validation that they understood their instructions. Evaluating the patient/family's understanding of their discharge instructions through a "teach-back" method was supported by Nurse Beckett: (the word translate is used synonymously with the word interpreter)

> I usually try to do the teach-back method, have them (patient/family) verbalize their understanding back to me that they know what to do. If they (patient/family) happen to speak Spanish, then I would rather have a PCT that speaks Spanish and does a lot of wound care with us to help me explain it. Instead of me using a translator (means interpreter) phone and having to speak to a translator (means interpreter) while showing them and then having the translator (means interpreter) repeat. It's defiantly more challenging and I felt like it adds an extra step which can make it more difficult for the parents or patient to understand. But if the PCA is not available or the family does not speak Spanish, I have to do what I can with the translator (means interpreter) phone. (Nurse Beckett)

Teenaged patients who understood and spoke English fluently and were "comfortable" interpreting were permitted by the nurses to interpret "simple" discharge instructions to the family. If the instructions involved medications, the nurses preferred to use interpretive services to ensure the family understood the instructions and had their questions answered in their preferred language.

Nurses were concerned with patients/families with LEP not comprehending their discharge instructions, specifically when noticed the patient/family return to the PED for the same chief complaint as their most recent visit. The majority of the nurses explained how challenging it was providing fever-management discharge instructions to patients/families with LEP. The nurses, using some form of interpretive service, provided the parents with written and verbal instructions on antipyretic medications, including specific dosages to administer to their child with time intervals. Despite the nurses' best efforts, they could not understand why the parents with LEP were not able to manage their child's temperature at home.

The PED re-admission rates for patients/families provided with discharge instructions on managing their child's fever at home motivated Nurse Harper to participate in the interprofessional collaborative development of a Spanish language fever management pamphlet. Although the pamphlet was available for PED nurses to distribute to patients/ families with LEP who were discharged with instructions to manage the child's fever at home, Nurse Harper believed the patients/families were not consistently offered the informational pamphlet due to the additional time and interpretive services the nurses perceived it would take to explain the information.

> Part of the reason why they do come back is because they do not understand the discharge instructions from the last time. Part of the language barrier is the cultural barrier. A child with a fever is an aspect of their culture that they take seriously. So even if you explain to them, you know, look for these signs instead of just that this child has a fever, rather to look for this or that, look for these symptoms. If you explain that and take your time they still come back sometimes and their reason for coming back is that their fever came back. There's that and there's also, that they did not understand their discharge instructions. (Nurse Wilder)

Most of the nurse participants stressed the importance of providing discharge instructions with the assistance of interpretive services so that the patient/family with LEP could clearly understand the details involved. Nurse Madison described her experience when a patient/family did not understand their post-operative follow-up instructions and she felt she may not have been as thorough in explaining their instructions:

> I remember getting called by my nurse manager and that patient, family telling the nurse manager that they did not get the correct discharge instructions, like to follow up with the surgeon and it was a post-op complication. So, which I vaguely remember, but it was a phone, it was before the iPad. So, there was a whole thing about follow-up

> with that post-op kid and they said they did not get the correct discharge instructions (Nurse Madison).

The nurse recalled the printed Spanish discharge instructions included following up with the surgeon; however, she realized how she still needed to "go into detail" when teaching the patient/family with LEP. This situation has been a constant reminder to the nurse to use the teach-back method with all patients/families with LEP to verify that they understood their discharge instructions by repeating them back to the nurse through the use of interpretive services.

Summary

In this chapter the nurse participants described their experiences while maintaining ongoing communication when informing, updating, and educating patients/families with LEP in the PED treatment area. They expressed the importance of ensuring the patients/families understood their treatment plan, treatment outcomes and, when indicated their discharge instructions. The nurses were active participants in acquiring Interpretive services for physicians' delivery of critical news involving cancer diagnosis, trauma situations and death notifications.

The majority of the nurse participants used interpretive services to complete the initial patient/family interview, assessment, provide a timeline of provision of care in the treatment area and then only once again at discharge. Only a few nurse participants collaborated with PED physicians to have the interpretive service device in the patient's treatment room so that they were all present in the room to initially discuss the treatment plan with the patient/family.

To update the patient/family on their PED treatment plan throughout their stay, the nurses described using creative methods of communication, including body language, other bilingual staff, and props, to attempt to relay their message to the patients/families. The nurses remarked that they did not use IS for updating the patient/families throughout their PED visit unless there was critical news to be delivered. While planning the care of patients/families with LEP in the treatment area the PENs described situations which proved to be challenging in using interpreters on the electronic devices. Some nurses expressed confusion as to why some of the patients/families did not understand the questions interpreted by the certified interpreter on the electronic devices. The nurses believed the interpreters did not comprehend the medical terminology and therefore could not interpret their message correctly.

In trauma situations where time-sensitive life-saving protocols and medical interventions offered limited opportunity to facilitate communication with the patient or family, additional support staff, such as a child-life specialists and chaplains were instrumental in providing the family interpretive services and emotional support.

Critical news that was conveyed to the patients/families by the physicians included explaining a poor prognosis to the parent, describing the severity of a child's illness requiring a transfer to another acute care facility for higher level care, and reporting the death of a child to the parent.

Some of the nurses reported the PED physicians or medical residents provided the discharge instructions to the patients/families with LEP with the assistance of an interpretive service device or in-person interpreter.

The nurse participants responsible for providing discharge instructions to a patient/family described the importance of using interpretive services to ensure the patient/family understood their medication prescriptions and follow up instructions. They had access to language specific computer-generated patient discharge instructions in selected languages. If a patient/family's preferred language was not available in the PED's language specific computer-generated list, some of the PED physicians used other internet-based resources to generate PED discharge instructions in the patient/family's preferred language and an interpretive service would be accessed to assist in the delivery of the discharge instructions by the physician and nurse. The accuracy of discharge instructions delivered by one of the nurse participants became the topic of concern for a patient/family that contacted the PED nurse manager to discuss their receiving inaccurate discharge instructions on following up with their child's surgeon for a post-operative complication.

All the PEN participants highlighted their experiences in delivering and maintaining ongoing communication in different forms to their patients/families with LEP from the treatment area through disposition. The nurses' assurance of the accuracy of the interpretation of critical information remained their concern throughout the patient/family's stay in the PED. The importance of delivering accurate information was emphasized by all the nurses when they described choosing the appropriate interpretive services to assist them in teaching the patient accurate details of their discharge care. Some nurses described feeling empathy for their patients when they were receiving critical news and wished they could clearly express their emotions directly to the patient/family.

CHAPTER VI

FINDINGS: CERTIFIED PROFESSIONAL MEDICAL INTERPRETERS

Introduction

In addition to the fifteen pediatric emergency nurses (PENs), five certified professional medical interpreters (CPMIs) were also interviewed to understand their experiences working with pediatric emergency nurses. Certified professional medical interpreters encountered their own challenges in assisting the nurses when providing interpretive services to patients/families with limited-English proficiency (LEP).

Three themes emerged from the interview data collected from the CPMIs: *interpreting is not as easy as it seems, challenging interpretations* and *patient/family considerations*. The themes are prefaced by a brief summary of the pediatric emergency nurses' description of their experiences, followed by the CPMIs' perspective on working with the nurses caring for patients/families with LEP.

Interpreting is Not as Easy as it Appears

Conducting medical interpretation requires language proficiency and a knowledge of medical terminology to ensure a mutual understating between the patient/family and the health care provider. Working with CPMIs, most of the PENs expected them to interpret their message to the patient/family word for word; and to be knowledgeable in medical terminology. "The interpreter has to maintain the flow of the conversation, it is not word for word. It is a message that you have to understand the message before you can interpret it in the target language (CPMI Rios)."

Not a Simple Task

Assisting PENs with interpretations was not as simple as repeating the words of the nurse in a different language. Before starting with the interpretation process the CPMIs followed a formal introduction and requested permission from the patient/family to proceed with the interpretation, as described by CPMI Vega (the word translate is used synonymously with the word interpret):

> I always ask for permission when I go in the (patient's) room. I introduce myself, that is the first thing I always do, and I also introduce the physician and the nurse. And I make sure I get authorization from the parent for me to translate. I will not translate, if they tell me 'No, I do not want you to translate.' I will not translate. That is one of my policies because I don't want them to feel like I am invading their privacy…Whether it is in triage, whether it is in a patient's room. Wherever I go to be used as a translator, I always ask for authorization from the families (CPMI Vega).

As the CPMIs introduced themselves and initiated a conversation with the patient/family, they reported using their situational awareness to inform themselves of the patient/family's level of communication skills and any factors they should consider before starting their interpretive services. They took the patient/family's language proficiency into consideration as they attempted to find the best method to interpret the PEN's message for the patient/family to understand:

> Interpreting sometimes is not as easy as it would seem. And you can get frustrated for the nurse because it's like, cause the nurse feels like you are saying too much when in actuality you have to because that person is not as proficient as you would think the average person is, depending on their background. So, that sometimes got a little frustrating for them. Because they are like, "I feel you are saying what I am not saying." (CMPI Duran).

CPMI Duran described a situation when she had to interpret to the parents that the PEN needed to take a rectal temperature on their baby. She recalled how the PED physician could not understand why she could not simply say to the parents, in Spanish, that the baby needed a rectal temperature. CPMI Duran explained to the PED physician how the parents had "never been exposed" to this method of taking a temperature and she needed to explain to the parents in simple terms the reason and method for taking the temperature, until they could comprehend her.

Not Enough In-Person Interpreters

Although the nurses that had access to in-person interpreters appreciated their service, they also agreed that one in-person interpreter per shift was not enough to accommodate the language needs of the increasing volume of patients/families with LEP visiting the PED. When asked how many times in an 8-hour shift they were called to assist with interpretations, the CPMI participants that served as in-person interpreters recalled getting called "15-20 times a shift" and "I don't know how I did it, but it was a lot (laughing)" (CPMI Rios). CPMI Portes who participated in the hospital's certified interpreter database remembered getting called "at least 2 to 3 times a shift"; CPMI Rios was called "in one day at least 15-20 times"; and CMPI Duran commented, "it was just too many times, it was an everyday thing."

> It is not easy. It's not because, being an interpreter sometimes they want you to go back and forth. You know you're going, the doctor says this, and then the patient is saying this, cause that's the way they certified us in class. They said you look at the doctor, the doctor says whatever they are going to say, you turn to the patient and just talk. Like if you were the voice of that doctor and then for the patient the same thing, whatever they say, you turn again, towards the doctor and you just say what they said. Well sometimes I would be stuck in the middle and the patient would say to me or the parent of the patient would say to me, "that's not what I said". But it is, but I just can't. It does not make sense for me to go word for word (CMPI Duran).

The participants found themselves interpreting for the PED physicians more often than for the nurses. They believed this was due to the nurses using the electronic IS devices more often than the PED physicians, especially when they were not available to assist the nurses with interpretations. The in-person CPMIs were not always readily available when each nurse needed them due to assisting other patients/families or in some cases supporting a family (both non-LEP and LEP) through a trauma situation:

> It all depends on the case. I go case by case. If I had a trauma, ok, my concern is taking care of that family. So, I don’t leave that family until that trauma is taken care of. I always stay with the family. Uhm, because they need that support at that time. That takes priority over everything else. So, I tell them (the ER staff) if you cannot wait for me then use the language services, because that is why we have language services. And sometimes they don’t want to use it, so. They say it takes too long to turn the program on. They don’t want to take the five minutes to do that (CPMI Vega).

Another participant reiterated the importance, as a patient liaison, of being present at every trauma in the PED. “When there is a trauma, everybody goes to the trauma room. The other patients, they have to wait, and we have not only one, but two, three, traumas sometimes” (CPMI Palma). Furthermore, CPMI Palma expressed how she would like to see more than one in-person interpreter in the PED, per shift, because when she was busy interpreting for a patient/family the nurses would request her help to clarify interpretations (which the nurse received through an interpretive service device) or interpret discharge instructions for a patient/family. Waiting for her would often cause delays in the nurse communicating with the patient/family or providing their discharge instructions The in-person CPMIs expressed their concern in wishing they could help all the nurses in a timely manner that needed their assistance in interpreting for their patients/families:

> When they (the nurses) see me, you should see them in the morning when they see me. “Oh my god, you are here today. Yes! Yes!” It makes me feel good because they know I am there for them as well. I am not just there for the patients and their families. I am there for all of you (CMPI Vega).

One CPMI who also worked as a patient care technician (PCA) in a pediatric emergency department would assist the pediatric emergency department (PED) staff with interpretations as often as she could. She expressed how, at times, she was the only certified interpreter and PCA working on one shift. She would go back and forth between triage and the treatment area helping both nurse and doctors with interpretations and was still expected to complete her PCA responsibilities of taking vital signs, assisting with discharge instructions (i.e., crutches, slings) and rounding on all the patients in the PED. “Sometimes it would be unrealistic, there’s only one of me (CPMI Duran).”

Interpreter Limitations

Similar to the PEN participants, **t**he CPMI participants expressed their desire to learn more Spanish medical terminology to improve on their medical interpretation. In a situation when a CPMI did not understand a medical term (i.e., interpreting medical terms for a neurologist or neurosurgeon) she would repeat the medical term to the patient/family in English and waited to hear back from the patient/family to confirm their understanding. The participant was not comfortable explaining to the patient/family something she herself did not understand; therefore, she would inform the physician or nurse that the patient/family wanted an explanation. “So, I am learning that there are certain ways of using medical terminology with patients or the families to provide better information and about the patient’s care and welfare” (CPMI Vega).

CPMI Vega, who served as an in-person interpreter in a PED described how she would frequently get called by the nurses to provide interpretive services to a patient/family because the PCA or registration clerk were unable to assist with the interpretation “due to a language misunderstanding”. Both nurses and CPMI participants often encountered situations when the patient/family with LEP were unable to understand the interpretation provided by ad-hoc interpreters.

A CPMI participant expressed her “frustration” when she would round on the patients/families in the PED and discovered that they had been seen by the nurse or physician and verbally given information in English which they did not understand. The participant described this as a recurring event in which she would advocate for the patient/family and explain to the PED physician that they needed to call her when speaking to a patient/family with LEP.

> That is the biggest mistake I see in the emergency department. Not just the nurses but I see it with the doctors too. They try to speak Spanish or whatever language and then they assume that the person understood, and they didn't. Sometimes people (the patient/family) just want to get the medical treatment quicker by saying "yes". The patients assume that. Sometimes the doctors do not want to wait for the interpreters or for the program to start (the interpretive service device), so they try to handle it themselves because they are in a hurry. You know to get patients in and out (CPMI Vega).

In addition to wanting to learn more medical terminology in Spanish, one interpreter also expressed how she wanted to learn another language so that she could help other patients/families with LEP. Furthermore, she explained how serving as an in-person interpretive services (IS) she was able to offer emotional support to the patient/family and advocated for the patient/family if they were not understanding.

> It takes training and…it is not that simple as "ok, let's go just say this", no it's not like that. The interpreter has to maintain the flow of the conversation, it's better not to interrupt with clarifying questions, but if I need to, I will do it. I have to maintain the conversation so that those two people can have a connection. It's like the interpreter is invisible there, unless there's something that I know they are not getting. So, when I see that the patient is not getting it and they are repeating their questions. Or if they don't say it, I can see it in their face. And then I have to say something. Because we are an advocate for them, So, if I see that they don't get it and the provider is about to end the session, I have to stop them and say "wait a minute she did not understand what you are saying. Can you repeat it"(CPMI Rios).

Challenging Interpretations

The CPMIs were asked to elaborate upon a personally challenging situation when their interpretive services were used. They described their experiences in assisting health care providers in delivering critical news and expressed their frustration when questioned about the accuracy of their interpretation in the presence of the patient/family with LEP.

Delivering Critical News

The CPMI participants described their experiences interpreting the delivery of critical news from the PED physicians to the patient/family as "being a mediator between everyone and not taking sides for the sake of the child" (CPMI Vega); "challenging to express the emotions of the patient" (CPMI Rios); and "a time to comfort the patient/family after they receive the news" (CPMI Duran).

CPMI Rios expressed how challenging it was to interpret the emotions of the patient/family during the delivery of "bad news":

> The interpreter has to say and express the emotions of the patients. You have to say everything that they are saying. It is very hard, as an interpreter I have to listen very carefully to the words so that I can interpret back and forth (CPMI Rios).

CPMI Vega described being a "mediator" in situations where law enforcement was involved, and she had to interpret to assist the PED physicians and nurses evaluate the situation at hand. She explains how she was "never judgmental" and assured the patient/family that she wanted to help everyone involved.

CPMI Palma recalled a situation in the PED in which she interpreted for a "young mother with three children and one more baby on the way". She recalled how she told the mother that the physician and nurse were going to notify children's protective services to get her help with her children. "She was not a bad mother, but she could not handle the situation, she needs help" (CPMI Palma). The CPMI participant remembers the mother was "afraid" and after assisting the PED physician with his interpretation, she stayed with the mother so she could explain the situation once again to the mother to allay her fears.

CPMI Palma elucidated how although the situations were "terrible" and "sad" for all involved she had to be present to interpret for the physician and patient/family. She recalls moments when it was not easy for her and she cried, and "even the doctors cried when they gave the news to the family members, especially when there were kids involved." The traumatic events which some of the CPMIs had to provide interpretative services for took a toll on their emotional state. “Sometimes you get traumatized by the things that you see from abused kids and the death of a child.”(CPMI Palma).

> So, you know, you’re interpreting, and these are the facts. But in the back of your head and in your own person you’re like, “I get it, it’s someone’s child.” There were times where certain situations were hard to process for me. It took me time. Seeing a child that drowned took me time. Seeing a child that committed suicide took me time. It was like there were cases where I was like ‘why did I come to work today?’ (CPMI Duran).

Questioning Validity

Interpreting was, at times, challenging for the interpreter when their interpretive skills, or the accuracy of their interpretation was questioned. Additionally, their ethical responsibility was put to the test when they recognized the inaccuracy of an interpretive service.

The accuracy of the CPMIs’ interpretation during discharge instructions was a concern for them as they interpreted dosages, times and medication names for the patient/family with LEP. The participants realized how precise their interpretations regarding medications had to be, “every single time” to ensure that the patient/family were receiving the correct information in their primary language. In a family meeting situation where CPMI Vega was asked to attend as a patient representative for a patient/family with LEP she intervened as an advocate for the family when she questioned accuracy of the IS interpreter on the phone. She explained:

> It was a family meeting, this patient had cancer and they needed to make decisions on what to prepare the family and the patient with. So, they had used the phone interpreter and they called me, because I was a patient representative. I was there to be a support system for the family as well as the staff and I am listening to the doctor explain to the family what type of cancer she had, why she was going through these processes, why the treatment wasn’t working, how to deal with the process of death. Uhm, this gentleman (the service interpreter) just kept saying, you know, it just wasn’t exactly what the doctor was saying. It was like, you need to question the doctor about this, he (the interpreter) was giving the family suggestions, plus, on top of that he wasn’t talking to them about the services we were going to provide for the patient and the family. So, that is why I had to intervene because it was a serious situation. I am glad that I did, because then we were able to get a live person (in-person interpreter) to come in the next day and then it was a better outcome (CPMI Vega).

The CPMIs prided themselves in assisting the patients/families and establishing a rapport with them while they were in the PED. At times the health care provider would hinder the CPMI's encounter with the patient/family with LEP when they questioned the CPMI's ability to interpret accurately. Some of the participants reported how the health care providers would interrupt them while they were interpreting for the patient/family. CPMI Duran described her experience with a physician:

> She would always interrupt me when I was interpreting. I told her when she did that, it makes it look to the patient that I am telling them something totally incorrect and they are not going to trust me (CPMI Duran).

Patient/Family Considerations

The confidentiality, cultural background and emotional status of the patient/family was important for the CPMI participants to determine the communication needs of the patients/families. This approach established a connection between the CPMI and the patient/family.

Patient Confidentiality

Protecting the confidentiality of the patient/family was imperative for the CPMIs who were often present during crucial moments in the patients' lives. The participants were aware of the patient privacy guidelines in the hospitals and did not discuss patient cases outside of the patient/family treatment rooms.

Cultural Sensitivity

Job longevity and experience contributed to the CPMIs' knowledge of various language dialects and cultural traditions which they expressed was a form of demonstrating respect for the patient/family diversity.

> My experience was that I learned a lot from the different cultures. I mean, we all speak Spanish, but we are all from different countries. People from different countries will speak different dialects. And this was a great experience because I learned a lot from different people from different countries. What are the words they use and what do they mean because they had a different meaning to me (CPMI Palma).

CPMI Duran considered the cultural background and nationality of the patient/family when assisting with interpretations to determine her choice of words when delivering the interpreted messages. For example, the situation in which she interpreted for a mother whose child was in the PED receiving emergency treatment for croup, she first had to determine the mother's "level of understanding":

> I have to take what the nurse is saying and which most of the time it's medical and then kind of interpret it in my head and then interpret it in another fashion based on that person. You know, some people have knowledge of what an illness can be and some others depending on, I would say, background, environment, income level, no, they do not (CPMI Duran).

Some of the participants expressed how when assisting physicians with interpretations, they noticed how the questions they asked would "sometimes come across as offensive in a patient's culture" and how "they are cut and dry with their words." They would advocate for the patient by asking the provider if they would consider rephrasing their question so the patient/family could understand them better. They explained how they would like to see the staff get a class on culture competency, the same as they had in their interpreter certification courses.

> They (patients with LEP) have expressions, it depends on where they are from. What country they are from. You can pick up some expressions and slang words. Knowing this, you describe better what they (patients with LEP) are feeling (CPMI Rios).

CPMI Portes is a bilingual nurse who serves as a certified interpreter for various hospital units, including the PED. She explains how she would ask the nurse she was interpreting for "What is she looking for and what questions she has for the patient" up front, so that she would ask the patient. Additionally, the CPMI assured herself that the patient/family understood her interpretation by using the “teach back method.”

> I would ask them to repeat to me what I just said to them. If they need me to clarify anything. I give them time to ask questions. It makes me proud that I am able to help people of my culture. I feel like I am empowering them (CPMI Portes).

Empathy

The CPMI participants described how having been in similar situations themselves, they empathized with the patients/families with LEP and how rewarding it was for them to be able to use their language skills to help those that needed interpretation assistance. They explain how they noticed the difference they made in the patient/family’s trust in them when they discovered they spoke the same language.

> Honestly, I put myself in their shoes. How would I feel, how do they feel coming in somewhere and not understanding the language and how uncomfortable I would feel. They tell me, ‘When I come here, I know that you are here, so I come looking for you, I ask for you.” You know. That is a good thing. It makes me feel very good to know that families trust me (CPMI Vega)

After interpreting information for the health care providers, some of the CPMIs described how they often stayed with the patient to ascertain that they understood and to reassure them. “They (the nurses and physicians) kind of forget the piece that the parent needs reassurance even in another language (CPMI Duran).”

Summary

In this chapter the CPMI participants described their experiences when working with pediatric emergency nurses when interpreting for patients/families with LEP. Although the CPMI interpreters found their work rewarding in helping patients/families with LEP, they described their experiences as challenging, and unexpectedly traumatizing at times. They reported that interpreting was not as easy as it appears; it is not simply interpreting word for word to the patient/family. The CPMI participants felt the importance of including patient confidentiality, cultural sensitivity, and empathy when structuring their interpretation of what is to be interpreted for the patient/family with LEP to understand the entire message. Certified professional medical interpreters considered themselves advocates of the patients/families with LEP and a support system for the staff.

CHAPTER VII

DISCUSSION

The purpose of this interpretive descriptive study was to examine how pediatric emergency nurses (PENS) initiate, provide care and communicate with children and families of limited-English proficiency (LEP). The literature review referenced in Chapter 2 yielded data indicating how nurses caring for pediatric patients in various pediatric nursing specialties reported both positive and negative experiences and how interpretive services were not consistently used by nurses to communicate with patients/families with LEP. These previous research studies were limited in describing specific experiences of PENS when caring for pediatric patients/families with LEP in a pediatric emergency department (PED). In this study, in addition to PEN participants, certified professional medical interpreters (CPMIs) were also interviewed to add their perspective when assisting PENs in interpreting for patients/families with LEP.

The PEN participants described their experiences and challenges in establishing and maintaining ongoing communication with patients/families with LEP while providing emergency nursing care. They dealt with these challenges as best as they could when faced with limited time, scarce resources, unpredictable situations, emotional conflict, technology issues and life threatening traumas. Their common goal was to deliver safe, quality, and compassionate care to patients/families with LEP in these moments. Knowledge of the PENs' and CPMIs' individual accounts of their expereinces and their interventions to facilitate communication with patients/families with LEP provides insight into the specialty of pediatric emergency nursing.

This chapter will discuss the research findings in relation with the relevant existing body of knowledge. The discussion is organized into six themes: *Communication needs of* *patients/families with LEP, variability of available interpretive services, delivering critical news, collaboration with interpreters, providing discharge instructions and cultural considerations with communication*. In conclusion, strengths and limitations of this study are discussed in addition to the implications for research, education and practice.

Communication Needs of Patients/Families with LEP

The provision of safe, quality and compassionate nursing care for the increasingly diverse population in the United States with limited-English proficiency (LEP) is challenging for nurses of all specialties. Despite the current guidelines from the National Culturally and Linguistically Appropriate Services (U.S. Department of HHS, Office of Minority Health, 2018) and the required language service compliance of Title VI of the Civil Rights Act (U.S. Department of HHS, Office of Civil Rights, 2013b), the results of this study demonstrated how nurses experienced challenges with time constraints and limited resources leading to underutilization of interpretive services in their efforts to facilitate communication with patients/families with LEP. Furthermore, the Joint Commission (2022) requires health care staff to identify patients/families with LEP and to assess in what primary language they prefer to receive their healthcare information, as well as their need for interpretive services. Extensive research exists linking language barriers to poor communication between health care providers and patients/families with LEP, thus preventing the latter from receiving appropriate and timely medical treatment and linguistic resources.

Caring for patients/families with LEP required the nurse participants to devote additional time to determine and accommodate the communication and emergency care needs of these patients. Many times, this slowed down the nurses’ workflow and created a sense of frustration when realizing that other patients were waiting for them. These findings highlight the nurses’ struggle in completing time sensitive interventions while taking additional time to provide appropriate linguistic resources in a safe and timely manner to patients/families with LEP. Similar results were identified by Stephen (2021) in a phenomenological study of 15 pediatric medical-surgical nurses that were challenged to perform their tasks quicker in order to accommodate the additional time necessary to arrange and work with interpreters to help the patient/family with LEP with their care. Additionally, these nurses felt "personal frustration" (pg. 693), at not being able to communicate with and care for their patients/families with LEP in the same way they cared for English speaking patients/families. Findings suggest the need for more accessible interpretive services to lessen the waiting time for the PENs and to prevent disparities in care for both patients/families with LEP.

When encountering a patient/family with LEP in triage or the treatment area, the PENs did not consistently assess whether the patient/family needed interpretive services. Some of the nurse participants chose to get by with using their limited Spanish language skills to either elicit medical information or to provide brief instructions to the patient/family. This strategy was effective for the nurses only if the patient/family's response to the nurses' questions was comprehensible without interpretive services. If the patient/family's response was too in-depth, then the nurses would decide to access a form of interpretive service or search for a PED staff member to serve as an ad hoc interpreter to assist them. The PENs would often determine when they needed an interpreter to communicate with the patient/family regardless of the patient/family's preferred language entered in the electronic medical record (EMR) upon registration or from a previous medical record. These findings are supported by Lion, et al., (2021) who identified that pediatric emergency department nurses often used interpretive services at their discretion, and less frequently during medication administration and procedures.

However, some PENs reported that at times patients/families declined interpretive services when offered. This was due to the patient/family having some English proficiency or requesting to have a present family member interpret. Similarly, Schwei et al (2018) identified that Spanish and Hmong speaking patients with LEP self-identified their level of English proficiency and did not always think an interpreter was needed; however, if during the healthcare encounter with the provider the communication included unfamiliar medical terminology or complex information, then the Spanish and Hmong patient/family thought an interpreter would be necessary. These findings suggest the importance of nurses assessing the linguistic preferences and needs of the patients/families with LEP in addition to consistently offering them interpretive services in order for the patient/family to fully understand their care as proposed in the Patient Bill of Rights (National Institutes of Health, 2021).

Oftentimes when the nurses identified the language needs of the patient/family they were faced with the parents' request to allow a family member to interpret in place of an interpretive service. Unfamiliar with their facility's policies and procedures on caring for a patient/family with LEP, the PENs honored the family's request. Likewise, in studies conducted by Taira et al., (2020) and Breena et al. (2020), most of the emergency department nurses surveyed were not aware whether a hospital policy existed on caring for patients with LEP. The nurses' limited awareness of policy guidelines on caring for patients with LEP suggests the need for frequent educational reinforcement for the PENs as part of their annual competency performance evaluations. This is especially important for health care organizations that promote a patient family-centered care model (Institute for Patient and Family-Centered Care, 2016), which promotes engaging the family and patient in their health care decision making process.

The PENs in this current study frequently found themselves using graphics or written resources such as facility-provided language cards for the patient-family to identify their primary language. Sometimes a rare dialect was identified by the PENs for which no interpretive services were available; therefore, leaving the nurses with no option but to accept the assistance of an interpreter who spoke a similar language to the requested dialect. This finding aligns with a challenge identified in a qualitative study conducted by Tam et al. (2020) and Russel et al. (2015). Medical staff, interpreters, nurses, dieticians, social workers and child life specialists from a pediatric hospital encountered patients/families whose primary language or dialects were not easy to identify, or an interpreter did not exist for the primary language identified and required additional time to search for the appropriate interpretive services. This situation required additional time and resources that were not often readily available for the PENs caring for patients/families with LEP.

Some PENs in this study were faced with the complexity of arranging interpretive services for hearing impaired Spanish speaking patients/families in addition to accessing Spanish and English sign language interpreters. Sign language is a multifaceted form of communication that requires manual signing, body language, lip reading and facial expressions (Richardson, 2014), and various forms of sign languages exist worldwide. Although the PENs reported that these types of encounters did not occur frequently, nevertheless they requested more information on language resources and education to be better prepared to care for hearing-impaired patients with LEP in the future. Studies examining the nursing care of hearing-impaired LEP patients/families are sparce; however, clinical guidelines are available for nurses on how to communicate with a hearing impaired patient using American Sign Language (ASL) interpreters (Richardson, 2014).

When encountering a life-threatening emergency in triage, despite a language barrier, the PENs relied on their specialty training, assessment skills, and if available, standing physician orders, to initiate emergency lifesaving treatments. Although the nurses in this study did not expressly report experiencing a negative outcome when initiating stabilization before communication with the patient/family with LEP, the nurses were not consistently afforded the necessary linguistic resources to include the patient/family in their care as soon as they arrived to the PED. A language barrier may hinder the nurse from obtaining valuable health information from the patient/family needed to expedite their emergency medical care. Considering that the triage nurses are the first to assess the patients/families that arrive to the PED they require immediate accessibility to interpretive services to initiate communication with the patient/family, specifically if the pediatric patient is in obvious distress.

The use of verbal and non-verbal cues by the PENs to attempt communication with the patients/families was emphasized especially when time was a critical factor. Nurses used props, hand gestures, charades, and limited Spanish language to update patients/families or to prompt them on providing specimens or instructing on simple procedures (i.e., taking their vital signs or weight). These creative methods, and other actions, such as using toys, guessing games and pointing to objects, used by nurses were echoed in the findings of qualitative studies conducted by Stephen (2021) and Shuman et al. (2017). These findings underscore the frequent use of non-verbal communication and creative methods, without the use of interpretive services, by the PENs to update and communicate with patients/families while in the treatment area.

Variability of Available Interpretive Services

Although the nurse participants in this study were aware of the benefits of using interpretive services, they expressed their concerns regarding reliable internet access, device availability and access, the additional time required to access the interpretive service, and the quality and accuracy of interpretation delivered by certified professional medical interpreters

(CPMIs) which were seen as contributing to the nurses' frequent underutilization of interpretive services. Several studies reported similar challenges experienced by nurses using interpretive services: (a) availability and accessibility of interpreters (Ali & Watson, 2017; Phonpruk, 2018, Stephen, 2021;), (b) convenience (Ali & Watson, 2017), (c) the impact on the confidentiality and privacy of the patient/family with LEP (Ali & Watson, 2017), and (d) internet connectivity and low battery issues when using video interpreter devices (Tam et al., 2020; Marcus et al., 2020; Lion et al., 2015). Conversely, the benefits of using CPMI services is supported with documentation of cost effectiveness (Karliner et al., 2017), better patient outcomes (Muir et al., 2021), and patient satisfaction (Muir et al., 2021).

The variability of interpretive services was clearly noted in the nurse participants' reports on how they managed communication with the patient/family using various methods of linguistic services (i.e., video tablets, phones, in-person interpreters) to communicate with them throughout their PED visit. Interpretive services were mostly used in the treatment area at the beginning of the patient/family visit and when providing discharge instruction; however, interpretive services were not frequently used by the nurses in the middle of the patient/family's visit unless a critical incident required the presence of an interpreter. Time constraints and the nurses' impression that they did not need an interpreter to communicate simple phrases to the patient/family further led to the underutilization of interpretive services in the PED. Hartford et al. (2019), found that the majority of patients/families with LEP that visited a PED were recorded as being offered interpretive services during their initial assessment and for discharge teaching, with only a few of them receiving interpretive services during the middle of their PED visit. Further supporting how nurses in a PED focus on the immediate health problem at hand and may use interpretive services exclusively to complete their initial assessments and explain to the patient/family their plan of care or deliver discharge instructions, hindering the opportunity for the nurse to form a personal connection with the patient/family.

Overall, in-person CPMIs were preferred by the nurse participants in this study due to the personal approach that was offered with the interpretive intervention; these findings are similar to the results identified by Taira et al. (2020) and Stephen (2021). Likewise, findings in a study by Tam et al. (2020) demonstrated that in-person interpreters were preferred by nurses, due to the accuracy, effectiveness, their ability to use appropriate tones and their observation of visual cues from the patient/family. Benefits of including in-person interpreters as staff in PEDs were supported by the certified professional interpreters interviewed for this study. The CPMIs indicated that a personal connection, trust and relief was particularly evident in parents who were assisted by an in-person interpreter, when they assisted them in communicating with the PENs. These findings highlight the value of considering a personal connection when communicating with patients/families with LEP, by employing the services of in-person CPMIs or ensuring that all interpretive services offered electronically have a video component, the next best option to an in-person interpreter as reported by the PEN participants.

It is noteworthy to consider how frequently PENs and patient/families' referred to the internet based translation service, Google Translate® to communicate with each other. This service is limited in its translation accuracy and provides limited medical terminology which may lead to miscommunication and misunderstanding among its users (Allen, 2020; Taira et al. 2020; Stephen, 2021). Although the nurses in this study found the internet-based translation services easily accessible on their personal smart phones, they should be instructed on the disadvantages of using these types of language services which are not reliable in medical situations and are not in the best interest of the patient's privacy rights.

Ad Hoc Interpreters

The use of family members, minors and bilingual staff was frequently described by the nurse participants as their last resort when they were pressed for time and had limited access to professional interpreter services; although, the nurse participants were aware of the high risk for miscommunication using ad hoc interpreters. Communication errors are possible with any method of interpretive service, but more so with ad hoc interpreters, as supported by Napoles et al. (2016). More omissions, substitutions and additions in interpretations occurred with ad hoc interpreters as opposed to professional in-person interpreters and video device interpreters. These findings suggest nurses should use caution when determining the use of family members and other PED staff as ad hoc interpreters in emergency situations and make every effort to seek out professional interpretive services as required. Furthermore, the Emergency Nurses Association scope and standards of practice (ENA, 2017b) encourages PENs to collaborate with CPMIs to address linguistic barriers rather than use ad hoc interpreters which can increase the risk of adverse events.

According to the ANA Code of Ethics (2015), PENs are required to safeguard the patient/family's personal information obtained through their provision of emergency care. Moreover, this information may only be disclosed with the patient's authorization. The use of ad hoc interpreters may breach the patient/family's privacy. Patient/family medical information, whether written or communicated is protected under law by the Health Insurance Portability and Accountability Act (National Health Law Program, 2022). Certified professional medical interpreters are held to the same patient confidentiality standards as nurses. Further, nurses and CPMIs should be offered education regarding the federal and state mandates and organizational guidelines requiring the use of interpretive services in addition to safeguarding the patient/family’s privacy.

Children as Interpreters

Accepting the assistance of a child interpreter was at times the only option the PENs had to obtain details surrounding the circumstance of the emergency situation involving the child themselves or a sibling. Similarly, nurses from a pediatric teaching hospital, interviewed by Russell et al. (2015) reported asking children to serve as interpreters mostly in times of crises and when interpreters were not available. These findings suggest that children are used as interpreters in critical emergency situations. Children may not understand the complexities of medical emergency and it is not appropriate to expose children to serious situations without considering the emotional toll on the child. Health care organizations should ensure that policies include guidelines to protect children from these traumatic situations.

Teenagers, aged 14 and up, were regarded by the PEN participants in this study as capable, mature and knowledgeable and deemed them able to interpret for their parents as necessary. Likewise, Stephen (2021) found that pediatric nurses reported building a rapport with the teenaged patient was simpler when the pediatric patient was older and spoke English; however, the nurses described missing a similar connection with the parents. It is important to note that some of the PENs in this study expressed their concern in protecting the teenaged patient’s privacy when they were asked to interpret for their parents due to the sensitive nature of their medical presentations or diagnosis.

Bilingual Staff as Interpreters

The PENs in this study referred to working with more bilingual physicians than bilingual nurses. The bilingual physicians collaborated with the PENs in serving as interpreters during initial assessments and various interventions and procedures. Unfortunately, due to their shift responsibilities the bilingual physicians' availability was limited in providing assistance and continuous interpretations to assist the PENs in communicating with their patients/families with LEP. Additionally, the PENs were reluctant to request the interpretive assistance of a bilingual nurse since it resulted in added responsibilities for the interpreting nurse and the use of staff resources to cover the interpreting nurse's patient assignment. Similarly, patient care technicians, security guards and registration clerks were often pulled away from their responsibilities when the PENs used them as ad hoc interpreters. Hsieh (2014) found that nurses did not want to overwhelm bilingual nurses with the added task of interpreting, thus they would only ask for simple interpretations and have the patients wait for a professional interpreter if a thorough evaluation or discharge education was necessary. Whereas a study by Chang et al. (2021) which examined the experience of emergency department bilingual nurses as ad hoc interpreters revealed that they felt they were often "pulled away" (pg. 1053) from their responsibilities to interpret for nurses and doctors. Additionally, there was a misguided assumption among the ED staff that these bilingual nurses could interpret medical terminology or were fluent in their second language. Policies with specific guidelines on the accessibility and availability of bilingual staff are needed to ensure the appropriate use of these services with minimal interruption to the nurses workflow.

Delivering Critical News

Life threatening conditions, poor prognosis, and death are tragic circumstances that the PENs encounter in the PED. At times these situations involve patients/families with LEP. Although the PENs were not directly responsible for the delivery of critical news to the patient/family with LEP, they ensured a certified professional medical interpreter or video interpreter was available for the physician and family. Although present with the patient/family, the nurses felt disappointed that they could not verbally express their emotions to the parents with

LEP, despite having an interpreter present. Furthermore, when the PENs were asked to describe a situation in which they cared for a patient/family with LEP, many of the nurses recalled a trauma situation and they described their inability to express their empathy and compassion to the patient/family with LEP as memorable. They expressed feeling a lost emotional connection with the patient/family in a time of vulnerability and high emotional turmoil, which they regretted. McCall et al. (2022) identified how after working through a traumatic event trauma nurses, working at a level-1 trauma center, benefitted from peer support and debriefing sessions. Additionally, Stephen (2021), identified how a language barrier prevented pediatric medical-surgical nurses from forming an emotional connection with their patients/families further hindering their ability to express their empathy and compassion. No studies specific to PENs caring for patients/families with LEP during traumatic events in the PED were found in the existing literature.

The CPMIs in this study considered the importance of their role in relaying emotions to all recipients involved in a critical conversation. Although the CPMIs in this study expressed pride in helping patients/families with LEP, they also experienced the distress of having to interpret critical or grave information from physician to patient/family. The CPMIs in this study reported not having the opportunity to participate in debriefing sessions after serving as interpreters in traumatic events in the PEDs. The challenge of maintaining a neutral stance while interpreting and being present during traumatic events (i.e., death of a child) was described as emotionally overwhelming. After having observed these cases some of the CPMIs experienced sadness and recurring thoughts of the events. These results are consistent with the challenges of little to no time to process the emotional situations, vicarious trauma, and the complexity of the medical terminology used in traumatic situations (Villalobos et al., 2021). Furthermore, secondary trauma, burnout as well as compassion satisfaction were identified in interpreters serving trauma-focused mental health patients/families with LEP (Mehus & Becher, 2015). These key findings support the importance of including CPMIs in debriefing sessions after serving as interpreters during traumatic events.

Providing Discharge Instructions

PEN participants reported the consistent use of interpretive services to ensure accuracy in the delivery of discharge instructions to patients/families with LEP. Additionally, some of the PENs in this study emphasized the use of the teach-back method while providing discharge instructions to patients/families with LEP. Allen (2020) identified the teach back method effective for the nurses to identify any miscommunication in the interpretation. Furthermore, CPMIs also emphasized the benefits of using the teach back method to evaluate the patient/family's understanding of their discharge instructions (Latif et al., 2022). Conversely, Lee et al. (2018) and Gutman et al. (2018) concluded health care providers infrequently used interpretative services when offering discharge education to patients with LEP. The PEN participants in this study reported that most of the foreign language discharge instructions were available in Spanish; however, written discharge instructions for patients/families with LEP in languages other than Spanish were not as readily available, and this hindered the communication process and delivery of discharge education by the PENs. These results are consistent with a study by Isbey et al. (2022) which identified that discharged pediatric ED patients often do not receive written instructions in the preferred language.

Discharge instructions involve details important for the patient/family to continue their medical treatments and maintain their follow-up appointments. The accuracy of these details ensures the provision of safe quality nursing care and may ultimately prevent patients from returning to the PED for the same health reason. Given the findings of this study, it is imperative to establish a database of discharge instructions available in the most common languages and dialects in the communities surrounding the hospitals, to ensure health equity for all patients/families.

Cultural Considerations with Communication

PENs in this study described various cultural practices and traditions they encountered when caring for patients and families with LEP. They demonstrated an aspect of cultural competency, when they sought out appropriate interpretive services for patients/families that spoke a rare dialect. Furthermore, the PENs' exhibited the implementation of cultural and linguistic accommodations when they provided the services of a CPMI who could effectively communicate needed information, empathy and compassion to the patient/family with LEP. The CPMIs in this study highlighted the importance of nurses taking into consideration the cultural background of the patient/family when communicating with them and when delivering critical news to them. Similarly, Weaver et al. (2022) found that medical interpreters recognized the importance of considering the cultural needs of a family when interpreting critical news and offering them support during difficult moments.

CONCLUSION

Strengths of this Study

The literature on the experiences of PENs providing care to patients/families with LEP within the pediatric emergency department is limited; therefore, this study provides new knowledge on the challenges PENs encounter in the process of caring and communicating with patients/families with LEP using interpretive services and working with CPMIs. A strength of this study was using an interpretive description methodology to examine the clinically based phenomenon of communication with patients/families with LEP in the pediatric emergency department and informing practice. The semi-structured interviews conducted allowed for ongoing data analysis while exploring the experiences, thoughts, and feelings of the PENs and CPMIs, which additionally revealed their emotional vulnerabilities in serving their patients/families with LEP. Another strength of this study was including nurses with a diverse range of PED experience and ages.

The inclusion of interviewing CPMIs provided a secondary source of data which supported the responses by the PENs on the limited use and availability of interpretive services and the need for further training working with CPMIs and education on the provision of care provided to patients/families with LEP.

Limitations of this Study

As the findings of this study are based on the self-reported experiences of PENs and CPMIs in hospitals located in the east coast of the United States; the availability of interpretive services differed from facility to facility, all the CPMIs were Spanish interpreters only, the nurses' workflow and the patient populations served also varied, transferability of the findings may be limited. Furthermore, the findings of this study are limited to the unique environment of a pediatric emergency department, and a small number of female participants which may limit the transferability of the findings to other nursing specialties.

While originally planned as a potential additional data source, policy and procedure documents were not examined because the majority of the participants were unaware of the hospital-specific guidelines or protocols related to providing IS to the patients/families with LEP. Further research is necessary to influence and support education and practice implications in the pediatric emergency nursing care of patients/families with LEP.

Implications for Research

The results of this study indicate that PENs experienced workflow interruptions, time constraints, limited resource accessibility and emotional conflict when caring for patients/families with a language barrier. Furthermore, these findings suggest that patients/family participants of diverse linguistic backgrounds may not be receiving the nature of interpretive services that would most benefit their care needs. It is for these reasons that further research is needed to explore the experiences of patients/families with LEP receiving nursing care in the PED and the impact of communication on their healthcare outcomes.

Additionally, an examination of institutional policies, procedures, and department-specific competencies related to federal and state mandates in the health care and privacy requirements for patients/families with LEP is necessary to identify disparities in the provision of care to patients/families with LEP. The frequent use of ad hoc interpreters by the PENs justifies further research to examine the experience, linguistic training and perspectives of bilingual staff assisting with language interpretations.

Interpreting during critical events had an emotional impact on in-person CPMIs producing sadness and recurring thoughts of the traumatic cases they observed while serving as interpreters. Although the CPMIs recognized the challenges of assisting in the delivery of critical news, they reported their desire to use their bilingual skills to help and advocate for the patients/families with LEP. Further research is recommended to examine the experiences of CPMIs, who interpret during critical events, with inquiries into how they are trained and prepared to manage these situations in their line of work and language specialty.

Pediatric emergency nurses reported feelings of sorrow and empathy for their patients/families with LEP who suffered a traumatic event. The nurses regretted not being able to verbally express their empathy and sentiments to the patient/family. Further research is needed to explore the emotional experiences of PENs in supporting patients/families with LEP during tragic or critical events. Lastly, it would be valuable to investigate the experiences of the patients/families with LEP following traumatic events in the PED.

Implications for Education

The findings of this study suggest ways in which additional education may advance the delivery of educational opportunities for PENs on how to enhance their provision of care for patients/families with LEP. For example, training nurses and CPMIs to collaborate in the emotional care and communication needs of patients/families with LEP, including therapeutic communication during traumatic events in the PED. Due to the variability of interpretive service resources across hospitals, all PED staff would benefit from education on the appropriate use of the interpretive services available for their use, including the proper method to work with an in-person interpreter. Include a review of the American Nurses Association Code of Ethics regarding their responsibility for safeguarding the patient/family's privacy when introducing new interpretive service devices to the PENs.

The PENs expressed their interest in receiving continuing education programs in Spanish medical terminology to increase the opportunities for communication with patients/families with LEP. Include continuing education for nurses on the federal and state regulations regarding the health care services available and mandated for the care of patients/families with LEP including guidelines which prevent the use of minors as interpreters. Designing simulation-based training scenarios involving patients/families with LEP may not only help educate and prepare nursing students in the care of linguistically diverse populations but may facilitate and enhance the delivery of quality nursing care in all nursing specialties.

Implications for Practice

The nurses in this study reported confidence in their pediatric emergency nursing training; however, they requested more quality resources to provide safe, quality and compassionate care to patients/families with LEP. A standardization of available interpretive services may improve the reported underutilization of these services among nurses. Quality of the interpretative services should be evaluated by hospital operations administrators prior to purchasing interpretive service devices. Cost effectiveness may not equate to quality safe care and communication for patients/families with LEP or address the issues encountered by PENs when using interpretive services. Furthermore, it is necessary to offer ongoing education to nurses instructing them on the use of all interpretive service devices available to them, including information on the safe use of public internet translation services and the impact of these services on the patient/family privacy and confidentiality of medical information. The development of a database with discharge instructions available in all languages required for the patient populations served by the individual hospital would improve the safety and quality of patient care provided to patients/families with LEP. Incorporating certified professional medical language courses in nursing academic institutions may prepare future bilingual nurses for a role as a CPMI increasing the availability of interpretive services in healthcare organizations. Policies with specific guidelines on the accessibility and availability of bilingual staff are needed to ensure the appropriate use of these services with minimal interruption to the nurses workflow. In closing, incorporating interprofessional debriefing sessions, not only at the end of all traumatic events in the PED, but also at the end of the workday, for PENs and in-person CPMIs to attend after being involved in critical and traumatic events during a shift cannot be underestimated. These sessions would allow an opportunity and a safe space for the PED staff and CPMIs to reflect and support each other after experiencing difficult situations in their clinical practice.

Summary

Pediatric emergency nurses need additional training, linguistic resources and emotional support to continue providing care to the increasingly diverse patient/family population with limited English proficiency which continues to grow in the United States. Language barriers within any hospital setting can impact the ability of the nurse to communicate with patients/families when immediate interpretive service arrangements are not readily available. This study revealed that safe, quality, and compassionate provision of care for patients/families with LEP not only requires the availability of appropriate interpretative services, but also the professional development and support to the nurses and CPMIs experiencing challenges in their efforts to meet the healthcare needs of patients/families with LEP. Initially this study was intended to elucidate how pediatric emergency nurses communicated with pediatric patients/families with LEP; however, the voices of the PENs and CPMIs spoke to more than what was anticipated by the researcher, opening further avenues of inquiry.

REFERENCES

Abbe, M., Simon, C., Angiolillo, A., Ruccione, K., & Kodish, E. D. (2006). A survey of language barriers from the perspective of pediatric oncologists, interpreters, and parents. *Pediatric Blood Cancer*, *47*(6), 819-824. https:// doi:10.1002/pbc.20841

Ali, P. A. & Watson, R. (2017). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. *Journal of Clinical Nursing*, *27*, e1152-e1160. https://doi: 10.1111/jocn.14204

Allen, M. P., Johnson, R. E., McClave, E. Z. & Alvarado-Little, W. (2020). Language, interpretation, and translation: A clarification and reference checklist in service of health literacy and cultural respect. *Perspectives/ Expert Voices in Health & Health Care*, 1-11. https://doi: 10.31478/202002c

American Academy of Family Physicians (2014). *Definition of family*. http://www.aafp.org/about/policies/all/family-definition.html

American Academy of Pediatrics (2012). *Policy statement, patient & family centered care & the pediatrician's role.* https://DOI: 10.1542/peds.2011-3084

American Nurses Association (2015). *Guide to the code of ethics for nurses with interpretive statements*. Nursesbooks.org

American Nurses Association (2018). *Diversity awareness mission statement*. http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNu rsing/Improving-Your-Practice/Diversity-Awareness/Mission-Statement.html

Arthur, K. C., Mangione-Smith, R., Meischke, H., Zhou, C., Strelitz, B., Acosta Garcia, M., & Brown, J. C. (2015). Impact of English proficiency on care experiences in a pediatric emergency department. *Academic Pediatrics, 15*(2), 218-224. https://doi:10.1016/j.acap.2014.06.019

Balakrishnan, V., Roper, J., Cossey, K., Roman, C., & Jeanmonod, R. (2016). Misidentification of English Language Proficiency in triage: Impact on satisfaction and door-to-room time. *Journal of Immigrant Minority Health, 18*(2), 369-373. https:// doi: 10.1007/s10903-015-0174-4

Blankenship, A., Harrison, S., Brandt, S., Joy, B., & Simsic, J. M. (2015). Increasing parental participation during rounds in a pediatric cardiac intensive care unit. *American Journal of Critical Care*, *24*(6), 532-538. https://doi:10.4037/ajcc2015153.

Breena T. R., Torres, J., Nguyen, A., Guo, R. & Samra, S. (2020). Language assistance for the care of limited English proficiency (LEP) patients in the emergency department: A survey of providers and staff. *Journal of Immigrant and Minority Health, 22,* 439-447. https://doi.org/10.1007/s10903-019-00964-9

Brown, K., Mace, S. E., Dietrich, A. M., Knazik, S., & Schamban, N. E. (2008). Patient and family-centered care for pediatric patients in the emergency department. *CJEM, 10*(1), 38-43. https://pubmed.ncbi.nlm.nih.gov/18226317/

Byczkowski, T. L., Gillespie, G. L., Kennebeck, S. S., Fitzgerald, M. R., Downing, K. A., & Alessandrini, E. A. (2016). Family-centered pediatric emergency care: A framework for measuring what parents want and value. *Academic Pediatrics, 16*(4), 327-335. https://doi:10.1016/j.acap.2015.08.011

Castillo-Monterroso v. R.I. Hosp., 2009 R.I. Super. LEXIS 24 (Superior Court of Rhode Island, Providence February 4, 2009 Filed). https://advance-lexis-com.ezproxy.shu.edu/api/document?collection=cases&id=urn:contentItem:4VN4- DXV0-TXFW-H3CX-00000-00&context=1516831.

Chang, H., Hutchinson, C. and Gullick, J. (2021). Pulled away: the Experience of bilingual nurses as ad hoc interpreters in the emergency department. *Ethnicity & Health*, *26* (7), 1045-1064. https://doi.org/10.1080/13557858.2019.1613518

Coleman, J., & Angosta, A. (2016). The lived experience of acute-care bedside registered nurses caring for patients and their families with limited English proficiency: A silent shift. *Journal of Clinical Nursing*, *26*(5-6), 678-689. https://doi: 10.1111/jcon.13567

Davies, B., Contro, N., Larson, J., & Widger, K. (2010). Culturally sensitive information-sharing in pediatric palliative care. *Pediatrics*, *125*(4), 859-865. https://doi:10.1542/peds.2009-0722

de Moissac, D., & Bowen, S. (2019). Impact of language barriers on quality of care and patient safety for official language minority Francophones in Canada. *Journal of Patient Experience*, *6*(1), 24-32. https://doi: 10.1177/2374373518769008

Dudley, N., Ackerman, A., Brown, K. M., & Snow, S. K. (2015). Technical report, Patient-and-family-centered-care of children in the emergency department. *Pediatrics*, *135*(1), 255-272. https://doi: 10.1542/peds.2014-3424

Emergency Nurses Association (2023). *ENA 50th Anniversary Timeline*. https://www.ena.org/my-account/home/ena-50th-anniversary/our-history

Emergency Nurses Association (2020). *Emergency Nursing Pediatric Course, an ENA Course* (*5th* ed.). Jones & Bartlett.

Emergency Nurses Association (2017a). Nursing Code of Ethics: Provisions and interpretative statements for emergency nurses. *Journal of Emergency Nursing*, *43*(6), 497-503. https://doi:10.10161/j.jen2017.09.011

Emergency Nurses Association (2017b). *Emergency Nursing Scope & Standards of Practice (2nd ed.)*. Jones & Bartlett.

Eneriz-Wiemer, M., Sanders, L. M., Barr, D. A., & Mendoza, F. S. (2014). Parental limited English proficiency and health outcomes for children with special health care needs: A systematic review. *Academic Pediatrics*, *14*(2), 128-136. https://doi:10.1016/j.acap.2013.10.003

Enlow, E., Herbert, S. L., Jovel, I. J., Lorch, S. A., Anderson, C., & Chamberlain, L. J. (2014). Neonatal intensive care unit to home: The transition from parent and pediatrician perspectives, a prospective cohort study. *Journal of Perinatology, 34*(10), 761-766. https://doi:10.1038/jp.2014.75

Fields, A., Abraham, M., Gaughan, J., Haines, C., & Hoehn, S. (2016). Language matters: Race, Trust, and outcomes in the pediatric emergency department. *Pediatric Emergency Care, 32*(4), 222-226. https://doi:10.1097/PEC.0000000000000453

Fletcher, T., Glasper, A., Prudhoe, G., Battrick, C., Coles, L., Weaver, K., & Ireland, L. (2011). Building the future: Children's views on nurses and hospital care. *British Journal of Nursing*, *20*(1), 39-45. https://doi:10.12968/bjon.2011.20.1.39

Free, C., Green, J., Bhavnani, V. & Newman, A. (2003). Bilingual young people's experiences of interpreting in primary care: A qualitative study. *British Journal of General Practice*, *53*, 530-535.

Galinato, J., Montie, M., Shuman, C., Patak, L., & Titler, M. (2016). Perspectives of nurses on patients with limited English proficiency and their call light use. *Global Qualitative Nursing Research,* 3,1-9. https://doi: 10:1177/2333393616637764

Garrett, P. W., Forero, R., Dickson, H. G., & Klinken Whelan, A. (2008). How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review, 32*(4), 755-764. https://doi:10.1071/ah080755

Gil, S., Hooke, M. C., & Niess, D. (2016). The limited English proficiency patient family advocate role: Fostering respectful and effective care across language and culture in a pediatric oncology setting. *Journal of Pediatric Oncology Nursing, 33*(3), 190-198. https://doi:10.1177/1043454215611082

Gillespie, G. L., Hounchell, M., Pettinichi, J, Mattei, J., & Rose, L. (2012). Caring in pediatric emergency nursing. *Research & Theory for Nursing Practice*, *26*(3), 216-232. https://doi:10.1891/1541-6577.26.3.216

Giordano, S. (2007). Overview of the advantages and disadvantages of professional and child interpreters for limited English proficiency patients in general health care situations. *Journal of Radiology Nursing*, *26*(4), 126-131. https://doi.org/10.1016/j.jradnu.2007.09.002

Gutman, C. K., Cousins, L., Gritton, J., Klein, E. J., Brown, J. C., Scannell, J., & Lion, K. C. (2018). Professional interpreter use and discharge communication in the pediatric emergency department. *Academic Pediatrics*, *18*(8), 935-943. https://doi: 10.1016/j.acap.2018.07.004

Hartford, E. A., Anderson, A. P., Klein, E. J., Caglar, D., Carlin, K. & Lion, C. (2019). The use and impact of professional interpretation in a pediatric emergency department. *Academic Pediatric Association*, *19*(8), 956-962. https://doi:10.1016/j.acap.2019.07.006

Hsieh, E. (2014). Not just "Getting by": Factors influencing providers' choice of interpreters. *Journal of General Internal Medicine*, *30*(1), 75-82. DOI: 10.1007/s11606-014-3066-8

Ian, C., Nakamura-Florez, E., & Lee, Y. (2016). Registered nurses' experiences with caring for non-English speaking patients. *Applied Nursing Research*, *30*, 257-260. https://DOI:10.1016/j.apnr.2015.11.009

Institute for Patient-and-Family Centered Care (2016). *Core concepts of patient-and family-centered care*. http://www.ipfcc.org/about/pfcc.html

Institute of Medicine of the National Academies (2007). *Emergency Care for Children: Growing Pains*. The National Academies Press.

Isbey, S. I., Badolato, G. & Kline, J. (2022). Pediatric emergency department discharge instructions for Spanish-speaking families: Are we getting it right? *Pediatric Emergency Care*, *38*(2), e867-e870. https://doi: 10.1097/PEC.0000000000002470

Jimenez, N., Jackson, D. L., Zhou, C., Ayala, N. C., & Ebel, B. E. (2014). Postoperative pain management in children, parental English proficiency, and access to interpretation. *Hospital Pediatrics*, *4*(1), 23-30. https://doi: 10.1542/hpeds.2013- 0031.

Jones, S. M. (2008). Emergency nurses' caring experiences with Mexican American patients. *Journal of Emergency Nursing*, *34*(3), 199-204. https://doi.org/10.1016/j.jen.2007.05.009

Karliner, L. S., Perez-Stable, E. J. & Gregorich, S. E. (2017). Convenient access to professional interpreters in the hospital decrease readmission rates and estimated hospital expenditures for patients with limited-English proficiency. Medical Care, *55*(3), 199-206. https://doi:10.1097/MLR.0000000000000643

Latif, Z., Makuvire, T., Feder, S. L., Crocker, J., Quintero Pinzon, P. & Warraich, H. J. (2022). Forgotten in the crowd: A qualitative study of medical interpreters' role in medical teams. *Journal of Hospital Medicine, 17*, 719-725. https://DOI: 10.1002/jhm.12925

Lee, J. S., Napoles, A., Mutha, S., Perez-Stable, E. J., Gregorich, S. E., Livaudais-Toman, J., & Karliner, L. S. (2018). Hospital discharge preparedness for patients with limited English proficiency: A mixed methods study of bedside interpreter-phones. *Patient Education and Counseling, 101*(1), 25-32. https://doi:10.1016/j.pec.2017.07.026

Levas, M. N., Cowden, J. D., & Dowd, M. D. (2011). Effects of the limited English proficiency of parents on hospital length of stay and home health care referral for their home health care-eligible children with infections. *Archives of Pediatric Adolescent Medicine, 165*(9), 831-836. https://doi:10.1001/archpediatrics.2011.61.

Levas, M. N., Dayan, P. S., Mittal, M. K., Stevenson, M. D., Bachur, R. G., Dudley, N.C., Bajaj, L., Macias, C., Bennett, J., Dowd, M., Thomas, A. J. & Kharbanda, A. B. (2014). Effect of Hispanic ethnicity and language barriers on appendiceal perforation rates and imaging in children. *Journal of Pediatrics*, *164*(6), 1286- 1291. https://doi:10.1016/j.jpeds.2014.01.006

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic Inquiry*. Sage.

Lion, K. C., Gritton, J., Scannell, J., Brown, J. C., Ebel, B. E, Klein, E. J. & Mangione-Smith, R. (2021). Patterns and predictors of professional interpreter use in the pediatric emergency department. *Pediatrics*, *147*(2), 1-9. https://doi:10.1542/peds.2019-3312

Lion, K. C., Brown, J., Ebel, B., Klein, E. J., Strelitz, B., Gutman, C. K., Hencz, P. Fernandez, J., & Mangione-Smith, R. (2015). Effect of telephone vs video interpretation on parent comprehension, communication, and utilization in the pediatric emergency department: A randomized clinical trial. *JAMA Pediatrics*, *169*(12), 1117-1125. https://doi:10.1001/jamapediatrics.2015.2630

Lion, K. C., Rafton, S. A., Shafii, J., Brownstein, D., Michel, E., Tolman, M., & Ebel, B. E. (2013). Association between language, serious adverse events, and length of stay among hospitalized children. *Hospital Pediatrics, 3*(3), 219-225. https://doi:10.1542/peds.2012-0091

Marcus, J., MacMillan, D., Ketchie, M., & Clark, P. (2020). Nurses' perceptions of technology used in language interpretation for patients with limited English proficiency. *American Journal of Nursing*, *120*(9), 48- 58. https://doi:10.1097/01.NAJ.0000697652.73975.37

Margaret, N., Clark, T., Warden, C. R., Magnusson, R., & Hedges, J. R. (2002). Patient satisfaction in the emergency department- A survey of pediatric patients and their parents. *Academy of Emergency Medicine*, *9*(12), 1379-1387. https://doi:10.1197/aemj.9.12.1379

McCall, W. T., Anderson, J. G., Myers, C. R., Sagherian, K. & Bamwine, P. (2022). "Was definitely different because of they were kids": Caring for patients from a school shooting. *Journal of Trauma Nursing*, *29*(5), 252-261. https://doi.org/10.1097/JTN.0000000000000673

Mehus, C. J. & Becher, E. H. (2015). Secondary traumatic stress, burnout, and compassion satisfaction in a sample of spoken-language interpreters. *Traumatology*, *22*(4), 249-254. http://dx.doi.org/10.1037/trm0000023

Merriam-Webster. (2022). Merriam-Webster.com dictionary. Retrieved October 13, 2022, from https://www.merriam-webster.com/dictionary/Spanglish

Migration Policy Institute, National Center on Immigrant Integration Policies (2011). *Limited English proficient individuals in the United States: Number, share, growth, & linguistic diversity*. https://www.migrationpolicy.org/research/limited-english-proficient-individuals-united-states-number-share-growth-and-linguistic

Miquel-Verges, F., Donohue, K., & Boss, R. D. (2011). Discharge of infants from NICU to Latino families with limited-English proficiency. *Journal of Immigrant Minority Health*, *13*(2), 309-314. https://doi 10:1007/s10903/010/9355-3

Montie, M., Galinato, J. G., Patak, L., & Titler (2016). Spanish-speaking limited English proficiency patients and call light use. *Hispanic Health Care International*, *14*(2), 65-72. https://doi:10.1177/1540415316645919

Muir, C., Michel, A., Joyce, C. & Nguyen, T. (2021). Assessment of interpretation modality and patient comprehension in Spanish-Speaking limited English proficiency (LEP) patients presenting to the emergency department. *Journal of Health Care for the Poor and Underserved, 32*, 2143-2153. https://doi:10.1353/hpu.2021.0187

Munhall, P. (2012). *Nursing research a qualitative perspective (5th ed.)*. Jones & Bartlett Learning.

Napoles, A., M., Santoyo-Olsson, J., Karliner, L. S., Gregorich, S. E., & Perez-Stable, E. J. (2016). Inaccurate language interpretation and its clinical significance in the medical encounters of Spanish-Speaking Latinos. *Medical Care*, *53*(11), 940-947. https://doi:10.1097/MLR.0000000000000422

National Health Law Program (2022). *HIPPA and language services in health care*. https://www.migrationpolicy.org/sites/default/files/language_portal/hipaaandinterpreters.pdf

National Institutes of Health (2021). *Clinical Center Home, Patient Bill of Rights*. https://clinicalcenter.nih.gov/participate/patientinfo/legal/bill_of_rights.html

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1-13. https://Doi:10.1177/1609406917733847

Obregon, E., Martin, C. R., Frantz, I. D., Patel, P., & Smith, V. C. (2019). Neonatal intensive care unit discharge preparedness among families with limited English proficiency. *Journal of Perinatology*, *39*(1), 135-142. https://doi:10.1038/s41372-018-0255-z

Olivarez, G. A., Pham, P. H., & Liberman, D. B. (2017). The effect of language on the discharge process in a pediatric emergency department. *Journal of Immigrant Minority Health*, *19*(6), 1397-1403. https://doi: 10.1007/s10903-016-0366-6

Patel, D. N., Wakeam, E., Genoff, M., Mujawar, I., Ashley, S. W., & Diamond, L. C. (2016). Preoperative consent for patients with limited-English proficiency. *Journal of Surgical Research*, *200*(2), 514-522. https://doi:10.1016/j.jss.2015.09.033

Parsons, J. A., Baker, N. A., Smith-Gorvie, T., & Hudak, P. (2014). To ‘get by’ or ‘get help’? A qualitative study of physicians’ challenges and dilemmas when patients have limited English proficiency. *BMJ Open*, *4*(6), 1-9. https://doi:10.1136/bmjopen- 2013-004613.

Peplau, H. E. (1988*). Interpersonal relations in nursing, a conceptual frame of reference for psychodynamic nursing*. Springer Publishing Company.

Perez, G. K., Mutchler, J., Yang, M. S., Tree-Mcgrath, C. F., & Park, E. R. (2016). Promoting quality care in patients with cancer with limited English proficiency: Perspectives of medical interpreters. *Psycho-Oncology*, *25*(10), 1241-1245. https://doi:10.1002/pon.4176

Phonpruk, K., Flowers, K., Fulbrook, P. & Naughton, G. (2018). Pediatric emergency nurses’ perceptions of parents’ understanding of discharge information: A qualitative study. Australian Emergency Care*, 21*, 56-63. https://doi.org/10.1016/j.auec.2018.05.001

Polit, D., & Beck, C. T., (2017). *Nursing research generating and assessing evidence for nursing practice* (10th Ed). Philadelphia, PA: Wolters Kluwer.

Pytel, C., Fielden, N. M., Meyer, K. H., & Albert, N. (2009). Nurse-Patient/visitor communications in the emergency department. *Journal of Emergency Nursing*, *35*(5), 406- 411. https://doi:10.10161j.jen.2008.09.002

Ramirez, D., Engel, K. G., & Tang, T. S. (2008). Language interpreter utilization in the emergency department setting: A clinical review. *Journal of Health Care for the Poor & Underserved, 19*(2), 352-362. https://doi:10.1353/hpu.0.0019

Ramsdell, K. D., Morrison, M., Kassam-Adams, N., & Marsac, M. L. (2016). A qualitative analysis of children’s emotional reactions during hospitalization following injury. *Journal of Trauma Nursing*, *23*(4), 194-201. https://doi:10.1097/JTN.0000000000000217

Remick, K., Joseph, M., & Wright, J. (2018). Pediatric readiness in the emergency department: Policy Statement. *Pediatrics*, *142*(5), 1-14. https://doi:10.1542/peds.2018-2459

Richardson, K. (2014). Deaf culture. *The Nurse Practitioner, 39*(5), 20-28. https://doi:10.1097/01.NPR.0000445956.21045.c4

Russell, B. R., Morales, A., & Ravert, R. D. (2015). Using children as informal interpreters in pediatric consultations. *International Journal of Human Rights in Healthcare, 8*(3), 132-143. https://doi:10.1108/IJHRH-07-2013-0009

Salmela, M., Salantera, S., & Aronen, E. (2009). Child-Reported hospital fears in 4 to 6-year-old children. *Pediatric Nursing, 35*(5), 269-303. https://doi:10.1111/j.1365-2214.2010.01171.x

Samuels-Kalow, M. E., Stack, A. M., & Porter, S. C. (2013). Parental language and dosing errors after discharge from the pediatric emergency department. *Pediatric Emergency Care*, *29*(9), 982-987. https://doi: 10.1097/PEC.0b013e3182a269ec

Seidel, J. S. (1986). Emergency medical services and the pediatric patient: Are the needs being met? Training and equipping emergency medical services providers for pediatric emergencies. *Pediatrics, 78*(5), 808-812.

Seidel J. S., Hornbein, M., Yoshiyama, K., Kuznets, D., Finklestein, J. Z., & St Geme, J. W. (1984). Emergency medical services and the pediatric patient: Are the needs being met? *Pediatrics*, *73*(6), 769-772.

Senn, J. F. (2013). Peplau’s theory of interpersonal relations: Application in emergency and rural nursing. *Nursing Science Quarterly*, *26*(1), 31-35. https://doi:10.1177/0894318412466744

Schenk, E., & Edgerton, E. (2015). A tale of two populations: Addressing pediatric needs in the continuum of emergency care. *Annals of Emergency Medicine*, *65*(6), 673-678. http://dx.doi.org/10.1016/j.annemergmed.2014.09.018

Shuman. C., Montie, M., Galinato, J., Patak, L. & Titler, M. (2017). Registered nurse and nursing assistant perceptions of limited English proficient patient-clinical communication. *Journal of Nursing Administration*, *47*(12), 589-591. Doi:10.1097/NNA.0000000000000549.

Schwei, R. J., Schroeder, M., Ejebe, I., Lor, M., Park, L., Xiong, P., & Jacobs, E. A. (2018). Limited English proficient patients' perceptions of when interpreters are needed and how the decision to utilize interpreters is made. *Health Communication*, *33*(12), 1503-1508. https://doi.org/10.1080/10410236.2017.1372047

Society of Pediatric Nurses (2017). *Pediatric residency core competencies*. http://www.pedsnurses.org/page/core-competencies

Steinberg, E. M., Valenzuela-Araujo, D., Zickafoose, J. S., Kieffer, E., & DeCamp, L. R. (2016). The "Battle" of managing language barriers in healthcare. *Clinical Pediatrics*, *55*(14), 1318-1327. https://doi: 10.1177/0009922816629760

Stephen, J. M. (2021). Pediatric nurses' expereinces in caring for non-English speaking patients and families. *Journal of Transcultural Nursing*, *32*(6), 690-696. Doi:10.1177/1043659620986607

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing, advancing the humanistic imperative (5th ed.).* Wolters Kluwer.

Taira, B. R., Torres, J., Nguyen, A., Guo, R., & Samra, S. (2020). Language assistance for the care of limited English proficiency (LEP) patients in the emergency department: A survey of providers and staff. *Journal of Immigrant and Minority Health*, *22*, 439-447. https://doi.org/10.1007/s10903-019-00964-9

Tam, I., Huang, M. Z., Patel, A., Rhee, K. E., & Fisher, E. (2020). Spanish interpreter services for the hospitalized pediatric patient : Provider and interpreter perceptions. Academic Pediatrics, *20*(2), 216-224. https://doi:10.1016/j.acap.2019.08.012

Tang, E. W., Go, J., Kwok, A., Leung, B., Lauck, S., Wong, S. T., Taipale, P. G., & Ratner, P. A. (2016). The relationship between language proficiency and surgical length of stay following cardiac bypass surgery. *European Journal of Cardiovascular Nursing*, *15*(6), 438-446. https://doi:10.1177/1474515115596645

Tate, R. C., Hodkinson, P. W., Meehan-Coussee, K., & Cooperstein, N. (2016). Strategies used by prehospital providers to overcome language barriers. *Prehospital Emergency Care, 20*(3), 404-414. https://doi:10.3109/10903127.2015.1102994

The Joint Commission (2022). *Medical Record – Preferred Language.* https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/record-of-care-treatment-and-services-rc/000001373/

The Joint Commission (2015). *Overcoming the challenges of providing care to LEP patients*. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf

The Joint Commission (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. The Joint Commission.

Thienprayoon, R., Marks, E., Funes, M., Martinez-Puente, L. M., Winick, N., & Lee, S. C. (2016). Perceptions of the pediatric hospice experience among English and Spanish-speaking families. *Journal of Palliative Medicine*, *19*(1), 30-41. https://doi:10.1089/jpm.2015.0137

Thorne, S. (2008). *Interpretive description*. Left Coast Press.

Thorne, S. (2016). *Interpretive description qualitative research for applied practice* (2nd ed). Routledge.

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Focus on Qualitative Methods, Interpretive Description: A noncategorical qualitative alternative or developing nursing knowledge. *Research in Science & Health*, *20*(2), 169-177.

Thorne, S., Kirkham, S., R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods*, *3*(1), 1-11. https://doi.org/10.1177/160940690400300101

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, *48*(4), 388-396. https://Doi:10.1111/j.1365-2648.2004.03207.x

United States Census Bureau (2015). *American community survey*. https://www.census.gov/programs-surveys/acs/guidance/comparing-acs- data/2015.html

United States Census Bureau (2015). *American community survey*. https://data.census.gov/table?q=S1603&tid=ACSST5Y2021.S1603

U. S. Department of Health & Human Services, Agency for Healthcare Research & Quality (2012). *Improving patient safety systems for patients with limited English Proficiency, a guide for hospitals.* https://www.ahrq.gov/professionals/systems/hospital/lepguide/index.html

U. S. Department of Health & Human Services, Agency for Healthcare Research & Quality (2013). *Healthcare cost & utilization project (HCUP).* https://www.ahrq.gov/data/hcup/index.html

U. S. Department of Health & Human Services, Guiding Principles for Ethical Research (2016). *Pursuing potential research participants protections*. https://www.nih.gov/health-information/nih-clinical-research-trials-you/guiding-principles-ethical-research

U. S. Department of Health & Human Services, Office of Civil Rights (2013b). *Civil rights requirements-A. Title VI of the civil rights act of 1964, 42 U.S.C. 2000d et seq.* https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html

U. S. Department of Health & Human Services, Office of Civil Rights (2013a). *Guidance to federal financial assistance recipients regarding Title VI & the prohibition against national origin discrimination affecting limited English proficiency persons – summary*. https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-VI/index.html

U. S. Department of Health & Human Services, Office for Human Research Protections (2018). *Electronic code of federal regulations*. https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=83cd09e1c0f5c6937cd9d7513160fc3f&pitd=20180719&n=pt45.1.46&r=PART&ty=HTML#se45.1.46_1116

U.S. Department of Health & Human Services, Office of Minority Health (2018). *The National CLAS Standards.* https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

U.S. Department of Health & Human Services, Office of Minority Health (2015). *Report to Congress on minority health activities as requested by the Patient Protection & Affordable Care Act (P.L. 111-148).* https://www.minorityhealth.hhs.gov/Assets/pdf/2015_0916_Report_to_Congress_on_Minority_Health_Activities_FINAL.pdf

U.S. Department of Health & Human Services, OPHS Office of Minority Health (2001). *National Standards for Culturally and Linguistically Appropriate Services in Healthcare, Final Report*. https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

van Rosse, F., Bruijne, M., Suurmond, J., Essink-Bot, M., & Wagner, C. (2016). Language barriers and patient safety risks in hospital care. A mixed methods study. *International Journal of Nursing Studies*, *54,* 45-53. http://dx.doi.org/10.1016/j.ijnurstu.2015.03.012

Villalobos, B. T., Orengo-Aguayo, R, Castellanos, R., Pastrana, F. & Stewart, R. (2021). Interpreter perspectives on working with trauma patients: Challenges and recommendations to improve access to care. *American Psychological Association*, *52*(5), 477-486. http://doi.org/10.1037/pro0000404

Watts, J., Cowden, J. D., Cupertino, A. P., Dowd, M. D., & Kennedy, C. (2011). 911 (nueve once): Spanish-speaking parents' perspectives on prehospital emergency care for children. *Journal for Immigrant Minority Health*, *13*(3), 526-532. https://doi: 10.1007/s10903-010-9422-9

Weaver, M. S., Roeth, A., Navaneethan, H., Shostrom, V. K., & Contreras-Nourse, M. (2022). Translating pediatric hospital interpreter' feedback from difficult conversations into improved communication. *Journal of Palliative Care*, 37(2), 159-163. https://doi:10.1177/0825859720933112

Zamora, E. R., Kaul, S., Kirchhoff, A. C., Gwilliam, V., Jimenez, O. A., Morreall, D. K., Montenegro, R. E., Kinney, A. Y., & Fluchel, M. N. (2016). The impact of language barriers and immigration status on the care experience for Spanish-Speaking caregivers of patients with pediatric cancer. *Pediatric Blood & Cancer*, *63*(12), 2173-2180. https://doi:10.1002/pbc.26150

Zong, J., & Batalova, J. (2015). The limited English proficient population in the United States. *The Online Journal of the Migration Policy Institute*. www.migration policy.org/article/limited-English-proficient-population-united-states

Zurca, A. D., Fisher, K. R., Flor, R. J., Gonzalez-Marques, C. D., Wang, J., Cheng, Y. I., & October, T. W. (2017). Communication with limited-English proficient families in the PICU. *Hospital Pediatrics* 7(1), 9-15. https://doi:10.1542/hpeds.2016-0071

Zwaigenbaum, L., Nicholas, D. B., Muskat, B., Kilmer, C., Newton, A. S., Craig, W. R., Ratnapalan, S., Cohen-Silver, J., Greenblatt, A., Roberts, W., & Sharon, R. (2016). Perspectives of health care providers regarding emergency department care of children and youth with autism spectrum disorder. *Journal of Autism Developmental Disorders, 46*(5), 1725-1736. https://doi:10.1007/s10803-016- 2703-y

APPENDIX A

DEMOGRAPHICS OF PEDIATRIC EMERGENCY NURSE PARTICIPANTS

Age	Gender	Ethnicity	Years as nurse	Years as a PEN	Specialty certification	State	Description of Hospital	Fluent in another language
29	Female	White	7	5	CPEN	NJ	University affiliated hospital	No
27	Female	White	7	7	No	NJ	University affiliated hospital	No
44	Female	Asian/Pacific Islander	25	8	No	NJ	University affiliated hospital	No
40	Female	White	17	16	No	NJ	Medical Center	No
41	Female	White	18	18	Pediatric NP	NJ	University affiliated hospital	No
42	Female	White	18	18	No	NJ	University affiliated hospital	No
32	Female	White	10	7	Forensic Nurse	NJ	Medical Center	No
37	Female	White	7	7	Trauma Certification	GA	Medical Center	No
36	Female	Asian/Pacific Islander	14	14	CPEN	NJ	Medical Center	Yes (Tagalog)
33	Female	Asian/Pacific Islander	11	11	No	NJ	Specialized Children’s Hospital	Yes (Korean)
48	Female	Asian/Pacific Islander	26	14	No	NJ	Medical Center	Yes (Tagalog)
34	Female	Asian/Pacific Islander	11	8	No	NY	Medical Center	Yes (Tagalog)
32	Female	White	10	8	CPEN	NY	Medical Center	No
47	Female	Asian/Pacific Islander	17	14	No	NJ	Community Hospital	No
35	Female	White	6	5	No	NJ	Community Hospital	Yes (Hebrew)

Age	Gender	Ethnicity	Years as nurse	Years as a PEN	Specialty Cert.	State	Description of Hospital	Fluent in another language
Total Range 27-48 years Mean 37 Mode 32	Total Female 15 (100%)	Total White-9 (60%) Asian/ Pacific Islander 6 (40%)	Total Range 7-26 years Mean 13.6 Mode 7	Total Range 5-18 years Mean 10.6 Bimodal 7, 8	Total Yes-6 (40%) No-9 (60%)	Total NJ- 12 (80%) NY-2 (13%) GA-1 (7%)	Total University Affiliated-5 (33%) Medical Center-7 (47%) Community Hospital-2 (13%) Children's Specialized Hospital-1 (7%)	Total No -10 (67%) Yes – 5 (33%)

APPENDIX B

DEMOGRAPHICS OF CERTIFIED PROFESSIONAL MEDICAL INTERPRETERS

Age	Gender	Ethnicity	Highest level of Education	How many years as CPMI	State	What other languages do you speak fluently	Description of Hospital
60	Female	Hispanic/Latina	Associate Degree	2 years	NJ	Spanish	Medical Center
65	Female	Hispanic/Latina	High School Diploma	10 years	NJ	Spanish	Medical Center
39	Female	Hispanic/Latina	Master's Degree	6 years	NJ	Spanish, Portuguese	Community Hospital
60	Female	Hispanic/Latina	Bachelor's Degree	5 years	GA	Spanish, Portuguese	Non-profit
50	Female	Hispanic/Latina	Associate Degree	4 years	FL	Spanish	Children's Specialized Hospital
Total Range 39-65 years Mean 54.8 Mode 60	Total Female-5 (100%)	Total Hispanic/Latina-5 (100%)	Total High School-1 Associates-2 Bachelor's-1 Master's-1	Total Range 2-6 years Mean 5.4	Total NJ-3 GA-1 FL-1	Total Spanish-5 Portuguese-2	Total Medical Center-2 Community Hospital-1 Non-Profit-1 Children's Specialized Hospital-1

APPENDIX C

SOLICITATION LETTER FOR PEDIATRIC EMERGENCY NURSES

Invitation to Participate in a Study Regarding Pediatric Emergency Nurses

Dear Pediatric Emergency Nurse:

My name is Caroline Meza, and I am a PhD student at Seton Hall University, College of Nursing. I am seeking pediatric emergency nurses to participate in my research study:

"How Pediatric Emergency Nurses Initiate and Provide Care to Children and Families with Limited-English Proficiency"

The purpose of this study is to explore the experience of pediatric emergency nurses who are engaged in providing care to pediatric patients and families with limited-English proficiency in a pediatric emergency department. Your participation in this study may generate a greater understanding of ways to navigate the delivery of emergency care offered to pediatric patients and families with limited-English proficiency.

To participate in the study, you must:

- Be a registered nurse providing direct patient care to pediatric patients in a pediatric emergency department
- Have experience caring for pediatric patients and families with limited-English proficiency
- Have read and signed research consent form agreeing to participate in study.

When participating in this study, you may expect the following:

- An in-person or virtual interview and completion of a brief demographic form that will take approximately 60-90 minutes.

- You will be asked questions about your experience working with pediatric patients and families with limited-English proficiency in a pediatric emergency department. All information shared during the interview will be held in strict confidentiality.

- The data collected during the interview will not include any identifying information and will be stored in a secure and locked location.

- Your participation is entirely voluntary. You may withdraw from the study at any time.

If you have any questions, or would like to participate in the study, please feel free to contact me:
Caroline Meza at (973)-851-6482 or email caroline.meza@student.shu.edu

Thank you for your consideration,

Caroline Meza MSN, RN, CEN
Seton Hall University, College of Nursing

APPENDIX D

SOLICITATION LETTER FOR CERTIFIED PROFESSIONAL MEDICAL INTERPRETERS

Invitation to Participate in a Study Regarding Pediatric Emergency Nurses

Dear Professional Medical Interpreter:

My name is Caroline Meza, and I am a PhD student at Seton Hall University, College of Nursing. I am seeking professional medical interpreters to participate in my research study:

"How Pediatric Emergency Nurses Initiate and Provide Care to Children and Families with Limited-English Proficiency"

The purpose of this study is to explore the experience of pediatric emergency nurses who are engaged in providing care to pediatric patients and families with limited-English proficiency in a pediatric emergency department. You qualify to participate in this study because you are a professional medical interpreter providing interpreter services for pediatric patients and families with limited-English proficiency.

Your participation in this study may generate a greater understanding of ways to navigate the delivery of emergency care offered to pediatric patients and families with limited-English proficiency.

When participating in this study, you may expect the following:

- An in-person audio-recorded interview and completion of a brief demographic form that will take approximately 60-90 minutes.

- You will be asked questions about your experience working with nurses to provide interpreter services for pediatric patients and families with limited-English proficiency. All information shared during the interview will be held in strict confidentiality.

- The data collected during the interview will not include any identifying information and will be stored in a secure and locked location.

- Your participation is entirely voluntary. You may withdraw from the study at any time.

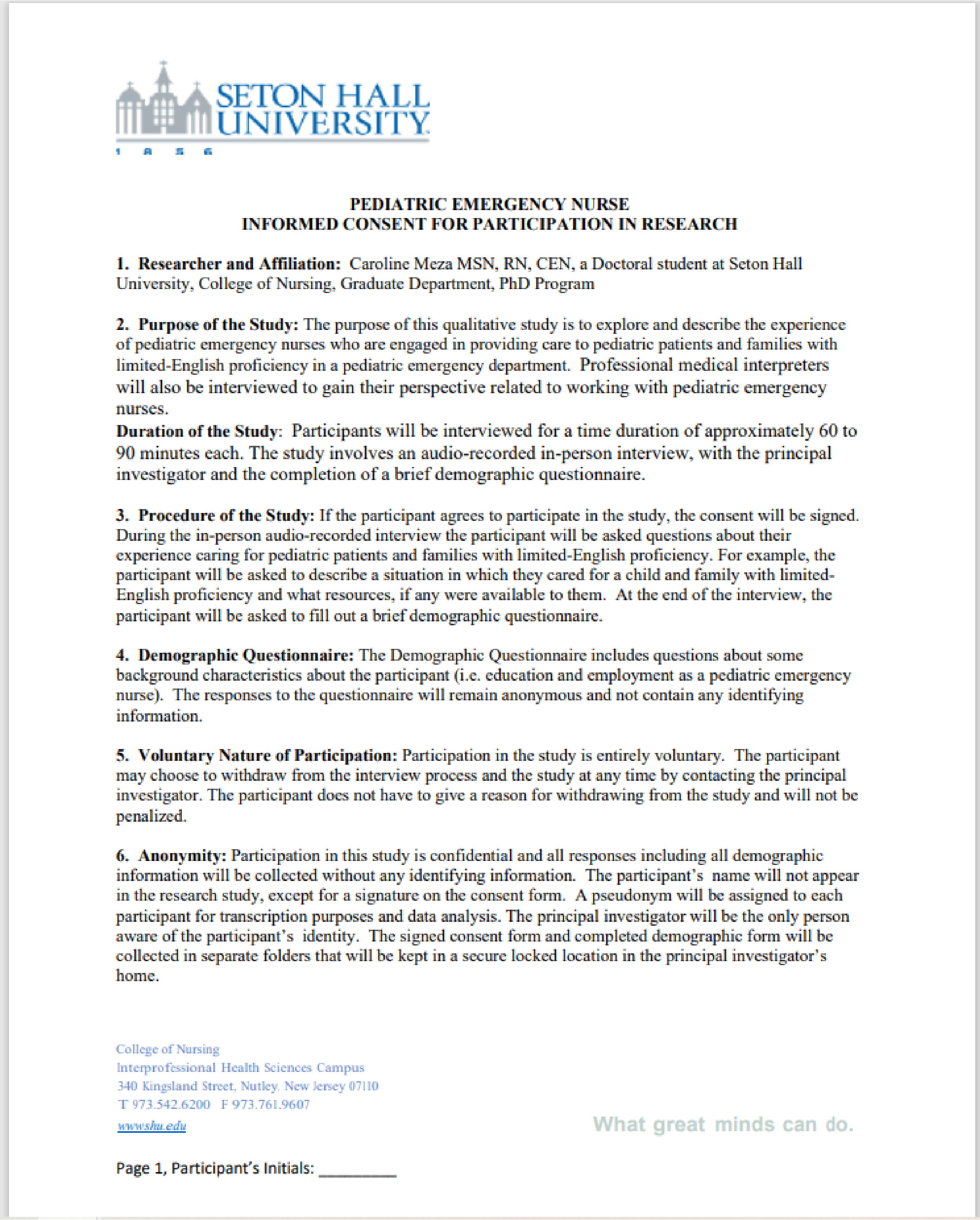
If you have any questions, or would like to participate in the study, please feel free to contact me:
Caroline Meza at (973)-851-6482 or email caroline.meza@student.shu.edu

Thank you for your consideration,

Caroline Meza MSN, RN, CEN
College of Nursing, Seton Hall University

APPENDIX E

CONSENT FORM FOR PEDIATRIC EMERGENCY NURSES



SETON HALL
UNIVERSITY
1 8 5 6

PEDIATRIC EMERGENCY NURSE
INFORMED CONSENT FOR PARTICIPATION IN RESEARCH

1. Researcher and Affiliation: Caroline Meza MSN, RN, CEN, a Doctoral student at Seton Hall University, College of Nursing, Graduate Department, PhD Program

2. Purpose of the Study: The purpose of this qualitative study is to explore and describe the experience of pediatric emergency nurses who are engaged in providing care to pediatric patients and families with limited-English proficiency in a pediatric emergency department. Professional medical interpreters will also be interviewed to gain their perspective related to working with pediatric emergency nurses.

Duration of the Study: Participants will be interviewed for a time duration of approximately 60 to 90 minutes each. The study involves an audio-recorded in-person interview, with the principal investigator and the completion of a brief demographic questionnaire.

3. Procedure of the Study: If the participant agrees to participate in the study, the consent will be signed. During the in-person audio-recorded interview the participant will be asked questions about their experience caring for pediatric patients and families with limited-English proficiency. For example, the participant will be asked to describe a situation in which they cared for a child and family with limited-English proficiency and what resources, if any were available to them. At the end of the interview, the participant will be asked to fill out a brief demographic questionnaire.

4. Demographic Questionnaire: The Demographic Questionnaire includes questions about some background characteristics about the participant (i.e. education and employment as a pediatric emergency nurse). The responses to the questionnaire will remain anonymous and not contain any identifying information.

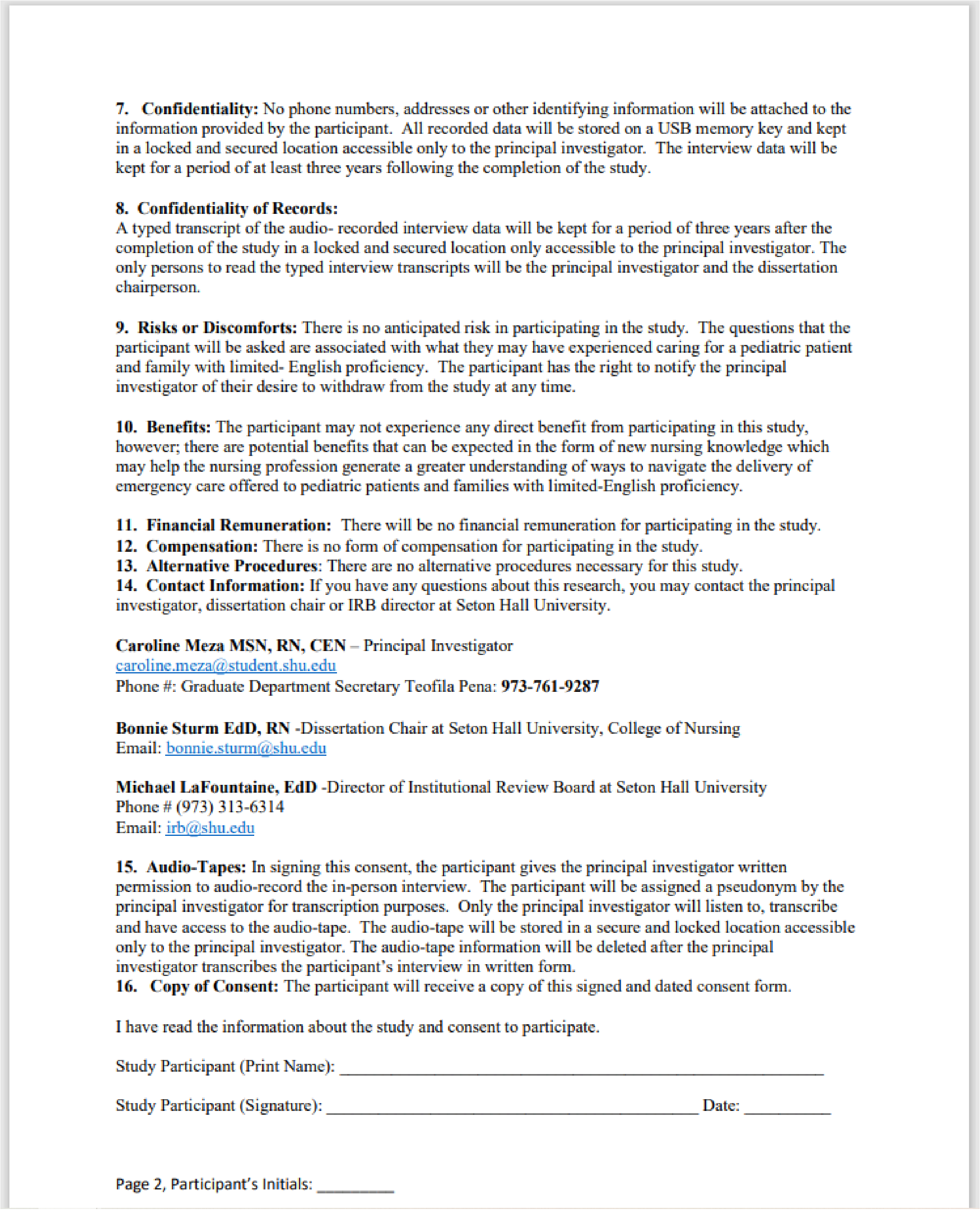
5. Voluntary Nature of Participation: Participation in the study is entirely voluntary. The participant may choose to withdraw from the interview process and the study at any time by contacting the principal investigator. The participant does not have to give a reason for withdrawing from the study and will not be penalized.

6. Anonymity: Participation in this study is confidential and all responses including all demographic information will be collected without any identifying information. The participant's name will not appear in the research study, except for a signature on the consent form. A pseudonym will be assigned to each participant for transcription purposes and data analysis. The principal investigator will be the only person aware of the participant's identity. The signed consent form and completed demographic form will be collected in separate folders that will be kept in a secure locked location in the principal investigator's home.

College of Nursing
Interprofessional Health Sciences Campus
340 Kingsland Street, Nutley, New Jersey 07110
T 973.542.6200 F 973.761.9607
www.shu.edu

What great minds can do.

Page 1, Participant's Initials: __________



7. Confidentiality: No phone numbers, addresses or other identifying information will be attached to the information provided by the participant. All recorded data will be stored on a USB memory key and kept in a locked and secured location accessible only to the principal investigator. The interview data will be kept for a period of at least three years following the completion of the study.

8. Confidentiality of Records:
A typed transcript of the audio- recorded interview data will be kept for a period of three years after the completion of the study in a locked and secured location only accessible to the principal investigator. The only persons to read the typed interview transcripts will be the principal investigator and the dissertation chairperson.

9. Risks or Discomforts: There is no anticipated risk in participating in the study. The questions that the participant will be asked are associated with what they may have experienced caring for a pediatric patient and family with limited- English proficiency. The participant has the right to notify the principal investigator of their desire to withdraw from the study at any time.

10. Benefits: The participant may not experience any direct benefit from participating in this study, however; there are potential benefits that can be expected in the form of new nursing knowledge which may help the nursing profession generate a greater understanding of ways to navigate the delivery of emergency care offered to pediatric patients and families with limited-English proficiency.

11. Financial Remuneration: There will be no financial remuneration for participating in the study.
12. Compensation: There is no form of compensation for participating in the study.
13. Alternative Procedures: There are no alternative procedures necessary for this study.
14. Contact Information: If you have any questions about this research, you may contact the principal investigator, dissertation chair or IRB director at Seton Hall University.

Caroline Meza MSN, RN, CEN – Principal Investigator
caroline.meza@student.shu.edu
Phone #: Graduate Department Secretary Teofila Pena: **973-761-9287**

Bonnie Sturm EdD, RN -Dissertation Chair at Seton Hall University, College of Nursing
Email: bonnie.sturm@shu.edu

Michael LaFountaine, EdD -Director of Institutional Review Board at Seton Hall University
Phone # (973) 313-6314
Email: irb@shu.edu

15. Audio-Tapes: In signing this consent, the participant gives the principal investigator written permission to audio-record the in-person interview. The participant will be assigned a pseudonym by the principal investigator for transcription purposes. Only the principal investigator will listen to, transcribe and have access to the audio-tape. The audio-tape will be stored in a secure and locked location accessible only to the principal investigator. The audio-tape information will be deleted after the principal investigator transcribes the participant's interview in written form.
16. Copy of Consent: The participant will receive a copy of this signed and dated consent form.

I have read the information about the study and consent to participate.

Study Participant (Print Name): ____

Study Participant (Signature): ________________________________ Date: _________

Page 2, Participant's Initials: ________

APPENDIX F

CONSENT FORM FOR CERTIFIED PROFESSIONAL MEDICAL INTERPRETERS

SETON HALL UNIVERSITY
1 8 5 6

PROFESSIONAL MEDICAL INTERPRETER
INFORMED CONSENT FOR PARTICIPATION IN RESEARCH

1. Researcher and Affiliation: Caroline Meza MSN, RN, CEN, a Doctoral student at Seton Hall University, College of Nursing, Graduate Department, PhD Program.

2. Purpose of the Study: The purpose of this study is to explore the experience of pediatric emergency nurses who are engaged in providing care to pediatric patients and families with limited-English proficiency in a pediatric emergency department. Professional medical interpreters will also be interviewed to gain their perspective related to working with pediatric emergency nurses. **Duration of the Study:** Participants will be interviewed for a time duration of approximately 60 to 90 minutes each. The study involves an audio-recorded in-person interview, with the principal investigator and the completion of a brief demographic questionnaire.

3. Procedure of the Study: The participant agrees to participate in the study by signing the consent. During the in-person audio-recorded interview the participant will be asked questions about their experience working with pediatric emergency nurses caring for pediatric patients and families with limited-English proficiency. For example, the participant will be asked to describe a situation when they interpreted a conversation between a pediatric emergency nurse and pediatric patient and family with limited-English proficiency, and explain, if any challenges occurred with the interpretation of the conversation between the nurse and patient/family. At the end of the interview, the participant will be asked to fill out a brief demographic questionnaire.

4. Demographic Questionnaire: The Demographic Questionnaire includes questions about the background characteristics about the participant (i.e. education and employment as a professional medical interpreter). The responses to the questionnaire will remain anonymous and not contain any identifying information.

5. Voluntary Nature of Participation: Participation in the study is entirely voluntary. The participant may choose to withdraw from the interview process and the study at any time by contacting the principal investigator. The participant does not have to give a reason for withdrawing from the study and will not be penalized.

6. Anonymity: Participation in this study is confidential and all responses including all demographic information will be collected without any identifying information. The participant's name will not appear in the research study, except for a signature on the consent form. A pseudonym will be assigned to each participant for transcription purposes and data analysis. The principal investigator will be the only person aware of the participant's identity. The signed consent form and completed demographic form will be collected in separate folders that will be kept in a secure locked location in the principal investigator's home.

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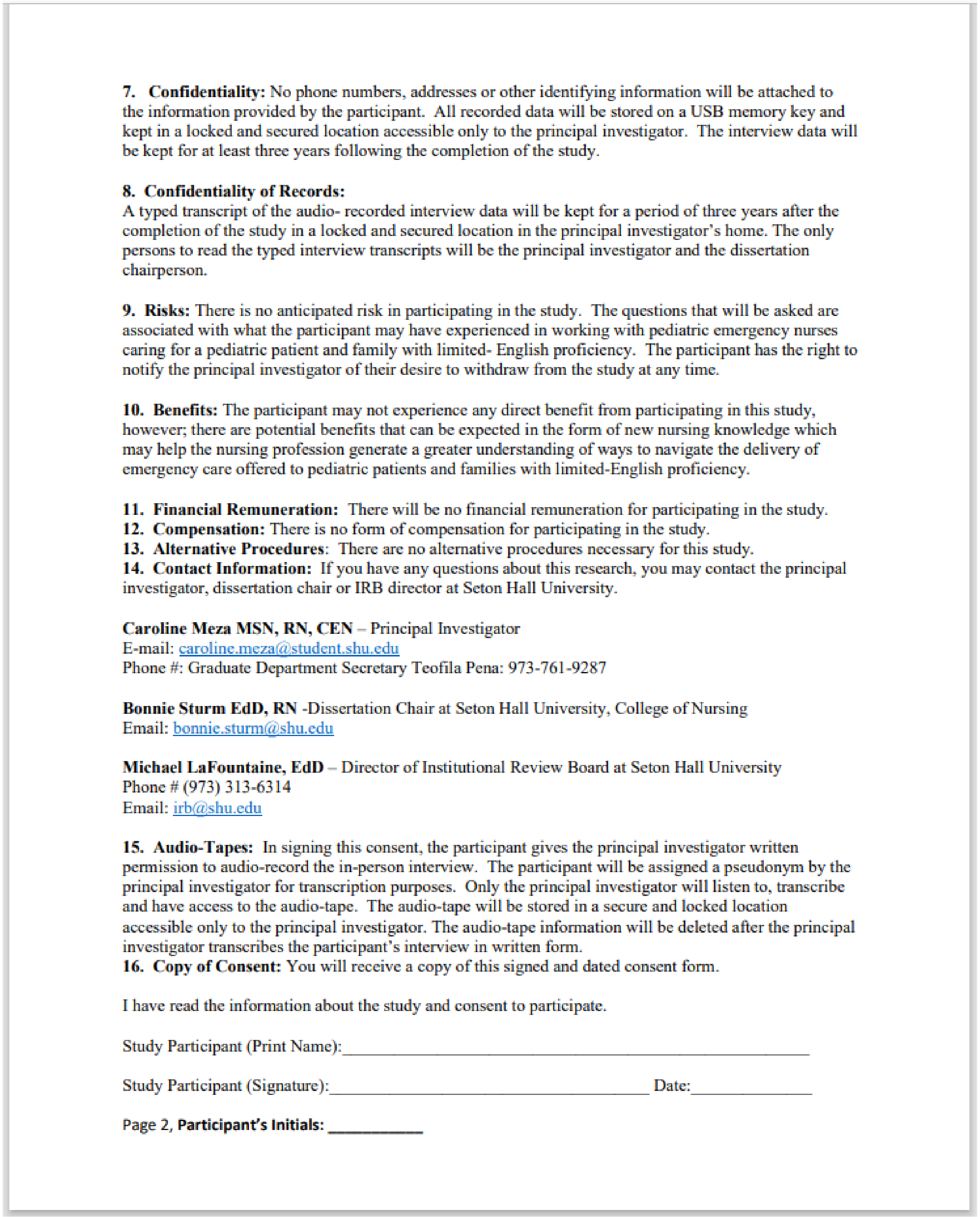
What great minds can do.

Page 1, Participant's Initials: ___________



7. Confidentiality: No phone numbers, addresses or other identifying information will be attached to the information provided by the participant. All recorded data will be stored on a USB memory key and kept in a locked and secured location accessible only to the principal investigator. The interview data will be kept for at least three years following the completion of the study.

8. Confidentiality of Records:
A typed transcript of the audio- recorded interview data will be kept for a period of three years after the completion of the study in a locked and secured location in the principal investigator's home. The only persons to read the typed interview transcripts will be the principal investigator and the dissertation chairperson.

9. Risks: There is no anticipated risk in participating in the study. The questions that will be asked are associated with what the participant may have experienced in working with pediatric emergency nurses caring for a pediatric patient and family with limited- English proficiency. The participant has the right to notify the principal investigator of their desire to withdraw from the study at any time.

10. Benefits: The participant may not experience any direct benefit from participating in this study, however; there are potential benefits that can be expected in the form of new nursing knowledge which may help the nursing profession generate a greater understanding of ways to navigate the delivery of emergency care offered to pediatric patients and families with limited-English proficiency.

11. Financial Remuneration: There will be no financial remuneration for participating in the study.
12. Compensation: There is no form of compensation for participating in the study.
13. Alternative Procedures: There are no alternative procedures necessary for this study.
14. Contact Information: If you have any questions about this research, you may contact the principal investigator, dissertation chair or IRB director at Seton Hall University.

Caroline Meza MSN, RN, CEN – Principal Investigator
E-mail: caroline.meza@student.shu.edu
Phone #: Graduate Department Secretary Teofila Pena: 973-761-9287

Bonnie Sturm EdD, RN -Dissertation Chair at Seton Hall University, College of Nursing
Email: bonnie.sturm@shu.edu

Michael LaFountaine, EdD – Director of Institutional Review Board at Seton Hall University
Phone # (973) 313-6314
Email: irb@shu.edu

15. Audio-Tapes: In signing this consent, the participant gives the principal investigator written permission to audio-record the in-person interview. The participant will be assigned a pseudonym by the principal investigator for transcription purposes. Only the principal investigator will listen to, transcribe and have access to the audio-tape. The audio-tape will be stored in a secure and locked location accessible only to the principal investigator. The audio-tape information will be deleted after the principal investigator transcribes the participant's interview in written form.
16. Copy of Consent: You will receive a copy of this signed and dated consent form.

I have read the information about the study and consent to participate.

Study Participant (Print Name):____

Study Participant (Signature):_________________________________ Date:____________

Page 2, **Participant's Initials: __________**

APPENDIX G

INTERVIEW GUIDE FOR PEDIATRIC EMERGENCY NURSES

1. What happens when a pediatric patient and family with limited-English proficiency (LEP) come to the ED?
   How do you begin their care? What resources, if any, are available to you?

2. Please describe a situation when you cared for a pediatric patient and family with limited-English proficiency (LEP) in the pediatric emergency department (PED)?
   a) What went well in this situation?
   b) What was challenging about this situation?

3. How do you manage communication with a pediatric patient and family with LEP, throughout the visit, particularly about their ongoing status in the PED?

4. How do you deliver critical medical news (i.e., hospital admission, poor prognosis) to a family with LEP in the PED?

5. Please tell me how you provide discharge and follow-up instructions to a pediatric patient and family with LEP?

6. If you could change anything about how you provide emergency care to pediatric patients and families with LEP, what would it be?

7. Please describe any policies that you are aware of at your institution that address communicating with patients and families with LEP.

8. What else would you like to share with me about this topic?

APPENDIX H

INTERVIEW GUIDE FOR PROFESSIONAL MEDICAL INTERPRETERS

1. Please describe an experience with translating critical medical information to a pediatric patient and family with LEP that involved a nurse.

2. Please describe a situation when you interpreted a conversation between a pediatric patient and family with limited-English proficiency (LEP) and a PEN in the pediatric emergency department.
    a) What went well in this situation?
    b) What was challenging about this situation?

3. If you could change anything about how you provide professional interpretive services to pediatric patients and families with limited-English proficiency, what would it be?

4. What is your training to work as a professional medical interpreter for a hospital?

5. How often are you requested to translate for nurse and families with LEP in a pediatric emergency department during your workday?

6. What else would you like to share with me about this topic?

APPENDIX I

SETON HALL UNIVERSITY IRB APPROVAL LETTER

SETON HALL UNIVERSITY
1856

May 1, 2020

Caroline Meza
136 Claremont Ave
Saddle Brook, NJ 07663

Re: Study ID# 2020-070

Dear Mrs. Meza,

The Research Ethics Committee of the Seton Hall University Institutional Review Board reviewed and approved your research proposal entitled “How Pediatric Emergency Nurses Initiate and Provide Care to Children and Families with Limited-English Proficiency” as resubmitted. This memo serves as official notice of the aforementioned study’s approval as exempt. Enclosed for your records is the stamped original Consent Form. You can make copies of this form for your use.

The Institutional Review Board approval of your research is valid for a one-year period from the date of this letter. During this time, any changes to the research protocol, informed consent form or study team must be reviewed and approved by the IRB prior to their implementation.

You will receive a communication from the Institutional Review Board at least 1 month prior to your expiration date requesting that you submit an Annual Progress Report to keep the study active, or a Final Review of Human Subjects Research form to close the study. In all future correspondence with the Institutional Review Board, please reference the ID# listed above.

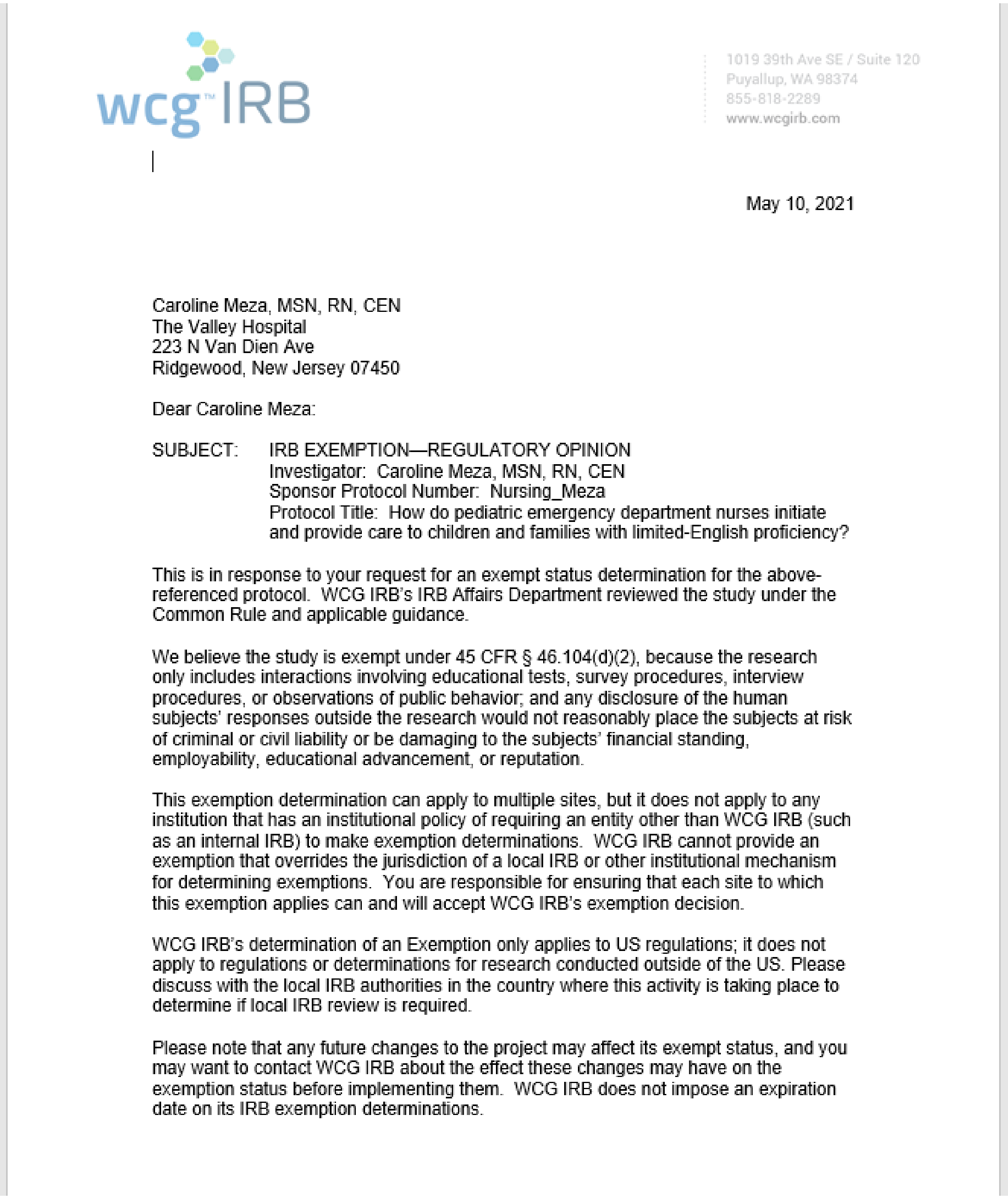
Thank you for your cooperation.

Sincerely,

Mara Podvey
Mara C. Podvey, PhD, OTR
Associate Professor
Co-Chair, Institutional Review Board

APPENDIX J

THE VALLEY HOSPITAL IRB APPROVAL LETTER



wcg IRB

1019 39th Ave SE / Suite 120
Puyallup, WA 98374
855-818-2289
www.wcgirb.com

May 10, 2021

Caroline Meza, MSN, RN, CEN
The Valley Hospital
223 N Van Dien Ave
Ridgewood, New Jersey 07450

Dear Caroline Meza:

SUBJECT: IRB EXEMPTION—REGULATORY OPINION
Investigator: Caroline Meza, MSN, RN, CEN
Sponsor Protocol Number: Nursing_Meza
Protocol Title: How do pediatric emergency department nurses initiate and provide care to children and families with limited-English proficiency?

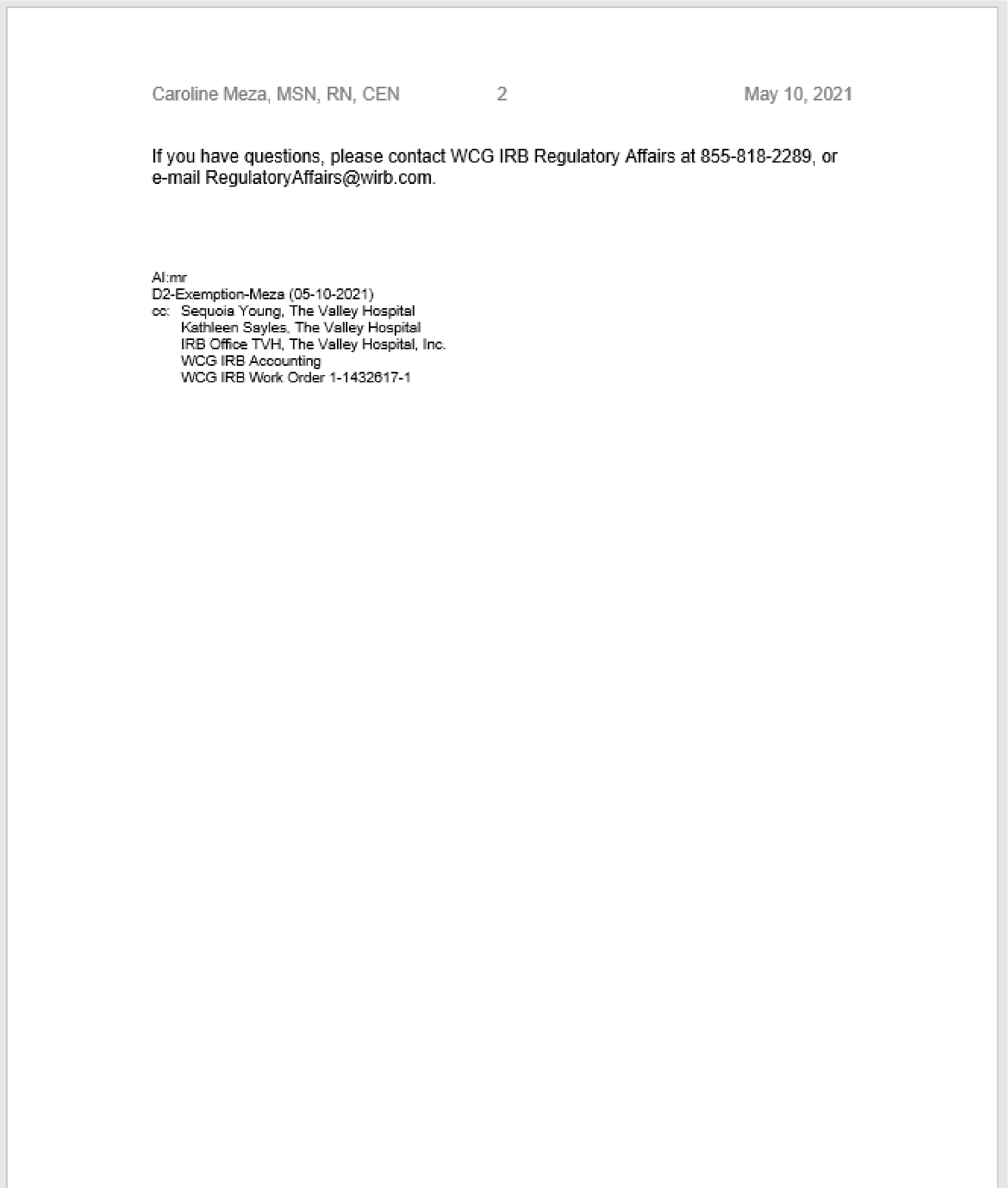
This is in response to your request for an exempt status determination for the above-referenced protocol. WCG IRB's IRB Affairs Department reviewed the study under the Common Rule and applicable guidance.

We believe the study is exempt under 45 CFR § 46.104(d)(2), because the research only includes interactions involving educational tests, survey procedures, interview procedures, or observations of public behavior; and any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation.

This exemption determination can apply to multiple sites, but it does not apply to any institution that has an institutional policy of requiring an entity other than WCG IRB (such as an internal IRB) to make exemption determinations. WCG IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions. You are responsible for ensuring that each site to which this exemption applies can and will accept WCG IRB's exemption decision.

WCG IRB's determination of an Exemption only applies to US regulations; it does not apply to regulations or determinations for research conducted outside of the US. Please discuss with the local IRB authorities in the country where this activity is taking place to determine if local IRB review is required.

Please note that any future changes to the project may affect its exempt status, and you may want to contact WCG IRB about the effect these changes may have on the exemption status before implementing them. WCG IRB does not impose an expiration date on its IRB exemption determinations.



If you have questions, please contact WCG IRB Regulatory Affairs at 855-818-2289, or e-mail RegulatoryAffairs@wirb.com.

AI:mr
D2-Exemption-Meza (05-10-2021)
cc: Sequoia Young, The Valley Hospital
Kathleen Sayles, The Valley Hospital
IRB Office TVH, The Valley Hospital, Inc.
WCG IRB Accounting
WCG IRB Work Order 1-1432617-1