CLINICAL EFFECTIVENESS MODULE

Improving Communication for Patients with Limited English Proficiency

A critical review of a practice process to improve patient experience and equity

Dr Ben Gray
Dr Roshan Perera

The Royal New Zealand College of General Practitioners

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Introduction

CLINICAL EFFECTIVENESS MODULES

Clinical Effectiveness Modules are learning and improvement resources, which incorporate evidence, information, guidance, tools and processes to encourage learning and best-practice improvements. They provide a simple, systematic method to understand actual and potential problems associated with current processes and identify solutions; they can be applied to any topic of interest, including practice, organisation or a clinical activity.

Modules are a useful practice team tool as they encourage teams to learn and reflect on their practice – this extends to primary care and other interfaces which are not always areas considered in quality improvement activities. The process to complete a module helps teams to break down complex interactions and activities to gain a better understanding of an issue. They include useful tools to help the review. Methods incorporated can be applied to any topic of interest to undertake a systematic and critical review of practice, clinical quality or an aspect of integrated care.

They provide guidance on:

- team processes, continuous quality improvement processes, critical thinking methods, and where consideration of data, information or other services might improve effectiveness of care or support continuity of patient care
- how practices can identify improvements in systems and processes, make sense of complex relationships or interactions in an integrated working environment and where linking might improve outcomes of care for patients
- using the RNZCGP Quality Framework[1,2] (Appendix 1), which is a useful tool for making sense of data, information, process flows and connections that impact on patient care
- applying the RNZCGP Template for a Clinical Effectiveness Activity (*Aiming for Excellence* 2011[3]) as a useful critical analysis tool for understanding practice or health interfaces, which incorporates PDSA cycles, and the Quality Framework to guide reflection, planning, mapping and rationalising new and existing activities within the context of day-to-day clinical work
- PDSA cycles[4] which, when incorporated into improvement activity, provide a simple approach for systematically working through an issue to make sense of complex and comprehensive components of health and community interfaces.

Clinical Effectiveness Modules are designed for use by New Zealand general practice teams to achieve their annual CORNERSTONE® clinical improvement activity:

- *Aiming for Excellence*, Criterion 10.4: The practice identifies an annual quality improvement activity related to the management of a targeted area of clinical care[5]).
- Clinicians may also use the template in Step 4 of this module to meet their Maintenance of Professional Standards (MOPS) requirements.

Resources

This module contains resources to support practice teams who are undertaking a critical review of their processes related to good communication with patients with limited English proficiency. The module is broken up into sections which integrate useful resources.

The reasons for selecting a particular topic for critical review of practice processes can be multifactorial and range from personal interest to the result of a critical or adverse event. In this instance, an adverse event is provided as an example of the impetus for reviewing practice activity.

The workbook is based on the Template for a Clinical Effectiveness Activity in *Aiming for Excellence*, and is adapted to assessing how the practice team manages communication with patients who have limited English proficiency, and related issues considered important by the practice.

In working through the material, it is important to remember that quality improvement is an iterative process, and after consideration of some questions it may be necessary to revisit aspects of earlier questions.

IMPORTANT POINTS

- Patients should always be the focus of clinical activity.
- Activities chosen must be relevant to your practice or practice population. It could be a personal interest or the result of a critical or adverse event.
- Use the process to understand where patient contact and clinical care and/or technical interventions occur in the system.
- Understanding the global picture and layers of practice activity will help map problems, understand links or discover where better integration might help improve continuity of care.

QUALITY IMPROVEMENT

- The Quality Framework
- PDSA Cycles
- The Interpreter Toolkit

PDSA cycles, the Quality Framework (Appendix 1) and the Interpreter Toolkit (Appendix 2) are combined to apply a critical review and identify how to improve processes for communicating with patients who have limited English proficiency. It is important to work systematically through the document to understand the range of actual and potential problems associated with current processes and identify appropriate solutions.

The Quality Framework provides a useful point of reference to help:

- understand where quality processes interact
- map information processes
- identify where there are links to secondary and community interfaces
- identify and assess the complex and comprehensive components of primary care and interfaces
- provide a global overview to map patient information and pathways, understand links or discover where integration might help.

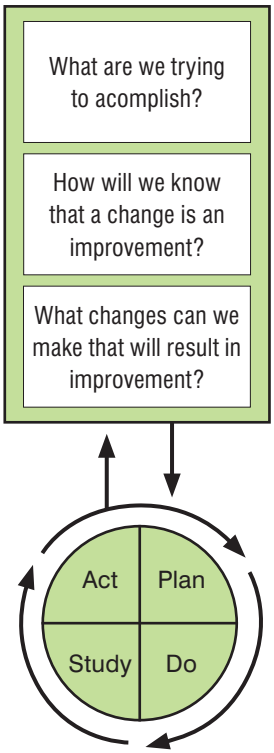
Patients are at the centre of the framework and the diagram (Appendix 1) shows where patient contact and clinical care and/or technical interventions occur in the system. This is surrounded by layers of practice activity, and identifies relationships necessary for providing continuity of care and what types of quality activity practices are engaged in. The framework is not intended to be hierarchical, and the entry point may be from any place in the diagram, such as sentinel/adverse events reporting.

PDSA CYCLES

The principle of all quality activity is that it leads to improvement through change. PDSA cycles are useful because they outline a simple and systematic approach to review which involves all members of the practice team. They guide incremental and continuous change through identifying actions to close gaps in care.[6]

THE APPROACH

- Teamwork is essential and should always involve or inform the whole team.
- The method can be applied to any aspect of patient care or service.
- It encourages consideration of patients and whanau/families, or practice populations.
- It uses learning and reflection to understand the effect of care on outcomes.
- It guides process improvement to improve quality of life for patients.[7]



Limited English proficiency – why is it an issue?

New Zealand is becoming more ethnically diverse[1] with increasing numbers of permanent residents born overseas.[8] The number of people with limited English proficiency is also growing. While comprehensive statistics are not collected, census data shows that there are increasing numbers of recent immigrants from Asia, with people of Chinese origin now the second largest group of migrants.[9] Clinical consultations in which the patient does not have adequate English to get optimal care are therefore increasingly common.

Effective communication is essential for good medical care.[10,11] Communication problems occur more frequently in consultations with patients who have limited English proficiency,[12,13] with an increased risk of adverse outcomes when professional interpreters are not used.[14,15] Despite this, interpreters are often not used in the US,[16] Australia[17] or New Zealand.[18]

Under the New Zealand Code of Health and Disability Services Consumers' Rights[19] patients have a right to effective communication, including the right to a competent interpreter. Lack of funding, especially in primary care, is an acknowledged obstacle to interpreter use.[20,21]

The use of trained interpreters for all medical encounters with patients who have limited English proficiency is generally presented as best practice. This does not take into account the financial constraints and complexity of clinical interactions.

Improving communication with patients who have limited English proficiency

The topic of improving communication with patients who have limited English proficiency (LEP) was selected as a Clinical Effectiveness Module for three main reasons:

1. Until recently there has been little funding for interpreter use in primary health care, and many practices are unlikely to have a well-thought-through process for ensuring good communication with patients who have limited English proficiency.
2. A toolkit to help practices with interpretation issues in general practice has been developed by Gray, Hilder and Stubbe (Appendix 2).[22]
3. New Zealand is a multicultural nation, with increasing numbers of non-English-speakers seen in general practice and a low uptake of interpreters.[23]

STEP 1: Planning and defining parameters

'WHAT ARE WE DOING NOW?'

Using the process outlined in this module will help teams to begin the process of understanding how they communicate with patients who have limited English proficiency. Having established the baseline, they can then explore in greater depth to understand and identify what they need to do to target and improve current processes.

To do this, the team will use the process outlined in the module to:

- analyse the problem in more detail and provide information to enable them to identify and discuss possible solutions, and address outstanding issues
- identify the issues so the team can plan and institute appropriate interventions for individual and systems change
- monitor effectiveness of any interventions to determine which changes worked and which did not.

The practice quality improvement plan is a good place to record actions for discussion and to monitor progress. Regular review of the plan provides information for further learning and reflection by the team.

When planning the activity consider:

- What do we want to do? Define the activity
- Why do we want to do this? Define the drivers for undertaking the activity
- What do we want to achieve? Determine the goal
- What are the realistic parameters? Determine the scope of the activity
- What do we need? Identify the resources required:
  - Time and budgetary constraints need to be identified and resolved before starting the activity
  - Funding: What existing resources can be used? Will external funding be needed?

INVOLVE THE TEAM

- Best results happen when the whole team is involved in identifying the work and planning how it should be done
- People – identify roles, relationships, responsibilities
- Buy in – arrange to meet frequently, communicate activity with the whole practice and others involved outside the practice

THE ISSUE: LIMITED ENGLISH PROFICIENCY

The reasons for selecting a topic for critical review of practice processes can be multifactorial and range from personal interest to a critical or adverse event. In this instance, an adverse event is proposed as providing the impetus for review of practice activity.

The scenario presented in this module highlights events that led to an adverse event due to poor communication with a patient with limited English proficiency. It illustrates the process for a critical review by a practice team for improving processes related to communication with patients with limited English proficiency.

By working through the module systematically, a raft of actual and potential problems associated with current processes can be identified, and solutions relevant to the patient can be developed. The process includes a thorough review of the following.

The activity	Critical review of practice processes to identify and resolve safety and equity issues. Questions: • What did we do well? • What didn't we do well and why? • How can we improve what we do?
The drivers	What is the practice concerned about? • Patient safety concerns • Prevention of a further adverse event • Improved communication with LEP patients
The goal	To improve quality of care, equity of access and communication for patients with limited English proficiency.
The scope	The chosen scope may be wide, but in this case, is narrowed to specific circumstances. • To understand current practice activity in relation to communication with patients who have limited English proficiency • To create protocols for identifying limited English proficiency patients • Facilitate use of interpreters within the practice A realistic timeframe for completing the activity according to availability of resources should also be identified within the scope of the activity.
Resources	To understand the practice capacity and capability to undertake this exercise, a toolkit incorporated at the back of the module provides useful information and tools to facilitate communication with patients who have limited English proficiency. Practices are encouraged to work through the module to review their processes for communicating with patients with limited English proficiency.

AN EXAMPLE OF A PRACTICE SCENARIO

A COMMUNICATION ISSUE ARISING FROM A PATIENT WITH LIMITED ENGLISH PROFICIENCY

The issue

An adverse event has occurred in the practice which is potentially due to poor communication or miscommunication with a patient who has limited English proficiency. The practice team considers that the event may have been averted by using an interpreter.

Practice profile

This is a practice owned by the four doctors who work there. It employs a practice manager, who has significant autonomy to run the business, and staff (three nurses and two receptionists). One of the doctors speaks reasonably fluent French, and one of the nurses speaks Afrikaans, but all other team members are monolingual. A podiatrist runs a clinic once a month. The practice is in a self-contained suburb of mid to low socioeconomic status in a large city. There are quite a few people from non-English-speaking backgrounds, but no data has been collected in relation to that, so it is not clear how many non-English-speaking patients belong to the practice. The practice is a member of a large PHO that has some funds available for practice development initiatives around Services to Improve Access (SIA).

The incident

A Tongan patient was seen who had headaches. She spoke English well enough for working as a cleaner. The history that was taken did not suggest any serious cause and she was given a prescription for analgesia. She returned four weeks later, accompanied by a friend who had much better English, complaining of visual problems in addition to the headaches. A more detailed history was able to be taken which included a history of her losing vision on bending over. She was referred to neurology and found to have visual field loss caused by benign intracranial hypertension. This was treated, but she now has a permanent partial loss of visual field.

A patient safety report was generated. The report identified that the patient's loss of vision might have been avoided if an interpreter had been present at the original consultation.

It was also noted in the report that a significant number of Tongan patients, in addition to patients from other non-English-speaking backgrounds, attend the practice, and that not using interpreters could be a significant problem for the practice.

The practice decided to review their practice processes for communicating with patients who have limited English proficiency.

STEP 2: Understanding the issues

Understanding the underlying issues that might have led to the adverse event is vital in providing the right solutions. The Quality Framework (Appendix 1) divides practice activities into:

Structure The characteristics of the setting where care takes place

Process What is actually done during the delivery of care

Outcome The effects of care

The current situation in the practice in relation to each of these areas is critically reviewed to gain an understanding of the issues and identify potential solutions which may be inter-linked and have cross-overs. The next steps guide the practice through the review, highlighting each relevant category and sub-category of the framework under consideration.

CONSIDER PRACTICE STRUCTURES

Structural practice activities strengthen the practice environment and ensure operational safety. They fall into four sub-categories, as shown in the boxes below. These are assessed in detail below, in relation to communication with patients who have limited English proficiency.

'Competent' and appropriate setting within which care occurs	Competence of the professional providing the care	Organisational and practice supporting activity and resources	Functional interface between practitioner, management, resources, technology

PRACTICE SCENARIO: Identify issues	
Practice population of interest	Practice team members believe there is a significant population of patients with limited English proficiency, but specifics are uncertain.
Location of care	All patients are seen in the practice premises, but not always by their regular general practitioner (GP).
Personnel	The first contact is with the receptionist, but all team members interact with patients.
Infrastructure	The practice has no protocols in place for LEP patients. The practice has a few phones that have speaker-phone capacity. Most consulting rooms are sufficiently large and usually have one extra patient chair.

1. COMPETENT AND APPROPRIATE SETTING FOR CARE DELIVERY

This section should be used in conjunction with the Gray Hilder Stubbe Toolkit (Appendix 3).

Understanding the issues

'Competent' and appropriate setting within which care occurs	**Description of current situation:**	Consider location, infrastructure, hours of operation, personnel
	Perceived problems or questions about the current situation:	Is the setting safe and appropriate? What feature could be improved? In what other settings does this activity occur?
	Potential solutions:	Identify what is needed and the processes required to achieve the required results

DEFINING THE CURRENT SITUATION	
Practice population of interest	Patients with limited English proficiency
Location of care	Consider all locations, including the practice: the patient's home and other potential community locations
Personnel	Identify all team members who interact with patients who have limited English proficiency, such as receptionists and practice manager(s), nurses, doctors, locums and other temporary or visiting staff, and others who see the patient in the practice.
Infrastructure	Identify requirements for good communication, such as practice protocols for interpreter use, a list of interpreters, consultation rooms equipped with speaker-phones, sufficient space in consulting rooms to accommodate additional people, sufficient chairs in consulting rooms.

2. PROFESSIONAL COMPETENCIES NECESSARY

This section should be used in conjunction with the Gray Hilder Stubbe Toolkit (Appendix 3).

Understanding the issues

Organisation and practice supporting activity and resources	**Description of current situation:**	Identify the competencies required by relevant practitioners.
	Perceived problems or questions about the current situation:	Is the knowledge and skills of all relevant practitioners appropriate and sufficient? Are additional educational activities available?
	Potential solutions:	Identify what is needed and the processes required to achieve the required results

Assessing the need for an interpreter for patients from a non-English-speaking background begins from the time of arrival at the practice.

- All team members require some competency in dealing with people with limited English proficiency.
- The type and level of competency required varies depending on the context and their role in the team.
- The necessary competencies of all practice team members who interact with patients who have limited English proficiency need to be determined.
- All staff identify that they regularly interact with patients who have limited English proficiency.

A. DEFINING CURRENT COMPETENCIES

Current knowledge:

- Identify levels of comfort and knowledge of use of interpreters, and communicating with people who have limited English proficiency.
- Determine the availability of interpreters, how to contact interpreter services and how to use an interpreter.

Current skill and experience:

- Identify team members who can speak other languages.
- Identify team members with experience in using interpreters.

Education and training requirements:

- Determine requirements for training on understanding the need for communication and knowledge of issues.
- Determine requirements for training in determining the need for an interpreter, accessing an interpreter and using an interpreter.

PRACTICE SCENARIO: Identify issues	
All team members identify that they regularly interact with patients who have limited English proficiency.	
Knowledge and skills:	• Clinical team members identify that, within a consultation, they have no experience in accessing interpreters unless the patient is accompanied by someone who can interpret. They also have no training in use of interpreters. • The practice has one team member who speaks French and one who speaks Afrikaans.

B. DEFINING CURRENT SYSTEMS – PRACTICE ORGANISATION

Understanding the issues

Organisation and practice supporting activity and resources	**Description of current situation:**	Identify relevant supporting systems and processes Consider both formal and informal practice systems, and interaction with systems in related organisations such as the PHO.
	Perceived problems or questions about the current situation:	What other activities, support and resources are required at a practice or external organisational level?
	Potential solutions:	Identify what is needed and the processes required to achieve the required results

PRACTICE SCENARIO: Define current systems for the practice organisation	
Practice protocols	The practice discovers that they have no protocols that provide for LEP patients or interpreter use.
Record-keeping	The presence of a family member to interpret for a patient may be noted in the text of a patient record. It is not necessarily transferred to other documents.
Technological support	There is a field in the practice management system for ethnicity. This has been filled in for approximately 10 percent of patients.
Other systems	The practice is currently not registered with an interpreter service. There is no contact list of interpreters.
Resources	The practice budget currently has no allocated funding for the needs of LEP patients, or for employing interpreters.

Practice protocols:

- Determine whether processes for registration of new patients and booking processes specifically include provision for language preferences and the need for an interpreter.
- Consider protocols for charging patients, such as when longer consultations are required.

Record-keeping:

- Identify practice management systems that could be used for recording relevant information, such as preferred language and the need for an interpreter.
- Identify where relevant information could be routinely included in other documentation, such as referral letters.

Technological support:

- Determine whether the practice management system is enabled to easily record relevant information, such as having fields for recording a patient's preferred language and whether an interpreter is needed.

Other systems:

- Determine whether the practice has considered registration with an interpreter service, such as Language Line or Auckland Primary Care Interpreting Service.
- Determine whether the practice has access to a contact list of available local interpreters.

Resources:

- Determine the budget allocation for employing interpreters.
- Determine the availability of District Health Board (DHB) or Primary Health Organisation (PHO) funding streams for additional support.

C. UNDERSTANDING THE ISSUES – DEFINING FUNCTIONALITY OF PRACTICE SYSTEMS

Understanding the issues

Organisation and practice supporting activity and resources	**Description of current situation:**	Identify issues that impact on practitioners when seeing LEP patients.
	Perceived problems or questions about the current situation:	What gaps can be identified? What are the issues?
	Potential solutions:	Identify what is needed and the processes required to achieve the required results

PRACTICE SCENARIO: Identify practice functionality and sustainability	
Practice protocols	The practice manager volunteers to develop the protocols in consultation with all team members.
Record-keeping	• Reception team members accept responsibility for recording and maintaining limited English proficiency information. • New patients will have language preferences included on registration. • Decision-making about the need for interpreters will be the responsibility of clinical members and will be written in the patient notes. • When inserted, this information will be included in all referral letters and will appear on the practice management system (PMS) header.
Technological support	All consulting room phones will be upgraded.
Other systems	• The practice will register with Language Line. • The practice manager will identify whether there are face-to-face interpreters available from any local interpreting service. • Reception team members will ensure that phone numbers for contacting interpreters are in the PMS phone book.
Resources	SIA funding will be accessed for improving communication with LEP patients.

Defining current functionality and sustainability of practice systems

Practice protocols:

- Determine which protocols address patients with limited English proficiency, such as registering new patients (determining the need for an interpreter), booking appointments (booking longer appointments when using an interpreter) and charging (decision-making about how to charge patients using interpreters).
- Determine whether patients with limited English proficiency should be charged an extra fee for the longer consultation time.
- Review patient information availability and the practice complaints policy.

Record-keeping:

- Determine responsibility for ensuring record-keeping is accurate in relation to LEP requirements.
- Identify when an interpreter is used and who it is.

Technological support:

- Determine optimal requirements for technological support.

Other systems:

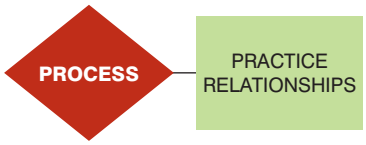
- Schedule practice meetings to determine how to set protocols.
- Determine the composition of meetings – ideally all team members should be involved.
- Determine whether all team members know how to contact interpreters if needed.
- Determine whether team members have been trained in how to make the decision when it is not acceptable to use a family member as an interpreter.
- Determine whether team members have been trained to recognise whether an interpreter is likely to be interpreting accurately.

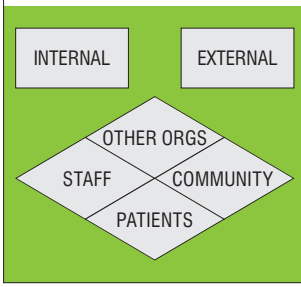
Resources:

- Determine responsibility and authority for budget.
- Make decisions about applying for additional funding from the PHO/DHB for caring for LEP patients.

D. DEFINING IMPORTANT RELATIONSHIPS

Understanding the issues





Description of current situation:	Consider formal and informal relationships necessary
Perceived problems or questions about the current situation:	What gaps can be identified? What are the issues?
Potential solutions:	Identify what is needed and the processes required to achieve the required results

PRACTICE SCENARIO: Identify important relationships	
Within the practice	• Reception team members do not attend or have input into practice management meetings. • It is the reception team who book the appointments and who need to know clinicians' expectations for arranging an interpreter in advance for particular patients, and the length of consultation required if there is an interpreter.
Other providers	• Members of the practice team have no current dealings with professional interpreters or interpreting services. • The team do access ad hoc interpreters on occasion.
Patients	• There is no current means of identifying patients who may need interpreting services before the consultation. • The receptionist occasionally suggests to some patients that they bring along a family member who can translate.
Community relationships	Several communities attend the practice, but the practice is not clear as to how to identify community leaders or how to engage more directly with the relevant communities.

Within the practice:

Understand and define preferred approaches to communication between team members, and the available communication channels.

Other providers:

- Investigate interpreter services and interpreters.
- Understand what criteria an interpreting service uses when it employs interpreters and what type of training the interpreters have had.
- Verify whether interpreters have agreed to practise according to an ethical code of conduct.

Patients with limited English Proficiency and their families:

Find out which families prefer family members to interpret.

Community relationships:

- Identify representative groups in the community.
- If the practice cares for significant numbers of patients from a specific ethnic community, have some culture-specific training in the beliefs and values of that culture.
- If there is a representative group of the community, take advice from that organisation on how the practice service is perceived.

Resources:

Identify resources required.

E. SUMMARY OF ISSUES IDENTIFIED, POTENTIAL SOLUTIONS AND ALLOCATION OF RESOURCES TO INSTITUTE CHANGE

Equity

Equity of access to services is a requirement of the Health and Disability Commission's Code of Patient Rights. Some issues around improving access for people with limited English proficiency are low cost and within the control of the practice, such as adjusting the PMS to identify patients who need an interpreter and ensuring this information is included in referral letters.

Generally, inequity issues are addressed at a DHB or national level by providing funding and other resources.

If the practice identifies significant inequity that it cannot overcome, then there is a responsibility to address this at PHO, DHB or Ministry of Health level.

Cost of the service

Costs related to providing interpreter services are highly variable. Costs to the practice may include direct costs related to using professional interpreting services and practice systems. The indirect costs are longer consultations and more intensive use of team time. Passing costs onto patients is often not practicable or possible.

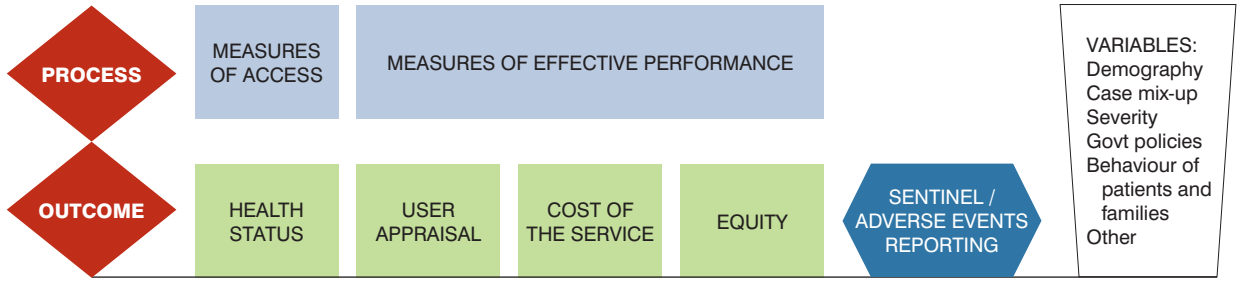
Funding for providing interpreter services is a necessity for any practice that has patients with limited English proficiency. Because of the low uptake of interpreter services, most practices use their own sources for interpreter contacts.

Some primary health organisations have limited budgets for interpreting services.

Most hospitals provide interpreters for their patients and the three Auckland DHBs have launched a fully funded Primary Care Interpreting Service.

STEP 3: Instituting and assessing change

Measuring change



Determine what will be measured, why and how:	What information can we gather and how? Define data to be collected; data collection methods and how it will be analysed. May include both qualitative and quantitative information.
Baseline measures: (pre-intervention)	What information is currently available?
Post-intervention (e.g. 6/12) review:	What gaps can be identified? What are the issues?

PRACTICE SCENARIO: Identify solutions	
The practice identified several gaps in its systems and processes in relation to communication with its patients who have limited English proficiency	• It worked through all the steps in a systematic manner to achieve its improvement goals. • It has identified all possible solutions through discussions involving all members of the practice team. • Resources were allocated (time, personnel and funding) to institute systems, processes and behavioural changes within the practice.
The practice has identified several issues relating to communication with patients who have limited English proficiency	• At a practice meeting, the team considers the most important factor is that they cannot identify how often patients with limited English proficiency require a consultation, and when and if interpreters are used. For example, they are not certain whether some patients come regularly with family members in support. • Patients are also usually not asked at the time of booking the consultation about their need for an interpreter and advised to bring along a family member if necessary.

continued

PRACTICE SCENARIO: Identify solutions	
Proposed solutions	• Changes relating to developing and instituting protocols, and record-keeping, particularly in relation to ethnicity and interpreter requirements. • Allocating a budget for limited English proficiency to engage interpreter services and training practice team members to identify and assess the language skills of patients. • Streamlining communication processes between team members. • Practice team members estimate they will need three months to institute policies and practices for improving communication with LEP patients and using interpreters.
The practice proposes to undertake a pre- and post- (six months after system and process changes are instituted) intervention audit of patients, using data from the PMS system	• Measures used include: • frequency of ethnicity data field coding, consultation rates for LEP patients and comparison with non-LEP patients • use of interpreters and cost to the practice and patient • use of specific services, such as immunisation, retinal screening in diabetic patients and cervical screening, by ethnicity • need for and use of an interpreter • reported adverse or Sentinel events by ethnicity.

The practice also feels it would be worthwhile to encourage patients with LEP to give feedback on their perception of care received from the practice, to help patients feel that they are partners in their own care. However, as by definition, LEP patients are a difficult group to get feedback from because an interpreter is required, the practice decides it would be worth getting an interpreter with a focus group of same-language patients for a facilitated discussion.

SUMMARY

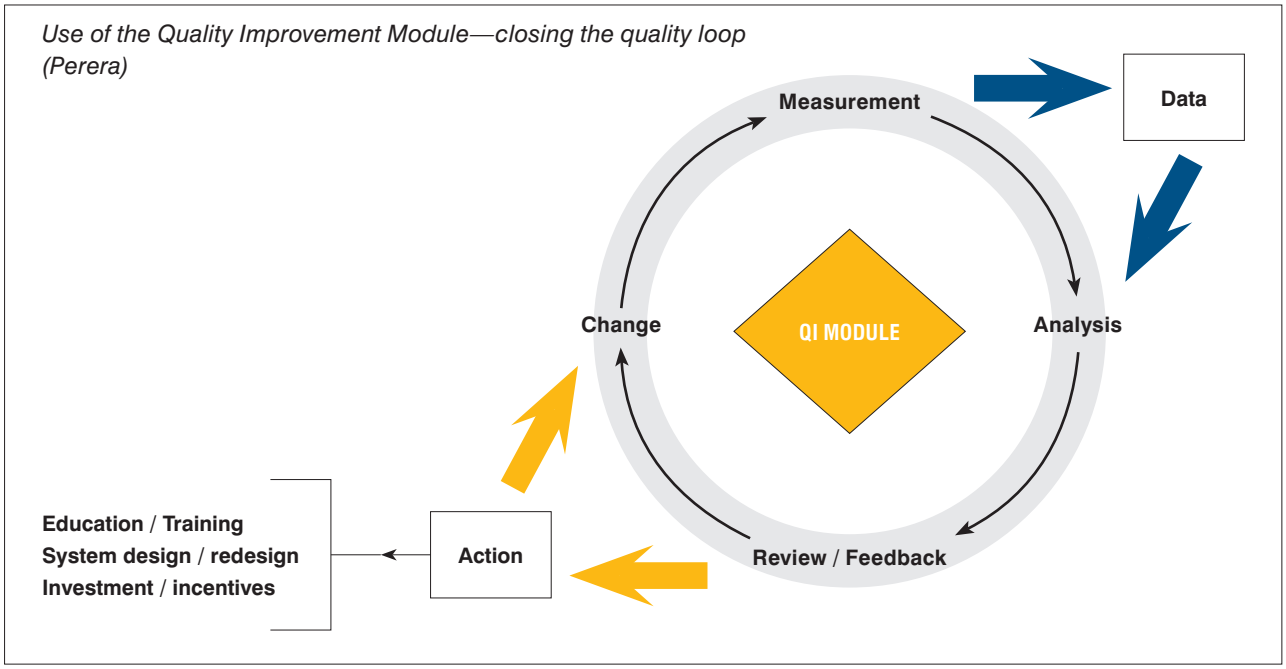
To institute the changes outlined in the previous sections, the practice team will need to determine the effectiveness or otherwise of their potential solutions by undertaking a PDSA cycle.

- Decide whether they should monitor and measure activity or selected outputs before and after implementation of proposed changes.
- Decide whether there is improvement in the systems and activities implemented by undertaking some baseline (pre-change) measurement using information available about the changes they are planning to implement.
- Measures chosen must be useful to the practice and easy to collect as part of day-to-day activity.
- The same measures should be reviewed in six months to determine whether the changes have led to improvement.

STEP 4: Post-intervention review and feedback

Quality improvement is a cyclical process. The steps described in this module allow a practice team to systematically identify current and potential problems, propose and action appropriate solutions, and determine whether the interventions instituted have created improvements to the quality of service provided. This final step of reflection and feedback to guide continuous improvement, and eventual re-application of measures, is vital to close the quality loop, for troubleshooting, and for identifying areas requiring further development.

Use of the Quality Improvement Module—closing the quality loop (Perera)



A template for reflection, learning and improvement opportunities, and peer review	
1 **Analysis of results**	• Were the objectives met? • What changes can be made to improve patient care as a result of the information obtained?
2 **Identification of discussion points**	• What type of information and results were generated? Was your choice of measures relevant suitable for the purpose? • Did you have any issues with data extraction and analysis, feasibility, potential inaccuracies in data collection and your ability to verify the accuracy of data? • Knowledge gaps • Areas for quality improvement • Learning, education or up-skilling highlighted • Assessment of risk and resilience • Availability of tools in general practice for risk assessment • Level of skill or comfort in using tools or in addressing patient health problems
3 **Discussion of results**	• Reasons for the results obtained, such as appropriateness of systems and behavioural changes introduced • What are the reasons for the results generated? • What is the gap between the information obtained and the expectations? • Feasibility or limitations identified
4 **Required changes at individual, organisational or systems level**	• Extent of knowledge and skill gaps highlighted • Systemic issues • Practice resources • Practice team issues and responsibilities • Training requirements • Link to educational material - are there any existing modules or educational material?
5 **Prioritisation checklist**	• Develop a checklist for change containing items such as resource availability or constraints, practice team communication and responsibilities, educational and training requirements, practice systems • What area will you address first?
6 **Ongoing activity**	• Plan for continuous review and improvement, such as instituting education and feedback cycles, developing additional measures as required and reviewing progress against agreed changes, and progression of practice-based improvement • Develop a quality action and management plan to address outstanding issues • Identify who takes responsibility for the actions • Meet regularly to ensure actions being implemented are successful • Discuss problems or benefits • Report on activity • Undertake a regular review of progress against changes agreed

Maintenance of Professional Standards (MOPS)

This module profiles communication with patients who have limited English proficiency as an important access issue. The module demonstrates the value of undertaking a systematic approach to addressing each of the issues identified in the RNZCGP Quality Framework. The relevance of each issue will vary, but if they are not systematically addressed then important opportunities for quality improvement can be missed.

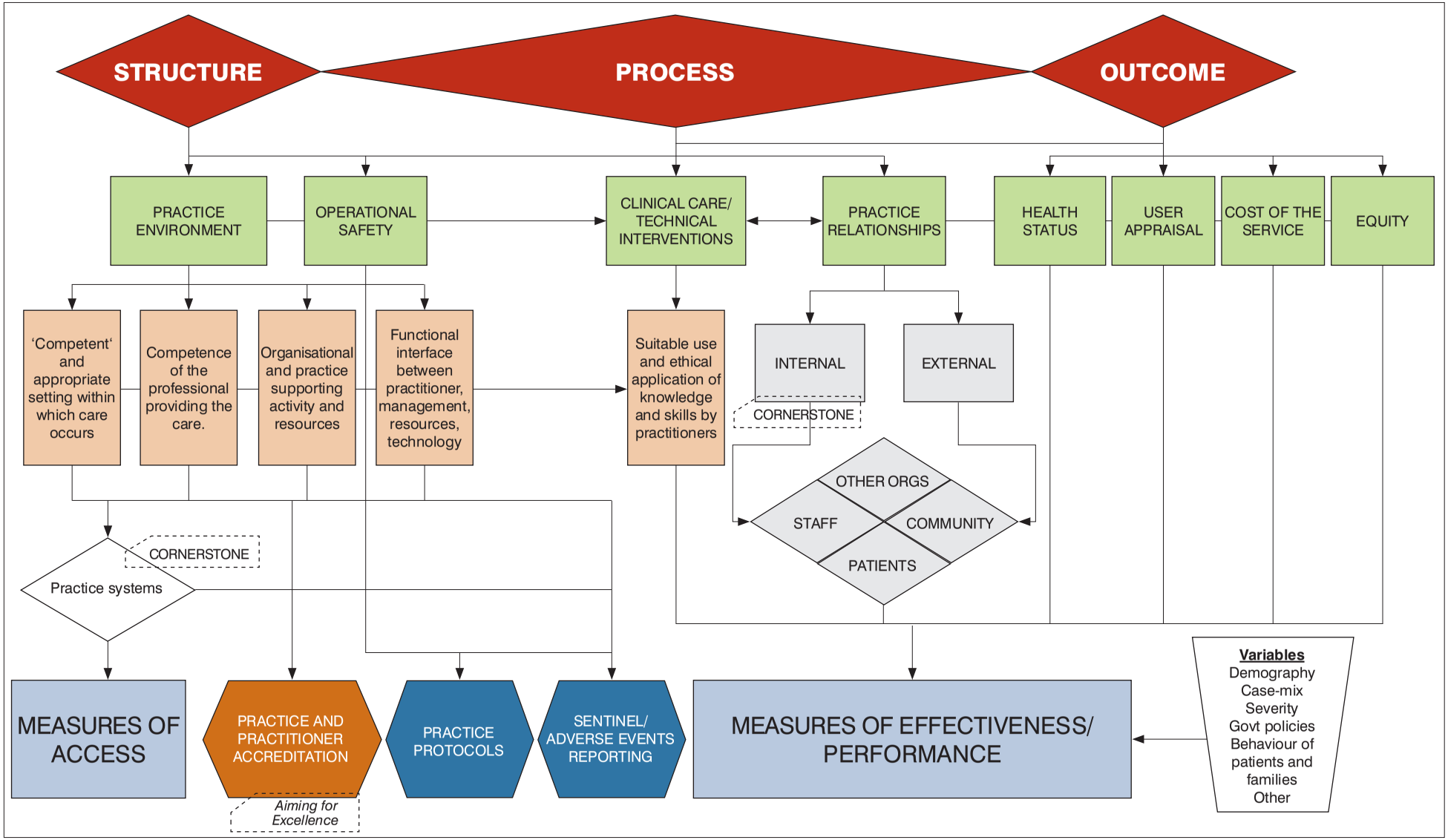
It is important that any quality improvement activity comes from issues identified within the practice, and that the practice has the interest and energy to apply to those issues.

A template for Maintenance of Professional Standards (MOPS)
Doctors can complete this section to claim MOPS CQI (Clinical Audit) credits
To complete this activity you will need to examine data and identify areas for improvement relevant to your individual practice

PLAN	• Identify what you want to do and develop measures (indicator, criteria, standard) • Select audit sample (what data you need to collect and test)
DO	**Data collection:** • What is your choice of measures? • Was your choice of measures relevant suitable for the purpose? • Did you have any issues with data extraction and analysis, feasibility, potential inaccuracies in data collection and your ability to verify the accuracy of data? • What type of information and results were generated? • Were the measures relevant for the purpose? • Availability of tools in general practice for risk assessment • Level of skill or comfort in using tools or in addressing patient health problems
STUDY	**Analyse the data** (What is the gap between actual and expected results?): • What type of information and results were generated? • Did you have any issues with data extraction and analysis, feasibility, potential inaccuracies in data collection and your ability to verify the accuracy of data? • Knowledge gaps • Areas for quality improvement • Were the objectives met? • What changes can be made to improve patient care as a result of the information obtained? • Learning, education or up-skilling highlighted • Assessment of risk and resilience

ACT	• Use the information to develop solutions and an action plan • Identify implement actions
OUTCOMES	**Outcomes**: The result of the improvements you made What was the impact of your actions? **Learning outcomes:** • Knowledge gaps • Areas for quality improvement • Learning, education or up-skilling highlighted • Assessment of risk and resilience • Availability of tools in general practice for risk assessment • Level of skill or comfort in using tools or in addressing patient health problems **Reflection:** What did you learn about patients from this activity?

APPENDIX 1: The RNZCGP Quality Framework[24]



For theoretical underpinning see Perera G.A.R Panning for Gold. The assessment of performance indicators in primary health care. PhD thesis University of Otago 2009
V2Q—Perera, Dowell, Morris

APPENDIX 2: How to use interpreters in general practice – a toolkit

By Ben Gray and Jo Hilder

INTRODUCTION

New Zealand's population is increasingly ethnically diverse and health services now deal more and more with significant numbers of Limited English Proficiency (LEP) patients. Effective communication is crucial to the provision of good medical care and for this reason it is vital that clinicians take more action to provide LEP patients with the means to communicate fully.

Interpreters are underutilised in medical consultations in New Zealand as they are in many countries. This is despite the well-known increased clinical risks of inadequate communication caused by a language barrier, the Right to Effective Communication contained in the Code of Patient's Rights and the growing availability of interpreter services.

The low uptake of interpreter services has been confirmed in recent New Zealand studies[25,26] which have also highlighted the complex issues associated with their use. While the default use of ad hoc interpreters (family members, friends, medical students or other staff members) rather than trained interpreters is rightly criticised for the many risks that this can pose, there is also a case for using such people in certain situations.

Health professionals need to become more aware of the importance of this issue and, crucially, need training in the complexity of the decisions around interpreter use. A systematic approach needs to be taken to improve communication with Limited English Proficiency (LEP) patients; merely addressing the content of a particular consultation may not be enough. With this in mind, this toolkit has been developed to be used within practices for staff training and continuous quality improvement. It contains a range of tools (flowcharts, scenarios and explanatory boxes addressing specific issues) to suit different purposes and different styles. They fit with the 'Voyage to Quality' framework developed by Perera,[27,28] which presents quality as something that can be addressed through structures, processes and outcomes – all of which interact in complex ways.

BUDGET CONSTRAINTS

Paying for interpreters is a big problem. There are times when using an interpreter can save money by more efficient use of staff time. There is a continuum in usage from fully funded and high use of trained interpreters to little use of trained interpreters because of no funding. We argue that clinicians should be making a conscious choice when they proceed with an untrained interpreter, based on an assessment that the clinical and medico-legal risks are low enough to justify this choice. We also argue that if a clinician does not know how to contact an interpreter, has not thought of clinical and medico-legal risks and has no budget for employing interpreters, then there will be occasions when LEP patients will receive unacceptable levels of care. Lobbying of funding agencies may be needed to establish budgets to provide acceptable care.

OUTLINE OF TOOLKIT

This toolkit is aimed at improving the decision making in this complex area. The first flowchart in the toolkit relates to structures, specifically the systems in a practice. It first focuses attention on basic requirements for patient records, then directs attention to policy issues which may more or less important depending on number of LEP patients seen in the practice. Seven action areas are described: budget, threshold for when interpreters are needed, interpreter sourcing, speaker phone availability, staff training, patient information and incident management systems.

The remaining flowcharts (2-4) deal with the decisions that need to be made when a patient from a Non-English Speaking Background (NESB) presents. They guide clinicians from the broadest question of whether an interpreter is needed through the increasingly focused case-by-case decisions involved in choosing the best kind of interpreter for the situation.

Several clinical scenarios with LEP (Limited English Proficiency) patients follow to illustrate situations that may arise and what actions or considerations should be followed in these circumstances. Eight boxes dealing with specific issues relating to interpreter use follow this.

CAVEATS

We wish to avoid giving the false impression that if this toolkit is fully implemented, some kind of interpreting ideal will be reached. We acknowledge that there are imperfections in any consultation; with LEP patients, there is a higher risk of miscommunication, and using an interpreter (not matter how well trained) inevitably adds another level of communication with potential for imperfections. Clinicians need to be aware of this potential in all interpreted consultations, as illustrated in the real-life examples given below.

REAL-LIFE EXAMPLES OF INTERPRETING ISSUES

Studies of actual clinical interactions in New Zealand have illustrated the types of errors and problems that can occur when interpreters (trained or otherwise) are used. Use of ad hoc interpreters (such as family members) can be very problematic when the person interpreting has insufficient English to do the job. For example, in one such consultation, a doctor spent about two minutes and three attempts to obtain an answer to the simple question: ‘how long has that problem been going for?’ This wastes a lot of time and it would be more efficient to obtain a trained interpreter on the phone, or to reschedule such an appointment to a time when a trained interpreter (or a more appropriate ad hoc interpreter at least) is available.

Even when an interpreter has sufficient language ability, it is quite likely that there will be omissions when they interpret what the clinician or patient has said. While this is more likely with untrained interpreters, it also occurs in perhaps more minor ways with trained interpreters. For example, a trained interpreter was seen to make a number of small omissions, including some of the empathic talk that the doctor used (e.g. ‘I’m sorry, you’re probably sick of them’ and ‘unfortunately’). This may or may not affect the success of the consultation.

Misinterpretation is another possible error type that can occur. In one diabetes consultation, the patient said that he had only been drinking water since coming to diabetes appointments. This was misinterpreted as ‘he’s been having a lot

fluid, the water intakes after coming to the appointments' which then led the clinician to talk about wanting to drink a lot being a symptom of diabetes, when in fact the patient was giving evidence of changed dietary habits in response to his diagnosis. Such misinterpretations do not necessarily lead to any consequential problems, but they might.

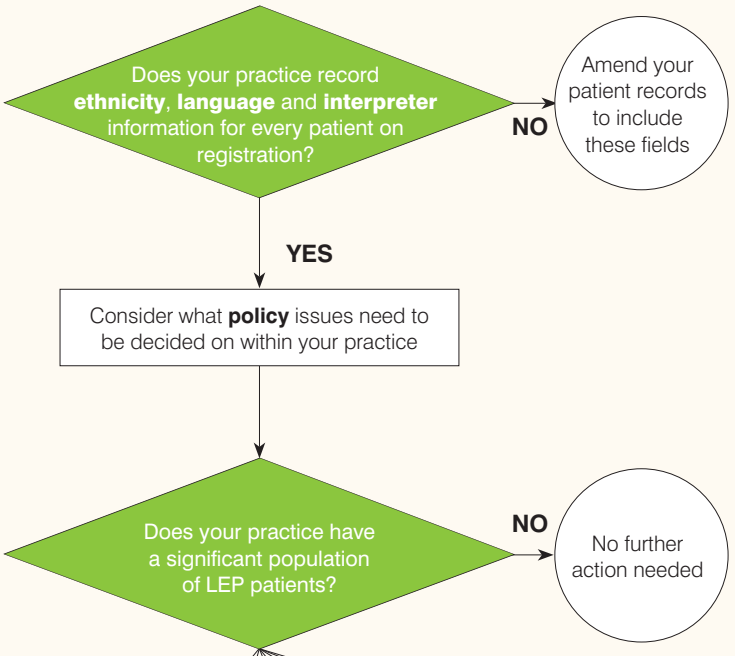
Another kind of problem in an interpreted consultation can be with the guideline for clinicians to direct their eye gaze towards to patient and speak directly to them (e.g. 'How are you?' spoken to the patient, rather than 'How is he/she?' to the interpreter). One patient whose consultations were recorded consistently avoided eye contact with the clinician most of the time. In response to this, the clinician understandably directed her gaze and speech more towards the interpreter. The individual circumstances will determine whether this is problematic or not.

FURTHER INFORMATION

The components of this toolkit are designed to be used as and when appropriate within individual practices that choose to focus on communication with LEP patients as a quality activity. See Gray et al.[29] for further detail on the studies that informed the development of this toolkit and for further references.

APPENDIX 3: Interpreter flowcharts

INTERPRETER FLOWCHART 1: PRACTICE REQUIREMENTS



Patient records
The RNZCGP Standards for NZ General Practice *Aiming for Excellence* (Indicator 22) states that the following should be recorded for each patient:

Demographic data
- Ethnicity
- Primary language
- Interpreter needed

Medical records
- Limited English Proficiency (this should include some assessment of their level of English)

Consultation records
- Name of interpreter used

Referral letters
- Referral letters automatically include whether an interpreter is needed and language required

In addition, some method should be found to indicate further detail:
- who their preferred/regular interpreter is
- whether or not a longer appointment should be routinely booked
- where applicable—additional languages spoken (for rare languages, an interpreter may not be available in their primary language, but there may be another language that they can communicate in)

Assign a **budget** for the employment of interpreters

Establish a policy for what the **threshold** should be for when an interpreter is needed (i.e. when 'interpreter needed' should be entered in a patient record) – in accordance with the available budget

Establish in advance where to **source interpreters**. Become a member of Language Line; locate face-to-face interpreters; if patient numbers in a language group justify it, consider hiring a regular face-to-face interpreter *(see Interpreter Flowchart 4)*

Have a **speaker phone** available in at least one consulting room to facilitate telephone interpreting

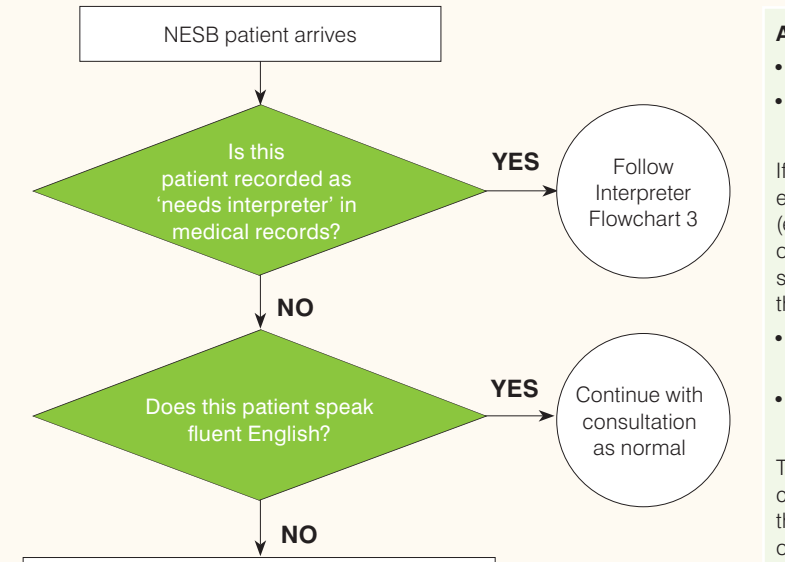
Provide **staff training** for all doctors, nurses and receptionists on:
- How to determine the need for an interpreter *(See Box 1)*
- How to determine the appropriate type of interpreter *(See Box 2)*
- How to access a trained interpreter
- How to work with an interpreter *(See Box 3)*

Consider making all **patient information** accessible to LEP patients (either in writing for the more common languages in your practice, or via interpreters).

This includes particularly:
- Information required for informed consent
- Signage
- Health promotion material

Make sure that your **Incident Management System** can flag incidents where a language barrier may have been a factor

INTERPRETER FLOWCHART 2: IS AN INTERPRETER NEEDED WHEN A PATIENT IS FROM A NON-ENGLISH SPEAKING BACKGROUND (NESB)?



Assessing English language ability

- to determine the need for an interpreter, or
- to evaluate the suitability of an untrained interpreter

If you suspect that a patient may not have enough English for a safe clinical consultation (e.g. their responses are only to nod or say 'yes' or they give inappropriate or inconsistent answers to questions), it is a good idea to confirm this by a simple test of their English:

- Ask an open-ended question (one that cannot be answered with just 'yes' or 'no')
- Ask them to repeat what you have just said in their own words.

The need for an interpreter may vary with the complexity of the consultation, but be aware that unexpected issues may arise during an otherwise simple consultation that may bring about the need for an interpreter when none was needed previously.

This can also be used to assess whether an untrained interpreter that has been proposed has sufficient English for the task.

Clinical presentation

Complexity

There is a continuum from simple to complex clinical presentation. Judgment will be needed as to whether the complexity warrants an interpreter in view of the level of English of the patient.

Sensitivity

In matters relating to sexuality or where abuse is suspected, careful judgment will have to be made of the best option if interpreting is needed (e.g. with respect to gender and family relationships).

Urgency

Urgency of need may lead to using 'the best available' option for an interpreter.

Vulnerability of patient

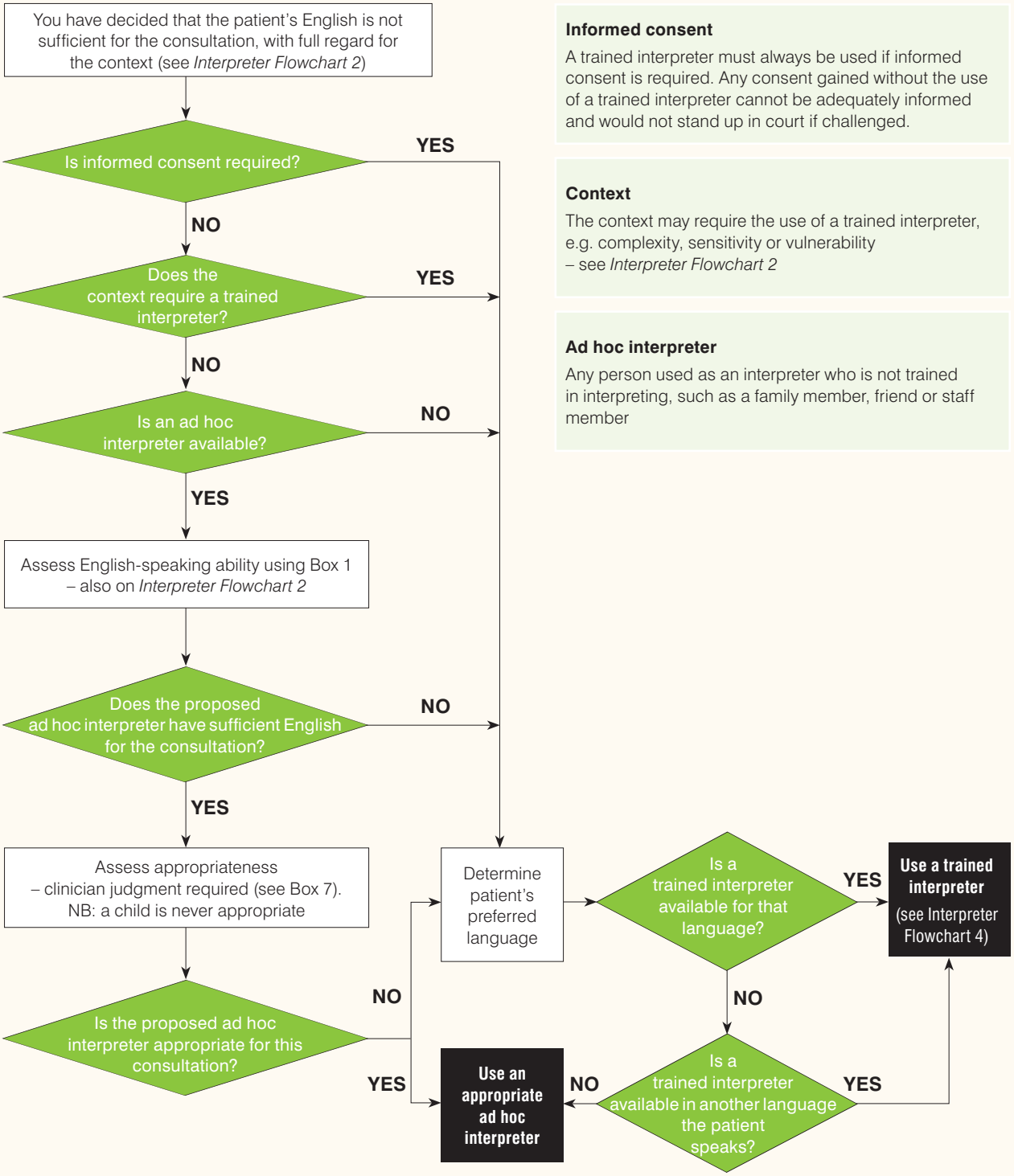
Patients from a refugee background or from a background that includes the likelihood of trauma are challenging to manage. Failure to use a trained interpreter is likely to make useful discussion of trauma issues impossible. Such issues are only likely to be able to be addressed with continuity of care and development of trust in both the clinician and the interpreter.

Wishes of patient

This includes issues of trust and confidentiality, and any stress or anxiety that insisting upon professional interpreting may bring – keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters.

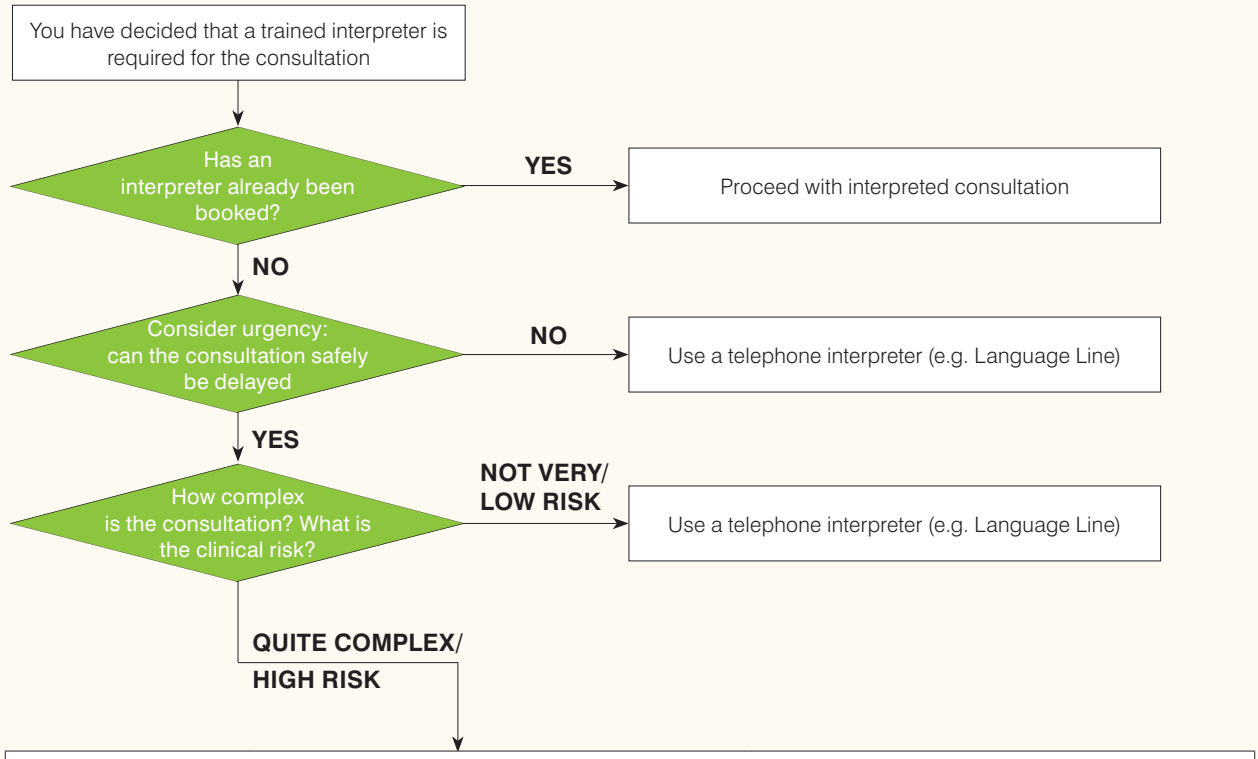
If, after assessing English ability in light of the context, an interpreter is needed, follow Flowchart 3

INTERPRETER FLOWCHART 3: TRAINED OR AD HOC? CHOOSING THE BEST INTERPRETER ON A CASE-BY-CASE BASIS



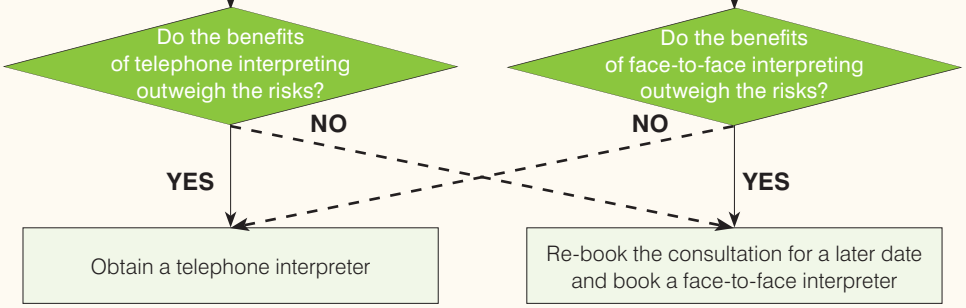
INTERPRETER FLOWCHART 4: CHOOSING THE BEST TRAINED INTERPRETER FOR THE SITUATION

A face-to-face interpreter is usually preferred (if possible) so that non-verbal communication and visual cues can also be interpreted and to avoid the distancing effect of the telephone



Consider the risks and benefits of using a telephone interpreter versus a face-to-face interpreter

	Telephone interpreter	Face-to-face interpreter
Benefits	• Anonymity of interpreter • Availability (greater availability for small language groups; available at short notice)	• Relative ease of communication including non-verbal • Easier if needing to consult with a family group
Disadvantages/risks	• Distancing effect of the phone • Possible background noise • Difficulty in gauging quality of interpreting • Lack of continuity	• Possible issues with confidentiality/comfort if the patient and interpreter are from a very small ethnic community



CLINICAL SCENARIOS WITH LEP (LIMITED ENGLISH PROFICIENCY) PATIENTS:

1. BOOKED APPOINTMENT

If a patient is coded as needing an interpreter, at the time of coding the notes should include who or what type the usual interpreter should be: face to face, telephone or ad hoc (and updated if further information comes to light). If such a patient books an appointment, their usual interpreter should be arranged in advance by practice staff.

2. LEP PATIENT ARRIVES WITHOUT INTERPRETER

- Assess English ability (see Box 1 below)
- How well do you know the patient? Have they previously been assessed as needing an interpreter?
- How easy is it to get an interpreter and how urgent is it to complete the consultation?
- Consider likely complexity of consultation
- Consider likely clinical risk of consultation

Action:

If a face-to-face interpreter is required and the appointment can be safely delayed, do so and book a face-to-face interpreter.

If a face-to-face interpreter is not considered necessary for the consultation at hand or if it is urgent, contact and use a phone interpreter (if available) on the spot.

3. LEP PATIENT ARRIVES WITH FRIEND/FAMILY MEMBER (AD HOC) TO INTERPRET

Before you decide whether to go ahead with this interpreter or obtain a trained interpreter instead, consider the following:

- How well do you know the patient and the ad hoc interpreter? Has this combination worked for previous consultations?
- How easy is it to get an interpreter and how urgent is it to complete the consultation?
- Assess the English ability (see Box 1 below) of the patient and proposed interpreter
- Consider the likely complexity of the consultation
- Consider the likely clinical risk of the consultation
- Consider the ethical issues that apply to this particular situation (see Box 4 below)
- Consider the benefits of using the chosen ad hoc interpreter (see Box 6 below)
- Is the patient aware of the interpreter options available?
- What is the health literacy status of the patient?
- How confident and competent do you feel with this ethnic group?
- Will using a professional interpreter instead cause interpersonal problems with the family, or undue stress or anxiety to the patient?

4. PROBLEMS ARISE DURING THE CONSULTATION

– for example, status quo (no interpreter/ad hoc interpreter) is not working

- Employ telephone interpreter on the spot, or
- Reschedule for a later appointment with a trained interpreter, on site or by telephone

(BOXES FROM TOOLKIT FOR USING INTERPRETERS IN GENERAL PRACTICE):

BOX 1: ASSESSING ENGLISH LANGUAGE ABILITY

- to determine the need for an interpreter, or
- to evaluate the suitability of an untrained interpreter

If you suspect that a patient may not have enough English for a safe clinical consultation (e.g. their responses are only to nod or say 'yes' or they give inappropriate or inconsistent answers to questions), it is a good idea to confirm this by a simple test of their English:

- Ask an open-ended question (one that cannot be answered with just 'yes' or 'no')
- Ask them to repeat what you have just said in their own words

The need for an interpreter may vary with the complexity of the consultation, but be aware that unexpected issues may arise during an otherwise simple consultation that may bring about the need for an interpreter when none was needed previously.

This can also be used to assess whether the untrained interpreter who has been proposed has sufficient English for the task.

(Based on guidelines from the American Medical Association, Auckland DHB and Waitemata DHB)

BOX 2: HOW TO CHOOSE AN APPROPRIATE INTERPRETER FOR YOUR SITUATION

The best interpreting option needs to be decided case by case. The following issues need to be considered.

Interpreter availability

Telephone interpreting is by far the best option because of ease of availability, but this does need to be weighed against the costs (in New Zealand) and the disadvantages of telephone interpreting, such as lack of continuity and personal relationship, the need to interpret body language, patient intolerance of phone use and possible problems with background noise. Face-to-face interpreters are more expensive and likely to be more limited in availability.

Characteristics of the interpreter

Depending on the situation, you may need to consider the gender of the interpreter and their ethnicity (a common language does not always mean common ethnicity, a potential problem especially where patients are from countries at war).

Language ability

English proficiency of the patient (and of the proposed interpreter if an untrained interpreter is considered) must be assessed. In addition, the language to be used for interpreting is a consideration - does the proposed interpreter (trained or untrained) speak the patient's native language, or their second language? Do they share the same dialect? This may affect the quality of the interpreting.

Familiarity with patient and family interpreter

A clinician can judge the English ability of an LEP patient (or family interpreter) over a number of consultations and determine with some accuracy what their language competence is (and their appropriateness as an interpreter, if relevant).

Vulnerability of the patient

Patients from a refugee background or from a background that includes the likelihood of trauma are challenging to manage. Failure to use a trained interpreter is likely to make useful discussion of trauma issues impossible. Such issues are only likely to be able to be addressed with continuity of care and development of trust in both the clinician and the interpreter.

Clinical presentation

This is important for several reasons – the complexity may affect how much language is needed, and the nature of the issue may make it necessary to consider the gender of the interpreter and the relationship to the patient, factors that may rule out any consideration of using family members for some sensitive discussions. Urgency of need may lead to using 'the best available'.

The wishes of the patient

This includes issues of trust and confidentiality, and any stress or anxiety that insisting on professional interpreting may bring, keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters.

The patient's need for advocacy and/or ongoing support

This may make using a family member better if a suitable one is available, although there is nothing precluding using a trained interpreter and having the family member present also.

Seeking informed consent

Any consent gained without the use of a trained interpreter cannot be adequately informed and would not stand up in court if challenged. A trained interpreter must always be used if informed consent is required.

Use of children

Non-adult children should not be used as interpreters due to the high risk of both linguistic and ethical issues, such as with the quality of the interpreting (due to their limited medical vocabulary and health literacy) and the ethical issue of requiring a child to take on such a potentially stressful role.

Other issues

Other issues that may influence the decision include the level of health literacy of the patient and the confidence and competence of the clinician with the cultural group concerned.

BOX 3: HOW TO WORK WITH AN INTERPRETER

What to do when using any kind of interpreter (trained or not)

- Introduce all the participants to each other (if necessary) and state the purpose of the consultation
- If using a trained interpreter, inform the patient that the interpreter will maintain confidentiality
- Talk directly to your patient as if you speak the same language (use 'I' and 'you')
- Speak clearly, with frequent breaks
- Don't interrupt or talk over others
- Don't ask the interpreter to step out of role, for example to give an opinion
- Provide written information in the patient's language where possible (much is available on the internet)

Face-to-face

- Sit opposite the patient
- Position the interpreter at an equal distance from you both (for example in a triangle)
- Maintain normal eye contact with the patient

Telephone

- Use a speaker phone if possible
- Wait while the interpreter is connected to the call

Cultural misunderstandings

- Be aware that cultural misunderstandings may impede communication, but that the interpreter and patient may not necessarily share the same cultural understandings
- Ask the interpreter for comment if you suspect a cultural misunderstanding, but ask them to repeat all cultural information that they give you to the patient as well to check they agree
- Allow the interpreter to volunteer cultural information if they think it is helpful

After the consultation – with trained interpreters

- Offer the opportunity for a debrief if the consultation was emotionally taxing
- Plan follow-up appointments so as to arrange continuity of interpreting if possible

Using untrained interpreters

- Ask them to interpret everything that you and the patient say, even if it doesn't seem important
- Be alert to any difficulties arising and switch to a trained interpreter if possible (at another appointment or immediately on the phone if urgent)
- Err on the side of very short turns at talk and interrupt and seek more information if a long turn at talk in the foreign language is followed by a short interpretation

BOX 4: ETHICAL ISSUES IN INTERPRETING SITUATIONS

Use of children

Children should not be used due to problems with conflicting family roles and the emotional and maturity levels to cope with difficult situations.

Confidentiality/openness

In some situations problems may arise from the interpreter being privy to the medical consultation. This is less likely with trained interpreters due to their training and ethical code of conduct, but may still arise in very small ethnic communities where patients may not wish the interpreter to know their problems. It is more of an issue with untrained interpreters, where the relationship may make open discussion of certain matters difficult.

Gender issues

Some matters will be best discussed with an interpreter of the same gender, especially but not only in the case of untrained interpreters.

Torture or trauma

For patients from a refugee or other background where there is the possibility of torture and trauma in their history, it is even more important to use a trained interpreter.

BOX 5: WHEN CAN A FAMILY MEMBER/FRIEND BE CONSIDERED AS AN ACCEPTABLE INTERPRETING OPTION?

A family member or friend may be a good option as an interpreter when specific conditions are met, such as when the untrained interpreter:

- has enough English to effectively interpret
- is not a child (under 18)
- is known to the clinician to be reliable and in a good relationship with the patient

and, when the consultation is fairly straightforward and non-sensitive.

BOX 6: POTENTIAL BENEFITS OF USING AN UNTRAINED/AD HOC INTERPRETER

If the untrained/ad hoc interpreter has adequate English ability, is over 18 and has a good and appropriate relationship with the patient, the following benefits **may** apply:

- High degree of trust and comfort for the patient
- Continuity of interpreting
- Advocacy for the patient
- Ongoing support for the patient within and outside the consultation
- Lack of financial cost

BOX 7: ASSESSING THE APPROPRIATENESS OF AN AD HOC INTERPRETER (CLINICIAN JUDGEMENT IS REQUIRED)

Consider:

- Relationship to the patient/clinician (is there a good relationship?)
- Clinical presentation (ad hoc interpreters are more suitable for simple matters)
- Wishes of the patient (this includes issues of trust and confidentiality, and any stress or anxiety that insisting on professional interpreting may bring, keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters)
- Patient's need for advocacy or ongoing support (this may make using a family member better if a suitable one is available, although there is nothing precluding using a trained interpreter and having the family member present also)
- Familiarity of clinician with the patient and ad hoc interpreter (a clinician can judge the English ability of an LEP patient or family interpreter over a number of consultations and determine with some accuracy what their language competence is and their appropriateness as an interpreter, if relevant)
- Gender (is the gender of the proposed interpreter suitable for the nature of the consultation?)
- Health literacy of the patient or proposed ad hoc interpreter (a trained interpreter may be helpful in cases of low health literacy)
- Clinician familiarity with the ethnic group (if you feel confident and competent in dealing with this group, this may lessen the need for a trained interpreter)

Note: Children should not be used. In exceptional circumstances, such as when there is no other option in an urgent situation, or for a very simple matter, a child might be considered as a last resort.

BOX 8: FINDING THE RIGHT TRAINED INTERPRETER

1. Find out the preferred language of the patient (Language Line have posters that can help with this).
2. Find out whether a trained interpreter is available for this language.
3. If options exist, decide whether a face-to-face or telephone interpreter is the best option (see Box 9 for the benefits and risks of each).
4. Where options exist, consider the suitability of the interpreter for the patient and the situation. This may include, where appropriate, gender, ethnicity (sharing a language may not mean sharing ethnicity and may be an issue where there has been ethnic conflict), and relationships within the ethnic community.
5. If the language is rare and no trained interpreter is available for it, find out whether the patient speaks another language.
6. Find out whether a trained interpreter is available for this second language.
7. If interpreting is provided in a patient's less preferred language, communication may be impaired even with the interpreter, so take extra care.
8. If no trained interpreter is available, seek help from whatever ad hoc interpreter can be found as a last resort.

BOX 9: CHART OF DIFFERENT INTERPRETER OPTIONS

Note: Patients should be informed of all the options available to them

	Type of interpreter	Advantages/benefits	Disadvantages/risks	Caveats and comments
PROFESSIONAL	**All**	• Trained in the skill of interpreting • Excellent language skills • Training in medical terminology • Training in ethics		
	In-house	• Continuity and ability to develop a relationship of trust • Face-to-face interaction	• If in a small ethnic community, patients may have issues with confidentiality and comfort	• Only possible if a large enough language group exists in a practice and there is a budget for it
	Face-to-face	• Face-to-face interaction	• If in a small ethnic community, patients may have issues with confidentiality and comfort • Lack of continuity	• Must be booked in advance
	Telephone	• Anonymity of interpreter • Greater availability when dealing with small language groups • Available at short notice	• Distancing effect of phone • Possible background noise • Difficult to gauge quality of interpreting • Lack of continuity	• Language Line only available during business hours • Language Line: http://www.ethnicaffairs.govt.nz/oeawebsite.nsf/wpg_url/language-line-Index
NON-PROFESSIONAL	**Bilingual staff member or medical student**	• Available at short notice • Potential continuity	• Potential role confusion • Uncertain language skill • Lack of interpreter training • Patient expectations of more than interpreting	• Need to be fully briefed about how to interpret • Agreement to work in this role needs to be soug…ht ahead of time
	Family/friend	• Continuity • Advocacy • Ongoing support (outside the consultation) • Trusted by patient • Comfort to the patient (Note: these benefits are not necessarily present and clinicians need to assess if this is the case)	• Uncertain language skill • Likely lack of medical terminology • Potential for inaccuracy, omissions and additions • Threat to confidentiality and privacy • Difficulty with sensitive discussions (depending on the relationship) • Potential conflict with usual family roles and dynamics • Own agenda of 'interpreter'	• Appropriate only for less complex clinical presentation • Clinician will need to assess language ability and appropriateness

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The Royal New Zealand
College of General Practitioners

Level 3, 88 The Terrace, Wellington 6011
PO Box 10440, Wellington 6143

Telephone: +64-4-496 5999
Facsimile: +64-4-496 5997

rnzcgp@rnzcgp.org.nz
www.rnzcgp.org.nz