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LANGUAGE BARRIERS IN NURSING CARE

A literature review of the effects and used strategies

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Abstract:

Nurses today are faced with the challenges of caring in a multicultural environment. One of these challenges is the inability to communicate with the patient due to differences in language. Communication plays a key role in the nurse-patient relationship and determines the outcome of the care provided. The theory of transcultural nursing aims to educate nurses in providing person-centred culturally competent care and is a suggested strategy to overcome the barriers. Previous research from mixed healthcare professionals' perceptions identify some effects and strategies, however without providing specific in depth insights into nursing. The aim of this study was to examine the effects of language barriers due to cultural differences on nursing care. An integrative literature review was conducted. Inclusion and exclusion criteria guided the selection. A literature search originating from the databases CINAHL and PubMed resulted in 15 included articles; 12 qualitative, two quantitative and one mixed-methods study. The analysis of the results gave rise to two major themes; *effects on nursing* and *strategies*. The results showed that nurses became aware of the effects both culture and language have on caring. Despite the time-consuming efforts of bridging the barrier, patients felt that the nurses' attempts were inadequate. Non-verbal gestures and the use of familiar language were appreciated in providing safety and trust but insufficient when providing information. The most preferred strategy of using a formal interpreter was thwarted by lack of organisation and education. In order to ensure culturally competent care, nurses need more education as well as access to resources. Further research with quantitative approaches are required in order to generalise and impact the subject area. Patient- and clinic-focused methods could potentially highlight the current environment as experienced by patients accessing health care despite language barriers.

Key words: language barriers, communication barriers, transcultural nursing, cultural competence, nursing care, interpreters

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Introduction

Increasing migration patterns are making Sweden a multicultural society (Kersey-Matusiak, 2015b). In the past decade the number of people living in Sweden who were born abroad has increased by half a million (Statistiska Centralbyrån, 2016). Moreover, conflicts around the world have forced people to displace themselves to other countries in search of humanitarian assistance. In Sweden the number of people seeking asylum increases with every year (Migrationsverket, 2016).

Gaining an optimal standard of health and access to healthcare is a fundamental human right (World Health Organisation, 2015). For people living in a country where they are part of a minority group, accessing health care can be precarious due to language barriers.

Clinical practices, personal experiences and work in health care in segregated areas have provided insight on the issue. Nursing education mentions the complexity of language barriers without the opportunity to delve deeper into the subject. Nurses are the outward face for both healthcare and society and have to be prepared to treat people regardless of the challenges. The subject area has been selected as an acknowledgement to the issue, recognising it as both a contemporary and future problem.

Background

Communication

Communication is a way of sharing information, feelings or ideas (Giger, 2013). People are able to send different messages by verbal or non-verbal means. Ultimately a connection is created where in the best of cases mutual understanding is achieved (Baggens & Sandén, 2014). In addition to allowing the transferral of thoughts and information, communication is important in building relationships and trust. Both non-verbal and verbal aspects have an impact on the interpretation of the communication.

Non-verbal communication comprises the messages sent by the human body both consciously and unconsciously (Baggens et al., 2014; Giger, 2013). Facial expressions, eye contact, touch and other forms of body language are part of this communication, each having a purpose. Although this enables direct communication, it lacks the profundity which verbal communication through a shared language provides.

Verbal communication is a means of accessing a person's thoughts or complex feelings through the use of language (Giger, 2013). What is said and how it is said affect how the receiver interprets the message. The meaning the words hold are formed by the individual's background and experiences. Adjusting intonation, speed and volume is a way of displaying different emotions. There is no right or wrong in verbal communication, as different languages engage in different patterns based on the grammatical needs (Kersey-Matusiak, 2015b).

Communication and nursing

The essence of nursing is to provide care that promotes health and well-being (Baggens et al., 2014). Establishing a functioning nurse-patient relationship is a way of achieving this.

Fundamental for the relationship is gaining the patient's trust, which relies on communication (Davidhizar & Giger, 2000). The communication can be signalled verbally or

non-verbally in all encounters with the patient. For nurses, who are often the first contact in health care, communication entails everything from aiding in activities of daily living to achieving care plans and motivational interviews (Baggens et al., 2014).

By being allowed to express their identity, thoughts and needs to the nurse, patients can be included in their care (Carnevale, Vissandjée, Nyland & Vinet-Bonin, 2006; Eldh, 2014). Inclusion in care promotes empowerment (Eldh, 2014). Furthermore the information collected provides the foundation for assessing the patient's situation and responding accordingly; which is part of the nursing process (Giger, 2013).

According to Swedish law, patients have a right to participate in their care as well as receive information that is customised according to their needs (SFS 1982:763; SFS 2014:821). The Patient Act establishes that nurses and other health care personnel are obliged to make sure that patients and their relatives receive and understand health-related information (SFS 2010:659; SFS 2014:821). Patient safety, confidentiality and consent for treatment and care can be upheld through effective communication (International Council of Nurses, 2012).

Culture

Culture is the worldview, beliefs, values and communication such as language that is passed on from generation to generation and inherited through social interaction (Giger, 2013; Jirwe, Momeni & Emami, 2014; Leininger & McFarland, 2006). Culture determines behaviour and decision-making becoming a part of a person's life and way of expressing themselves (Giger & Davidhizar, 2002). Background, social relations and geographical environment influence culture formation making it dynamic. The values learned through culture affect how health, wellbeing, death and disability are viewed and treated (Leininger & McFarland, 2006). For the purpose of limiting this paper "cultural differences" refers to the arising disparities when meeting people from different countries.

Cultural awareness emerges when meeting people from different cultural backgrounds (Jirwe et al., 2014). In these encounters, it is possible that certain cultural assumptions are made about people who are perceived as foreign. Appearing to have a different ethnicity is used by others to label a culture and associate it with certain prejudices. The cultural assumptions can be interpreted as the reason for certain behaviours which can become an issue when immigrants and ethnic minorities come in contact with health care (Jirwe et al., 2014).

Language and culture

Language and culture co-exist as cultural influences are reflected in language (Ferraro & Andreatta, 2014). Language is a way of expressing a culture. Each culture assigns different meanings to expressions and words (Giger; 2013, Jirwe et al., 2014) and in some cases there are no words for expressing different phenomena (Fadiman, 2012). Therefore being proficient in a language does not automatically imply a shared culture or even knowledge of it (Jirwe et al., 2014). The opposite is also true; not being able to speak a language does not necessarily entail behavioural differences associated with culture.

Theory of transcultural nursing

Nursing theories have recognised the effect culture has on health care. Transcultural nursing was first introduced by Leininger as the Culture Care Theory in the 1960s (Leininger & McFarland, 2006). It is a holistic nursing theory focused on care in relation to culture. Care is defined as the foundation for health, wellbeing and growth and is the essential focus of nursing. Leininger's theory builds on the cultural knowledge gained by studying people found in separate geographical environments. Other theorists have used Leininger's theory as groundwork and further developed it.

The metaparadigm of transcultural nursing by Giger & Davidhizar (2002) includes knowledge of health and wellness in relation to culture and the individual. Nurses ought to be aware that every person is culturally unique with different experiences that have shaped their identity and worldviews. It is furthermore essential for nurses to reflect on their own cultural background, values and prejudices in order to prevent projecting them onto the patient (Giger, 2013; Kersey-Matusiak, 2015a, Maier-Lorentz, 2008). Reflection aids in overcoming ethnocentrism which is the belief that one's own culture is superior (Giger, 2013).

Having learned the above, nurses should apply relevant health-promoting care strategies in all environments where nursing work takes place (Giger et al., 2002; Giger, 2013; Kersey-Matusiak, 2015a). Once this is done, cultural competence can be achieved. Cultural competence, cross-cultural competency, cultural congruence, culture care and culturally congruent or sensitive care are concepts used interchangeably (Shen, 2015). From here on "cultural competence" will be the term used.

To summarise, transcultural nursing is a means of providing person-centered, culturally competent care. In order to facilitate cultural competence and identification of cultural differences Giger and Davidhizar designed a Transcultural Assessment model (Giger et al., 2002; Giger, 2013). The model provides tools for assessment of the culturally unique individual based on six cultural phenomena: communication, space, social orientation, time, environmental control and biological variations. The key of the assessment model is the focus on the individual and what cultural aspects are of importance to them (Giger, 2013).

In order to limit this paper, communication is the only tool that will be discussed. Realising that all forms of communication are culturally bound is imperative for nurses' transcultural assessments. Vocal cues such as intonation and volume as well as non-verbal strategies such as body language and gestures are interpreted differently, thus requiring awareness from the nurse. Adopting a non-threatening, respectful and patient attitude in all forms of communication is imperative for the outcome of the nurse-patient relationship, especially if there is a language barrier (Giger, 2013).

Language barriers in health care

When it comes to communicating complex issues such as those concerning health, verbal communication through a shared language is unrivalled (Giger, 2013; Baggens et al., 2014). If the patient and the caregiver do not share a common language due to different cultural backgrounds, language becomes a barrier. Language barriers, linguistic barriers, limited language proficiency and language discordance are used interchangeably (Jacobs, Chen, Karliner, Agger-Gupta & Mutha, 2006). From here on the only term used will be "language barriers" and only in reference of being due to cultural differences. Increasing migration patterns have made encountering language barriers in health care a common occurrence (Giger, 2013; Kersey-Matusiak, 2015b).

Previous research shows that language barriers between patients and healthcare professionals led to incorrect referrals, longer waiting times, longer clinical encounters and an increased risk for errors such as misdiagnoses (Bischoff, Bovier, Isah, Françoise, Ariel & Louis, 2003; Carnevale et al., 2009; Flores, 2005; Maier-Lorentz, 2008). Furthermore, compliance was low and patients returned to the hospital more often than necessary, despite expressing dissatisfaction in the care received (Carnevale et al., 2009).

As mentioned above, communication is an essential aspect in providing culturally competent care. Language barriers are therefore important to overcome. Applying transcultural nursing is suggested, along with previously studied practical strategies (Flores, 2005; Jacobs et al., 2006, Maier-Lorentz, 2008). Staff communicating directly in the patient's primary language is perceived as the most satisfying alternative for the physician-patient relationship. Yet misinterpretations occurred and accuracy was questioned, especially in cases where an intensive language course was the source of the language skills (Flores, 2005; Jacobs et al., 2006). Instead, the preferred strategy to bridging language barriers is the use of professional interpreters (Carlsson & Björk Bramberg, 2014; Carnevale et al., 2014; Flores, 2005; Kersey-Matusiak, 2015b, Labun, 1999; Karliner, Jacobs, Chen & Mutha, 2007). However, due to lack of knowledge of interpreter services and incorrect language assessments the interpreter used was often a family member, friend, other patient or an unrelated person (i.e. cleaning or restaurant staff) all of which are referred to as informal "ad hoc" interpreters (Bernard et al., 2006; Jacobs et al., 2006; Kersey-Matusiak, 2015b). Instead of viewing interpreters as objective neutral translators (Carlsson et al., 2014) the content should be placed in a cultural context to ensure correct communication (Labun, 1999; Kersey-Matusiak, 2015b; Winkelman, 2009).

Problem

Language barriers are considered to be a significant problem given their effect on health care (Carlsson et al., 2014; Jacobs et al., 2006; Schwei et al., 2016). The effects of language barriers and some strategies to overcome them have been previously studied from mixed health care professionals' perspectives or physician-patient perspectives (Bernard et al., 2006; Flores, 2005; Jacobs et al., 2006; Schwei et al., 2016).

Recent evidence concerning attitudes and strategies specific to nursing care is scarce (Bernard et al., 2006; Blackford, Street & Parsons, 1997). Previous research suggests that nurses have trouble assessing language needs and do not know how to overcome language barriers (Blackford et al., 1997). Nursing knowledge and actions should reflect the increasing cultural diversity in Sweden. Considering the role nurses have in the everyday care of patients (Baggens et al., 2014), studying language barriers in relation to nursing care is important to be able to ensure the quality of care for patients with different cultural backgrounds. A review of the literature can provide an outline of nursing knowledge concerning the subject, eventual gaps as well as strategies to overcome this issue.

Aim

The aim of this study was to examine the effects of language barriers which arise from cultural differences on nursing care.

The following research questions were addressed:

- What are the effects of language barriers on nursing care?
- Which strategies are used to overcome the barrier?

Method

To assess the existing research within the problem area, the method of choice was an integrative literature review, as guided by Friberg (2012).

Literature search

After performing initial searches to get an overview of the subject area, structured searches were conducted using the online databases Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed (Karlsson, 2012). CINAHL Headings and Medical Subject Headings (MeSH) for the keywords “communication barriers”, “cultural competence” and “transcultural nursing” were used to ensure relevance to the subject. The word “nurs*” with truncation was added as an aiding tool in limiting results to the nursing field.

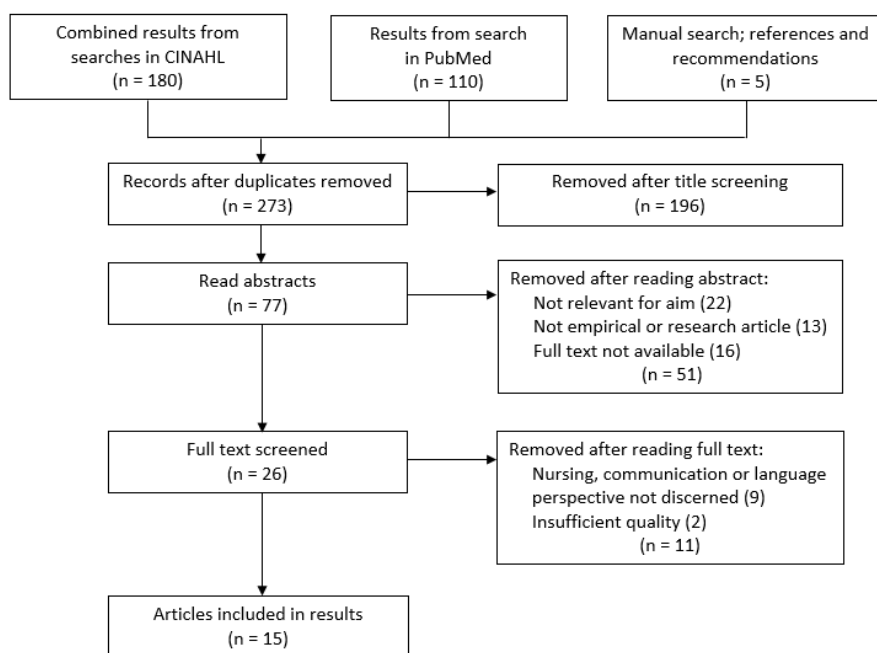
Inclusion was guided by the research questions. Only published, peer-reviewed research articles regarding language barriers in relation to nursing care were included. Limiting to articles published within the last ten years provided an insight in the research of recent years (Backman, 2008; Karlsson, 2012).

Articles discussing non-language related communication barriers (e.g. children, hearing impairments, dementia, aphasia and mechanical ventilation) were excluded. Also excluded were studies from contexts where care communication is complex, i.e. palliative care. Results where the nursing perspective was not discerned from other professions or students’ perspectives were excluded. The quality of the articles was assessed (see the section on Analysis) and only articles of medium to high quality were included.

Manual searches and the snowball method were used to review references from selected articles or article recommendations made by the databases (Karlsson, 2012).

A PRISMA flowchart inspired diagram of the literature search process is presented in Figure 1 (Friberg, 2012; Moher, Liberati, Tetzlaff, Altman & PRISMA Group, 2009). The database searches are presented in Appendix 1.

Figure 1. Flowchart of search process.



Analysis

The resulting articles were read several times to ensure understanding of them (Friberg, 2012). They were summarized in a separate document to ensure that no relevant aspects were excluded. Data from the articles' results relevant to the aim and research questions were compared and grouped into themes.

Quality was assessed based on the protocols by Willman, Stoltz & Bahtsevani (2011). Furthermore, the descriptions by Wallengren & Henricson (2012) were used to assess validity, reliability as well as credibility, dependability, confirmability and transferability.

Ethical considerations

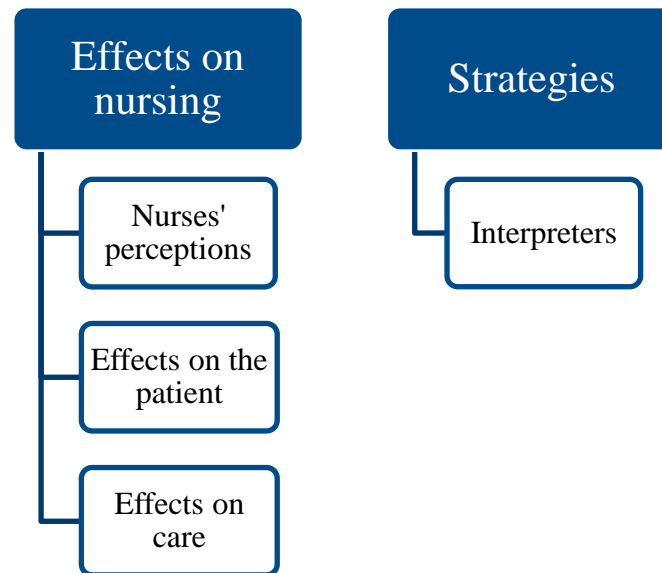
The studied area has value for clinical practice from a nursing, patient and societal perspective (Kjellström, 2012). Considering that a literature review requires no direct involvement in a clinical setting, no ethical approval was sought. As part of the quality check of the articles, the description of ethical considerations was taken into account (Willman, Stoltz & Bahtsevani, 2011). To prevent dishonesty and manipulation of data in the presenting of the articles' results, an open-minded attitude towards the subject was applied in the analysis process (Kjellström, 2012). Consequent referencing was used to prevent plagiarism.

Results

The search resulted in 15 articles. Two articles used quantitative methods, 12 articles were based on qualitative methods, and one used a mixed methods approach. Four articles included perceptions from patients, while the remaining articles were portrayed from the perspectives of health care professionals. The articles are presented in Appendix 2.

Guided by the research questions, two major themes arose: *effects on nursing and strategies*. The following subthemes were identified: *nurses' perceptions, effects on the patient, effects on care and interpreters*. The themes are presented in Figure 2.

Figure 2. Representation of resulting themes.



Effects on nursing

Nurses' perceptions

The inability to communicate due to language barriers left nurses feeling uncomfortable and inadequate in their work; not being able to provide the care they felt patients deserved (Jones, 2008; McCarthy, Cassidy, Graham & Tuohy, 2013; Nailon, 2006). Language barriers were also recurrently perceived as frustrating (Tuohy, McCarthy, Cassidy & Graham, 2008; Ian, Nakamura-Florez & Lee, 2015; Thyli, Athlin & Hedelin, 2007).

Nurses spent less time with the patients and more time in trying to find resources to bridge the language barrier (Nailon, 2006; Ian et al., 2015; Thyli et al, 2007). When discovering the time it took to overcome language barriers, nurses changed their approach and became better at planning and coordinating care (Ian et al., 2015).

Prejudices and biases expressed by nurses were identified as affecting communication (Hart & Marenó, 2013; Plaza del Pino, Soriano & Higginbottom, 2013). However once the language barrier was overcome the cultural differences could be identified and understood (Plaza del Pino et al., 2013). Nurses realised that in order to provide holistic care, an understanding of the patient is essential (Ian et al., 2015; Tuohy et al, 2008). From the interaction of cultures, the nurses gained insight of their own culture and how they projected it onto the patients (Hart et al., 2013; Thyli et al, 2007; Tuohy et al., 2008). The realisation of the effects of culture on health care inspired nurses to be patient, understanding and provide individual care (Jones, 2008; Ian et al., 2015).

Effects on the patient

The patients' vulnerability of being in an unfamiliar environment was further intensified by the inability to communicate needs (Eckhardt, Mott & Andrew, 2006; Sobel & Metzler Sawin, 2016). Moreover, the lack of involvement in their own treatment, which arose from

inadequate information provided, caused feelings of fear and frustration (Eckhardt et al., 2006). Patients expressed feelings of discrimination and abandonment despite needing help (Sobel et al., 2016) which is what some nurses feared would happen (Nailon, 2006; Thyli et al., 2007). Patients, aware of how busy nurses were and sensing frustration, were worried about being viewed as “troublemakers” or an inconvenience, which led to them being less prone to ask for help (Eckhardt et al., 2006; Sobel et al., 2016). Nurses however, described patients as being quiet and making no trouble of themselves (Plaza del Pino et al., 2013; Tuohy et al., 2008).

Patients heeded how nurses, who were their first contact in health care, were not properly able to assess their language ability and needs (Eckhardt et al., 2006; Sobel et al., 2016, van Rosse et al., 2016). For example, if a patient was able to speak a few words they could be mistaken for a fluent speaker or assessed to have no language skills at all (Sobel et al., 2016). Despite feeling that it is a nurse’s duty to ensure understanding, patients had no faith in the nurse’s ability to converse with them (Eckhardt et al., 2006). Instead, patients took on the responsibility of trying to learn the language or finding people who could help them, since requesting for an interpreter was difficult (Sobel et al., 2016).

Patients wished that nurses would put as much effort in bridging language barriers as in other nursing tasks, by learning how to correctly assess language skills and thereafter offering strategies to overcome the barrier (Eckhardt et al., 2006; Sobel et al., 2016). Patients also stressed a need for nurses to learn of cultural differences. Misunderstandings due to different interpretations of communication had implications on the care received (Eckhardt et al., 2006; Sobel et al., 2016).

Effects on care

Language barriers limited the information that could be collected from patients, providing a distorted image of the patient’s situation and needs, which affected nursing assessments and care (McCarthy et al., 2013; Nailon, 2006; Tuohy et al., 2008). Implementing small talk-tactics to ease patients was hindered by language barriers (Tuohy et al., 2008). Nurses were prevented in connecting and gaining trust from patients (Hart et al., 2013) therefore compromising the nurse-patient relationship (Jones, 2008).

Nursing tasks that are usually done by routine, such as informing the patient, performing identity-checks and risk assessments, were left out, leading to negative consequences of care (Eckhardt et al., 2006; van Rosse et al., 2016). Nurses also admitted to withholding information, especially that which was of severe nature, in fear of not being able to express it correctly (Tuohy et al., 2008). The outcome and care of the patients after discharge was also affected, with appointments missed, telephone follow ups left out or unsatisfactory, or revisiting the hospitals more than necessary (Hart et al., 2013; Jones, 2008; Nailon, 2006; van Rosse et al., 2015).

Strategies

In some cases nurses were described as taking no action to overcome language barriers; just “getting by” without communicating (Eckhardt et al., 2006; Schenker et al., 2011; van Rosse et al., 2015). The nurses working in silence were perceived as unsettling (Eckhardt et al., 2006).

Nurses often smiled at their patients to comfort them (Eckhardt et al., 2006). Smiling and other forms of non-verbal communications such as gestures, body language and general sign language were reported to have positive outcomes (McCarthy et al., 2013; Plaza del Pino

et al., 2013; Sobel et al., 2016). Patients felt this signalled the nurse's engagement and provided a connection (Sobel et al., 2016). Although the actions were deemed positive, non-verbal communication was recognised as insufficient in overcoming language barriers (McCarthy et al., 2013; Plaza del Pino et al., 2013).

A few studies mention the use of written information as an asset (Tuohy et al., 2008; Jones, 2008; El-Amouri & O'Neill, 2011) although the preferred way of communication was verbally; either directly in the patient's language or through an informal or a formal interpreter (Eckhardt et al., 2006; El-Amouri et al., 2011; Eklöf, Hupli & Leino-Kilpi, 2015; Hart et al., 2013; Ian et al., 2016; Jones, 2008; McCarthy et al., 2013; Nailon, 2006; Plaza del Pino et al., 2013; Schenker et al., 2011; Sobel et al., 2016; Thyli et al., 2007; Tuohy et al., 2008; van Rosse et al., 2015).

Speaking in the patient's own language, even only a few words, was recognised to be constructive in creating a connection with the patient, especially for reassurance (El-Amouri et al., 2011; Hart et al., 2013; Jones, 2008; Roberts, Irvine, Jones, Spencer, Baker & Williams, 2006; Sobel et al., 2016). For the patients it indicated sensitivity, willingness to understand and helpfulness (Sobel et al., 2016). The nurses felt the patient's appreciation and described the relationship as different compared to when treating native speakers (Jones, 2008). Despite the positive results, nurses were less likely to use the patient's own language when providing complex information (Roberts et al., 2006). Even moderate fluency in a language was expressed as insufficient when needing explanation on complicated terminology, resulting in the use of an interpreter (Nailon, 2006).

Interpreters

Informal interpreters such as family members, other patients and staff were distinguished as a common strategy to bridge the language barrier (Eckhardt et al., 2006; El-Amouri et al., 2011; Jones, 2008; Nailon, 2006; McCarthy et al., 2013; Plaza del Pino et al., 2013; Schenker, Pérez-Stable, Nickleach & Karliner, 2011; Sobel et al., 2016; Thyli et al., 2007; Tuohy et al., 2008; van Rosse et al., 2015). Patients indicated that they approved of having a relative interpret, especially if the alternative was no communication at all (Eckhardt et al., 2006).

Nurses used informal interpreters because they were easily accessible, cost-efficient and provided emotional support to the patient (Nailon, 2006; Plaza del Pino et al., 2013; van Rosse et al., 2015). In some cases the nurses did not reflect on why they used them (McCarthy et al., 2013) only noting that it had become a part of the informal work policy (van Rosse et al., 2016).

Problems arising with the use of informal interpreters were accuracy of the translation and confidentiality (Jones, 2008; McCarthy et al., 2013; Nailon, 2006). Furthermore relatives and family members could be accounted for withholding information which strained the care relationship and changed family roles (McCarthy et al., 2013; Tuohy et al., 2008). Another issue arose if the interpreter was a child (Jones, 2008; Thyli et al., 2007; Tuohy et al., 2008). Nurses when faced with no other option had to use children as interpreters although it was deemed inappropriate (Jones, 2008).

To uphold confidentiality, accuracy and an unbiased view, public healthcare nurses denied the use of relatives as interpreters despite patients indicating that they preferred it (Eklöf et al., 2015). Eckhardt et al. (2006) highlighted that not all patients had relatives or friends who could translate for them, requiring the use of other strategies.

The use of formal interpreters was acknowledged as the best solution to overcoming language barriers in nursing care (El-Amouri et al., 2011; Eklöf et al., 2015; Jones, 2008; McCarthy et al., 2013; Plaza del Pino et al., 2013; Tuohy et al., 2008). Interpreters were seen

as key in the construction of the nurse-patient relationship (Jones, 2008; McCarthy et al., 2013). When the interpreters were available nurses spent more time with the patients and asked as many questions as possible that were necessary for the care (Jones, 2008; McCarthy et al., 2013). Nurses recognised the need for continuity of interpreters in assuring a good connection as well as providing comfort and familiarity to the patient (Eklöf et al., 2015; Nailon, 2006; Tuohy et al., 2008). Furthermore interpreters were relied on to bridge cultural differences as well as language barriers (Eklöf et al., 2015).

In contrast to the above, the nurse-patient relationship could be compromised by the interpreter's personal traits and skills (Eklöf et al., 2015; Jones, 2008; McCarthy et al., 2013; Nailon et al., 2006). Interpreters who were well-received by patients became in some cases so familiar to the patient that the nurse was left outside the conversation, feeling like an outsider (Eklöf et al., 2015; Nailon, 2006). Interpreters when perceived as untrustworthy, or disengaged in the situation, left nurses feeling misrepresented as caregivers (Eklöf et al., 2015; Nailon, 2006). The influence interpreters had over the nurse-patient relationship was then a source of frustration (Nailon, 2006).

Even when using formal interpreters was favoured their use was limited due to lack of access, organisational policies and formal training, hence making it challenging and time-consuming for nurses to utilise them properly (Eckhardt et al., 2006; El-Amouri et al., 2011; Eklöf et al., 2015; Hart et al., 2013; Jones, 2008; McCarthy et al., 2013; Nailon, 2006; Schenker et al., 2011; Thyli et al., 2007; Tuohy et al., 2008; van Rosse et al., 2015).

Moreover nurses described prioritising interpreter use for the physician's meetings with the patient and only requesting them when the physician needed it (Nailon, 2006). Patients were satisfied with the care from physicians who used interpreters as they became properly informed enabling participation in their care. Consequently they were disappointed in nurses for not offering them the same option (Eckhardt et al., 2006) when they would have preferred having an interpreter present (Schenker et al., 2011; Sobel et al., 2016). Nurses however highlighted that in all daily nursing tasks the need for interpreter use was not always clear (Nailon, 2006; van Rosse et al., 2016).

Discussion

Findings

The findings of the study highlight the effect of language barriers on nursing as challenging from different perspectives. In relation to previous research, the findings highlight serious issues on patient safety and care due to misperceptions from language barriers (Carnevale et al., 2009; Flores, 2005; Maier-Lorentz, 2008). The nurse-patient relationship was jeopardised given the attitudes of the nurse and the limitations of opportunities in providing strategies to overcome the barrier.

When facing language barriers some nurses expressed prejudices and frustration which could be a sign of ethnocentrism (Giger, 2013). Further evidence of ethnocentrism is placing the responsibility of bridging the language barrier onto the patients, underscored by clinical experience. The sentiment suggests that the need to overcome the language barrier is not seen as mutual due to nurses regarding their culture as superior. This supports the blame culture which discourages the holistic, person-centred view of transcultural nursing (Giger, 2013) which is required in maintaining a healthy nurse-patient relationship (Baggens et al., 2014). Moreover it also shows neglecting nursing responsibilities of informing patients as

stated by law (SFS 2010:659). Nurses are part of an organisation that gives them the resources to provide for the patient's need. Limiting the patient in their means of communication by disregarding these needs is an abuse of power. Another expression of an imbalanced relationship was patients being unwilling to trouble the nurses or ask for interpreters. The difference in power affected the nurse-patient relationship negatively, decreasing the patient's participation in care. As results show nurses being otherwise invested in the patient's treatment, the abuse of power and misconduct of law seems unlikely of being a conscious decision but rather a consequence of lacking knowledge and strategies.

In contrast to the above, the findings indicate that the inability to communicate made nurses more sensitive to the patient's needs as well as their own cultural values. Through meeting people from different backgrounds nurses were able to gain cultural competence and describe views of individual care in line with transcultural nursing (Giger, 2013). Nurses were described as managing and spending lots of time in attempting to resolve the barrier. This suggests that they were aware of their responsibilities in overcoming the barrier, realising the positive effects on the nurse-patient relationship.

Despite nurses describing the efforts taken to bridge the language barriers, patients felt that nurses' language and culture assessments and strategies were inadequate, underscoring results of previous research (Bernard et al., 2006; Blackford et al., 1997). The disparity shows that there is a gap between the patients' experiences and the reflections made by the nurses. Even though nurses' reflections displayed cultural competence, the patients' dissatisfaction suggested that nursing was incorrectly implemented or strategies were wrongfully prioritised. Nurses felt inadequate when unable to overcome the language barrier whereas patients explained that it was insignificant to the perception of the nurse's caring. Non-verbal strategies expressing kindness, patience and respect were valued by the patients. This suggests that the guides by the Transcultural Assessment model are useful and correct (Giger, 2013). The implication of this is that patients rated expressions of caring higher for their well-being rather than full comprehension. A possible explanation for this is how these caring expressions can be interpreted as providing a sense of comfort and security which is central for nursing (Santamäki Fischer & Dahlqvist, 2014). Maintaining this caring attitude is central especially in cases where patients cannot connect to the nurse through means of language, as highlighted by Giger (2013).

Using the patient's own language was deemed positive for the professional-patient relationship in previous studies (Jacobs et al., 2006), also accentuated by the findings of this study. When using the patient's own language, nurses demonstrated an understanding of the need for comfort as well as cultural awareness in what language is perceived as familiar for the patient. Patients appreciated this, yet only nurses with fluency in the language could point out the positive effect which limits the generalisation of the results. Nurses felt it was effective in reassuring the patient but was not relied on when accuracy or information transfer was imperative. These cases resulted in the use of interpreters.

Patients felt care was lacking when they were uninformed or not offered strategies such as interpreters to be able to communicate. The use of formal interpreters varied depending on the clinical setting. Community, emergency and hospital care described a definite lack, whereas in public health care it was the only strategy used. Yet in all settings there was a lack of education, policies and access. Despite being aware of the issue, nurses did not have organisational resources or education to rely on. This implies that it is wrong to place the blame of misconduct in bridging of language barriers solely on nurses. Whereas the individual nurse's attitude can affect the nurse-patient relationship and connection, it cannot affect language fluency and informing the patient. The findings demonstrate that it is a

problem of organisational scale. Organisations need to provide their employees with proper resources such as better interpreter access and guidelines in health care in order to aid nurses in overcoming language barriers and enable environments where transcultural nursing is possible (Baggens et al., 2014; Giger, 2013; Kersey-Matusiak, 2015b).

The main purpose of the interpreters was overcoming the emergent need of informing or gaining information from the patient. When this was done nurses were able to better understand and realise the effects that other cultural aspects had on the situation. Every person is culturally unique including the nurse. To be able to fully comprehend patients' expectations on care, overcoming the language barrier is not enough as the understanding has to be placed in a cultural context. This goes both ways, suggesting the future role for the interpreter from a translator into a cultural broker (Labun, 1991). This means interpreters would gain even more responsibility and take on a larger role in interpreting. Whereas nurses relied on the interpreter for building the nurse-patient relationship, some also commented on the implications from the patient's perspective. Familiar and competent interpreters as well as uninvolved ones led to the nurses involvement decreasing or being misinterpreted.

The findings conclude that care given to patients with language barriers is dependent on the nurse's attitudes as well as environmental factors and resources. Transcultural nursing and the cultural competence gained are important in providing person-centred holistic care that promotes well-being (Giger, 2013).

Strengths and limitations

The aim of this study was adequately answered by the chosen method. The majority of the resulting articles were of qualitative design. The possible explanations for this could be an unconscious selection based on preconceptions of the subject. Nevertheless an unbiased approach was applied to avoid this and no limitations were made based on study design. Another reason could be due to limiting results where nursing perspectives were discerned. Nursing implies a holistic perception of humans, meaning that investigating the lived experiences of a phenomena could provide information useful for nurses in clinical practice (Miller, 2010). Conducting a qualitative literature review could provide insight into the experiences of a certain group e.g. nurses albeit not an overview of existing research from different aspects of the area (Segesten, 2012). The limited results of quantitative research points to a gap in knowledge suggesting future research using this method would be valuable.

Several studies investigated the perspectives from nurses among other health care professionals when discussing language barriers. These articles could have been included, offering a broader range of results. However differentiating the nursing perspective was fundamental to the aim and problem, justifying the exclusion.

A greater number of articles were excluded based on title alone suggesting that the combined search terms were not specific enough. Concerning language barriers there was no search term other than “communication barriers”. The non-language related subjects were therefore excluded manually. There were several synonyms to “cultural competence” that could have been used (Shen, 2015). An initial search in PubMed revealed two terms which yielded the most results which is why they were selected for the final searches. Using the truncation “nurs*” limited the results but not specifically to articles concerning nursing as a subject (Karlsson, 2012). This was deemed as appropriate in contrast to the risk of excluding relevant articles when limiting to certain subject headings.

A manual search of the articles’ references and the snowball method was recommended to properly grasp the research area (Karlsson, 2012). A more structured manual search from several sources e.g. looking in journals relevant to the subject area could have further raised the quality of the study (Whittemore & Knafl, 2005). Time constraints prevented this from being done.

Assessment of the articles’ quality and analysis were first conducted individually then discussed and categorised together. The thesis advisor was consulted when specific problems arose in order to secure credibility of the results (Henricson, 2012).

The included articles provided insight to different aspects of the problem area. Four articles were limited to studying interpreter use, five studied certain cultural groups and the remaining articles highlighted the subject from a general perspective. The strength of having articles with different perspectives is validating the results; articles with different approaches showing similarity in findings suggests the importance of the subject. A limitation of this however is making it hard to generalise the results which makes the findings inconclusive. Nearly all of the articles were based on questionnaires and interviews from nurse’s perspectives, which limits the reach of the results.

Included articles were from different contexts and from different parts of the world. All were from high-income countries, mostly from the United States of America and Europe, with one Australian and one Middle-Eastern article. This is a limitation of the study. Nonetheless the problem area has relevance no matter what location as language barriers are a global issue.

Implications for practice

The findings suggest that cultural competence is valuable for the care given and that nurses can learn it through experience. Most of the problems described when applying strategies could be avoided by organisational changes, routines modification and the development of guidelines promoting culturally competent care. Furthermore, education in transcultural nursing and interpreter use could aid in utilising resources. Once the clinical obstacles of communication barriers are overcome, nurses could be more focused on the treatment of patients regarding all aspects mentioned in Giger's Transcultural Assessment Model (Giger et al., 2002).

These suggestions will improve the working environment of nurses, yet this study suggests that most of the change comes from the nurses themselves. Awareness can be taught and reflected upon but how it is applied in practice relies on the individual nurse's qualities.

Conclusion

The study shows that research in nursing concerning language barriers is limited. Even though the scarcity in articles, they can be comprised into themes and knowledge valuable for the development of nurses' cultural competence. Language barriers affect nursing care by compromising patient safety and participation, largely due to the inability to form a beneficial nurse-patient relationship. Nurses face not only a problem of language barriers but also an internal struggle of disciplines; on one hand satisfying patients' needs for caring and security and on the other informing and ensuring participation. Finding balance between the two is essential for the experience of nursing care. It can be learned from experience but also requires reflection from the individual nurse. The results indicate both expressions of ethnocentrism and cultural competence which suggests that it is partly a matter of personal differences. In addition, the difference in strategies used in public health care compared to other care shows that opportunities vary due to the environment and resources. Even applied strategies were not without difficulty, as demonstrated by the identified effects of interpreter use. What this suggests is that nurses have the capability to reflect on their work and cultural values, striving to care for patients in an environment where the opportunities are limited.

This literature review illuminates remaining gaps in knowledge that could be filled with further research. The lack of quantitative research implies that conclusive results concerning effects and strategies are still needed. For instance, using pre-validated questionnaires concerning quality of care and comparing groups based on language skills is a suggested way to confirm whether there is a correlation between quality of care and language barriers or not. Furthermore considering the limited amount of studies that included patients' perspectives, future research in this area is of great concern. Insufficient knowledge of what patients feel makes it harder to suggest strategies. Studies where both nurses and patients are observed could provide an insight into this, possibly reflecting the clinical environment in areas that interviews and questionnaires might miss. Concerning the subject area, research into the interpreter's role in nursing could guide nurses in how to manage the situation and prevent the effects mentioned in this study. In order to provide care in the evolving multicultural society the strategies need to be implemented and nurses should become able to coordinate care involving interpreters as a part of the team.

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Appendix 1

Table 1. Literature search in CINAHL

Date	Search terms	Filters	Results	Read abstracts	Reviewed articles	Chosen articles
2016-10-27	(MM "Communication Barriers") AND (MW "Nurse")	Peer Reviewed Published Date: 2006-2016	59	22	11	Eckhardt et al. (2006) [†] Ian et al. (2016) [†] Plaza del Pino et al. (2013) [†] Roberts et al. (2006)
2016-10-27	(MH "Communication Barriers") AND (MH "Transcultural Care") OR (MH "Cultural Competence") OR (MH "Transcultural Nursing") AND nurs*	Peer Reviewed Published Date: 2006-2016	121	36	11	Jones (2008) Nailon (2006) Sobel et al. (2016) Thyli et al. (2007) Tuohy et al. (2008)

[†] indicates that the article was also found in another search

MM = Exact Major Subject Heading

MW = Word in Subject Heading

MH = Exact Subject Heading

Table 2. Literature search in PubMed

Date	Search terms	Filters	Results	Read abstracts	Reviewed articles	Chosen articles
2016-10-27	“communication barriers”[MeSH Terms]) AND "transcultural nursing" [MeSH Terms] OR "cultural competency"[MeSH Terms] AND nurs*	Publication dates: 10 years Language: English	110	29	9	Hart et al. (2014) [†] McCarthy et al. (2013) [†]

[†] indicates that the article was also found in another search

Table 3. Articles found through manual searches

Date	Chosen articles
2016-10-30	Eklöf et al. (2014) El-Amouri et al. (2011) Schenker et al. (2011)
2016-10-04	van Rosse et al. (2016)

Appendix 2

Table 1. Article summaries.

Author Year Country	Title	Aim	Design	Participants	Results	Assessed quality
Eckhardt et al. 2006 Australia	Culture and communication: identifying and overcoming the barriers in caring for non-English-speaking German patients	To explore the experiences of non-English speaking people when encountering Australian health-care.	Qualitative Phenomenology Interviews Purposive sampling	6 German-born, non-English speaking women aged 57-82 years	<i>Barriers:</i> Education and information provided inadequately to patients. Frustration. <i>Interpreters:</i> Patients' needs and nurses unable to satisfy them. <i>Culture:</i> Hospital culture effects and language barriers. Fear.	<i>Medium-high quality</i> + Detailed descriptions of participant selection, data collection, transcription verification and analysis. + Ethics committee approved + Preconceptions not identified. - Subject cross-check not used - Transferability not discussed
Eklöf et al. 2014 Finland	Nurses' perceptions of working with immigrant patients and interpreters in Finland	To describe nurses perceptions of the factors to consider when using interpreters in primary health care nursing with immigrant patients.	Qualitative Descriptive Inductive content analysis Interviews	8 female nurses	<i>Interpreter factors:</i> Professional role and knowledge, personal traits. <i>Nurse factors:</i> Planning, arranging the appointment. Education needs. <i>Patient and culture factors:</i> Perceptions and desires concerning care. Privacy.	<i>Medium-high quality</i> + Context, sample and analysis presented, securing confirmability + Discussion of transferability + Ethical guidelines followed - Subject cross-check not applied
El-Amouri et al. 2011 UAE	Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of UAE	To identify the kind of strategies in use to effectively communicate to provide culturally competent care.	Qualitative Survey with open-ended questions	153 nurses 143 female, 10 male Participants' ethnic origins presented.	Current strategies used Strategies to communicate with non-Arabic speakers Suggested strategies for developing culturally competent care Suggested strategies for hospital policy makers	<i>Medium quality</i> + Data collection and participant selection described. + Researcher previously familiar with working with context + Ethically cleared - Lacking confirmability and transferability

Hart et al. 2013 USA	Cultural challenges and barriers through the voices of nurses	To discover and describe challenges and barriers perceived by nurses in providing culturally competent care in their day-to-day encounters with diverse patient populations	Qualitative Descriptive Survey with open-ended questions Structured sampling	374 female, mostly Caucasian, English-speaking nurses	<i>Great diversity:</i> Many different cultures, lack of knowledge <i>Lack of resources:</i> No time to be educated, education lacking, language barriers and limited support. <i>Prejudices and biases</i> towards other cultures.	<i>High quality</i> + Credibility, confirmability and authenticity secured and discussed + Approved by university review board (ethics) + Limitations, transferability discussed
Ian et al. 2015 USA	Registered nurses' experiences with caring for non-English speaking patients	To explore registered nurses' experiences with caring for non-English speaking patients	Qualitative Exploratory Open-ended, demographic questionnaire Convenience sample	17 female nurses aged 26-54 years	<i>Availability of resources:</i> Available support. Challenges: time and barriers. <i>Changes in nursing practice:</i> Increased awareness of patient needs, knowledge of culture. Personal development, improved time and resource management.	<i>Medium-high quality</i> + Sample, data collection and analysis presented. + Limitations discussed + Approved by university review board - Credibility lacking, preconceptions not discussed.
Jones 2008 USA	Emergency nurses' caring experiences with Mexican American patients	To understand emergency nurses' experiences when caring for Mexican American patients	Qualitative Exploratory Interviews Purposive sampling	5 nurses aged 27-52 years	<i>Language barrier:</i> Lack of resources, questioned accuracy. Effect on relationship, different connection. <i>Continuity of care:</i> lacking. <i>Limited cultural knowledge</i> Placed in relation to culturally competent care. Data saturation achieved, 3 interviews	<i>High quality</i> + Theoretical framework, nursing, presented + Peer debriefing: credibility, confirmability and dependability secured + Limitations and transferability discussed + Approved by hospital review
McCarthy et al. 2013 Ireland	Conversations through barriers of language and interpretation	To describe nurses' experiences of language barriers and the use of interpreters within the context of evolving healthcare.	Qualitative Descriptive Interviews	7 nurses; 5 female, 2 male	<i>Language barriers:</i> Impact on nursing, initial strategies used. <i>Interpreter use:</i> Formal and informal. Pros, cons and challenges.	<i>Medium-high quality</i> + Dependability and confirmability secured + Limitations discussed + University ethics committee approved - Lacking credibility

Nailon 2006 USA	Nurses' Concerns and Practices with Using interpreters in the care of Latino patients in the emergency department	Describe nursing care of Latinos in the emergency department to determine how care is planned relative to the patient's ethnicity, including linguistic abilities.	Qualitative Interpretive phenomenology Group- and individual interviews 22 observations	15 nurses; 11 female, 4 male	<i>Interpreter reliance:</i> crucial to emergency department care. <i>Lack of availability:</i> Challenges in accessing interpreters → negative effect on care. Strategies used instead. <i>Communicating care requirements:</i> Interpreters effect, personal traits and knowledge, on nurse-patient relationship.	<i>High quality</i> + Trustworthiness secured and described, e.g. triangulation, peer debriefing + Researcher familiar with context + Detailed description of data sampling and + Transferability discussed + Review board approved
Plaza del Pino et al. 2013 Spain	Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in southern Spain: a focused ethnography	To ascertain how nurses perceive their intercultural communication with Moroccan patients and what barriers are evident which may be preventing effective communication and care.	Qualitative Focused ethnography Interviews Purposive sampling	32 nurses; 6 male, 26 female	<i>Cultural boundary:</i> Prejudices and stereotypes changing during care. <i>Social boundary:</i> Justification of xenophobic expressions, effect on relationship. <i>Language boundary:</i> Effects on care, strategies used, realisations. <i>Overcoming borders:</i> Dependent on overcoming communication barriers. Data saturation obtained	<i>High quality</i> + Trustworthiness secured through dependability and confirmability descriptions. + Acknowledging of researcher's role and preconceptions. + Detailed descriptions of data collection and analysis. + Discussed limitations + Ethically approved.
Roberts et al. 2006 Wales, UK	Language awareness in the bilingual healthcare setting: A national survey	To examine the factors that influence Welsh language awareness amongst healthcare professionals and the way in which they facilitate language choice for patients and clients.	Quantitative Questionnaire Stratified sample	1042 participants: 975 nurses 40 midwives 27 health visitors	<i>Welsh language proficiency:</i> 55% spoke a little 18% fluent <i>Welsh language attitudes:</i> 45% positive, 43% neutral, 12% negative <i>Welsh language use:</i> More use in providing reassurance and simple advice rather than formal use such as consent and counselling.	<i>High quality</i> + Method, sampling and analysis described well. + Criterion and content validity confirmed. + Reliability alpha 0.96. + Context presented and limitations discussed + Ethically approved

Schenker et al. 2011 USA	Patterns of Interpreter Use for Hospitalized Patients with Limited English Proficiency	To examine interpreter use for clinical encounters with physicians and nurses among patients with limited English proficiency.	Quantitative Cross-sectional Interviews and questionnaire Structured sampling	234 patients: Age range 18-88 54% male 85% Spanish-speaking 15% Cantonese- or Mandarin-speaking	Interpreter use with physicians presented. Interpreter presence of any kind with nurses: 37% 4% professional interpreters (p<0.0001) 38% reported “getting by” with nurse barely speaking to them. Multivariable analysis based on e.g. ward, age, education, sex.	<i>Medium-high quality</i> + Detailed descriptions of sampling, methods and analysis. + Used validated questionnaire + Repeatedly asking participants to specify answers + Limitations discussed + Ethically approved - Reliability not confirmed.
Sobel et al. 2016 USA	Guiding the Process of Culturally Competent Care With Hispanic Patients: A Grounded Theory Study	To explore nursing care actions that lead to culturally competent care for Hispanic patients	Qualitative Grounded theory Interviews Purposive sampling	26 Hispanic men and women	“Up to you”: health management, responsibilities in health care. “At the mercy of the system”: vulnerability and powerlessness due to language barriers and system issues. “Connectedness”: Nurse qualities that led to acceptable nurse-patient interaction: language use, cultural awareness and kindness.	<i>Medium-high quality</i> + Trustworthiness secured, confirmability attained. + Detailed descriptions of data collection and analysis + Limitations and transferability discussed + Review board approved - Sampling description inadequate.
Thyli et al. 2007 Norway	Challenges in community health nursing of old migrant patients in Norway - an exploratory study	To explore nurse managers’ perceptions of the content of community health nursing care of older people from non-western countries of origin, and the challenges associated with caring for this group of patients.	Qualitative Descriptive Questionnaire with both scales and open-ended questions. Purposive sampling	18 nurse managers	Demographic results, as well as challenges: <i>Language barriers</i> : frustration, strategies, risks. <i>Family involvement</i> : pros and cons and risks. <i>Deficiencies in multicultural competency</i> : insecurity in assessments, passive attitudes. <i>Need for development</i> .	<i>High quality</i> + Context presented in detail. + Method and analysis described in detail. + Credibility and dependability secured. + Limitations of transferability discussed + Ethical guidelines applied, approval obtained
Tuohy et al.	Educational	To discuss registered	Qualitative	7 nurses	<i>Dealing with cultural issues</i> : effects on	<i>Medium-high quality</i>

2008 Ireland	needs of nurses when nursing people of a different culture in Ireland	nurse's experiences of nursing people from a different culture.	Interviews: both individual and focus group Purposive sampling		nursing, cultural differences <i>Assessing and using interpreters:</i> challenging, formal and informal, optimal to care. <i>Planning and taking action:</i> Multicultural education. Resources availability.	+ Trustworthiness achieved in most areas. + Limitations acknowledged, transferability discussed + Ethically approved - Somewhat limited in dependability, sampling and context.
van Rosse et al. 2016 Netherlands	Language barriers and patient safety risks in hospital care. A mixed methods study	To investigate patient safety risks due to language barriers during hospitalization, and the way language barriers are detected, reported and bridged in Dutch hospital care.	Mixed methods, embedded in cohort-study. <i>Quantitative:</i> Patient records reviewed. Patient questionnaire on self-reported language proficiency <i>Qualitative:</i> In depth analysis of language barrier related text passages. Interviews.	Data from 576 patients with an ethnic minority background. 17 admissions from patients with different ethnic backgrounds. Completing interviews with one nurse and four physicians.	<i>Language barriers risk for patient safety:</i> Nursing tasks: e.g. risk assessments and communication. <i>Physician tasks.</i> <i>Noticing, reporting language barrier:</i> Missing data, inadequate reporting and documentation. Non-standardized. <i>How are language barriers bridged:</i> Involvement of family or relatives. Professional interpreters. Communication via gestures. Data saturation achieved	<i>Medium-high quality</i> + Analysis and methods described in detail. + Validated, reliable questionnaire and results (mixed methods implications). + Trustworthiness, confirmability, dependability and credibility secured: triangulation. + Ethically approved - Conclusions completed by interviewing only one nurse. - Part of a larger study, referring to other articles to find out more about data collection etc.