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ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

Speaking my patient's language: bilingual nurses' perspective about provision of language concordant care to patients with limited English proficiency

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Abstract

Aim. The aim of this study was to explore bilingual nurses' perspective about providing language concordant care to patients with limited English proficiency (LEP) and its impact on patients and nurses. Factors affecting the provision of language concordant care to patients LEP were also explored.

Background. With an increase in migration and mobility of people across the world, the likelihood of experiencing language barriers while providing and receiving care is high. Nurses are responsible for providing care to patients regardless of their culture, religion, ethnic background or language. Language barriers, however, are hurdles that hamper development of effective communication between nurses and patients. Eliminating language barriers is a crucial step in providing culturally competent and patient-centred care.

Design. Qualitative descriptive study.

Methods. During January-August 2015, 59 nurses, working in acute hospitals in the UK, participated in 26 individual in-depth interviews and three focus group discussions. The data were analysed using thematic analysis.

Findings. Four themes: 'when we speak the same language'; 'when I speak my patient's language'; 'what facilitates provision of language concordant care' and 'what hinders the provision of language concordant care' were identified. Factors affecting nurses' ability to provide language concordant care included individual factors (confidence; years of experience as a nurse; years of experience in the work setting; and relationship with colleagues), patients' expectation, attitudes of other patients, colleagues and nurse managers, organizational culture and organizational policies.

Conclusion. Bilingual nurses can play a very important role in the provision of language concordant for patients with LEP. Further research is needed to explore patient perspective.

Keywords: bilingual nurses, communication, language barriers, language concordant care, limited English proficiency, nursing, translation, translators

Why is this research or review needed?

- Language barriers hinder effective communication between patient and nurses
- Eliminating language barriers is a crucial step in providing culturally competent and patient-centred care.
- Not much research has been conducted to explore bilingual nurses' communication practices when providing care to patients with limited English proficiency in the UK and elsewhere.

What are the key findings?

- Provision of language concordant care is the most effective way of providing patient-centred care.
- Bilingual nurses can use their ability to speak in more than one language to provide care to their patients.
- Language concordant care improves patients' experience, increases their comfort, makes them feel listened to and enhances their satisfaction with the healthcare service.

How should the findings be used to influence policy/practice/research/education?

- These original insights into the experiences of bilingual nurses can inform language concordant care internationally'
- Nurses should be involved in the development and review of the language and interpretation policies.
- Bilingual nurses and other HCPs with a remit for clinical assessment should be allowed to use their language skills to provide care to patients for whom they are directly responsible.
- A register of bilingual nurses and other staff who are competent, confident and willing to use their language skills should be developed and kept in the clinical area.

Introduction

With an increase in the internal and external migration and mobility of people across the world, the likelihood of experiencing language barriers while providing and receiving care has increased. Nurses are responsible for providing care to patients regardless of their own or the patient's culture, religion, ethnic background and language. Language barriers, however, are hurdles that affect the provision of culturally competent and patient-centred care (Bischoff & Denhaerynck 2010, Hull 2016) and are associated with increased medical complications (Jacobs *et al.* 2007, Karliner *et al.* 2007). Language barriers are known, adversely, to affect adherence to treatment regimens, follow-up for chronic illnesses, comprehension of diagnosis and treatment (Wilson *et al.* 2005) and ability to seek information (Pippins *et al.* 2007). Language barriers may worsen the situation for already marginalised groups by negatively affecting their ability to access healthcare services and may contribute to health inequalities (Jacobs *et al.* 2004, 2007). For instance, evidence from the USA suggest that Spanish speaking patients, with limited English proficiency (LEP), are less likely to have cholesterol and blood pressure screening compared with English speaking patients (Jurkowski & Johnson 2005). Latinas with LEP, are less likely to be offered various screening tests such as Pap Smear, mammogram, faecal occult blood test and sigmoidoscopy (Goel *et al.* 2003).

Language barriers would not arise if healthcare professionals (HCPs) such as nurses were able to communicate with patients in their own language, something that is not always possible. Nevertheless, where possible, such provision can be valuable. Language concordant communication – where a clinician and a patient communicate with each other in the same language (Hull 2016) – is associated with improved patient–provider relationship (Free 2005, Eamranond *et al.* 2009, Traylor *et al.* 2010, Gill *et al.* 2011), better treatment compliance (Manson 1988, Fernandez *et al.* 2004), fewer emergency department visits, lower cost of care (Carter-Pokras *et al.* 2004, Jacobs *et al.* 2007) and higher patient satisfaction (Ngo-Metzger *et al.* 2007).

Background

According to the 2011 census, there are more than 100 languages spoken in the UK (Office of National Statistics 2013). These languages are diverse – from regional languages such as Welsh and Irish, to European languages such as French, Portuguese and Polish. Figure 1 shows 20 common languages spoken in England and Wales (Office of National Statistics 2013). Clearly, in a multilingual country such as the UK, providing language concordant care to every patient is not possible. To provide effective care to LEP patients, interpreters – most often telephone interpreters – are used across the UK National Health Service (NHS), though issues such as miscommunication, problems in establishing rapport (Jane Cioffi 2003, Richardson *et al.* 2006) and high cost of translation and interpretation services (Gill *et al.* 2011, Gan 2012) limit the effectiveness of such provision. Evidence also suggests that communication through an interpreter can never be as satisfying as direct communication (Eamranond *et al.* 2011) and may increase threats to patient safety (van Rosse *et al.* 2015). On the

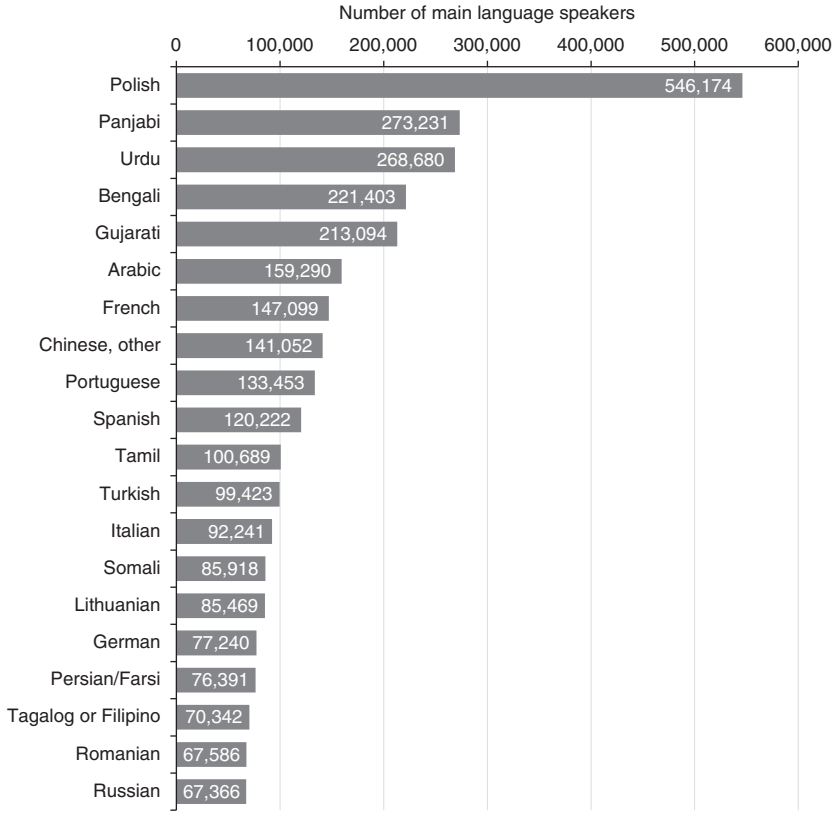

Figure 1 Twenty largest non-English main languages by number of speakers in England and Wales, 2011.

other hand, where possible, use of bilingual HCPs such as nurses who are able to speak the patient's language may help overcome many of these issues. During the past two decades, many overseas qualified nurses registered with the Nursing and Midwifery Council (NMC). The Royal College of Nursing (RCN) labour market review (Buchan & Seccombe 2012) states 'whilst there is not precise data on how many international nurses were recruited to, arrived in and continued to work in the UK, between 1998–2006, there were approximately 100,000 new non-UK nurse registrations with the NMC across that period' (p. 11). To be able to register to work as a nurse in the UK, overseas qualified nurses are required to demonstrate their ability to communicate in English by completing the International English Language Test (Gibson *et al.* 2015).

Presently, 20% of nurses and 37% of doctors working in the NHS in England are of Black and Minority Ethnic (BME) origin (Kline 2014a). In the UK, the term Black and Minority Ethnic (BME) community is used to refer to people of non-white descent. Only in London, 45% of the city population and 41% of the NHS staff are of BME origin (Kline 2014b). While statistics about the nurses or HCPs linguistic capabilities is not available, it may be safe to assume that a majority of HCPs from BME communities (and especially those qualified overseas) in the UK are able to speak at least one language other than English. It may be appropriate and even essential to use this resource effectively to improve the quality of care provided to LEP patients for economical and patient safety related reasons.

There is ample research demonstrating the effectiveness of language concordant communication between patients and HCPs in the clinical areas (especially outpatient areas) (Raynor 1992, Fernandez *et al.* 2004, Wilson *et al.* 2005, Eamranond *et al.* 2009) and community setting (Khan *et al.* 2010). Research has also been conducted to explore the impact of language barriers on the provision of care by nurses (Fatahi *et al.* 2010, Tay *et al.* 2012, Taylor *et al.* 2013). However, research about the effectiveness of language concordant care among bilingual nurses and LEP patients is scant. There is a need to investigate current communication practices of bilingual nurses when dealing with patients from a shared linguistic background. Such knowledge can help develop effective communication approaches, policies and guidance to allow bilingual nurses to provide language concordant care to their LEP patients. The study reported here attempts to fill this gap in the nursing and health care literature.

The study

Aims

The aim of this study was to explore bilingual nurses' perspective about provision of language concordant care to LEP patients and its impact on patients and nurses. Factors affecting the provision of language concordant care were also explored.

Design

A qualitative, exploratory design was used for this study. A qualitative approach is identified as a subjective but systematic method that can help a researcher explore, describe and interpret life experiences of the participants (Burns & Grove 2011). It helps to understand a social or human problem and facilitates development of a complex but holistic picture of participants' experiences and views about a particular phenomenon (Creswell 2009). The approach was considered suitable for this study as not much is known about the issue under study. The study was conducted in England, UK. Nurses, who participated in this study, were working in different parts of the country, including Sheffield, Bradford, Manchester, London, Hertfordshire, Birmingham, Nottingham, Lincolnshire, East Midlands, London and Hertfordshire.

Participants

A purposive and snowball sampling strategy was used to ensure selection of appropriate participants who had the knowledge of the issue (Polit & Beck 2008). RNs, able to communicate in a language other than English (in addition to English) were eligible to participate in the study. Initially, participants were identified with the help of professional networks and, as recruitment progressed, each participant was requested to identify other nurses who may be willing to contribute to the study. Once identified, potential participants were contacted through their preferred methods (phone/email).

Data collection

Data were collected (January-August 2015) through individual interviews and Focus Group Discussions (FGDs) using a semi structured interview guide. Two pilot interviews with non-research participants were conducted to determine the length, suitability and appropriateness of the language of the interview questions. As a result, a few probes related to participants' perceptions about language barriers were identified and added to the interview guide.

Each individual interview lasted 50-75 minutes. Depending on the participant's preference, face-to-face and telephone interviews were conducted. Given the nature of the topic, face-to-face or telephone interviews were considered equally useful. Preference was given to face-to-face interviews where possible, though the option of a Skype or telephone interview was welcomed by many participants. Face-to-face interviews were conducted at either participant's workplace or a public space near their home or work. We also conducted three face-to-face FGDs, each of which lasted 75-90 minutes (Table 1).

With participants' permission, interviews and FGDs were audio recorded. All significant occurrences, such as a description of the setting, participant's non-verbal behaviour and any interruptions during the interview process/FGDs were recorded. The questions were asked in a non-judgmental, non-threatening and culturally sensitive manner. A reflexive diary was kept throughout data collection and analysis.

Ethical considerations

The study was reviewed and approved by the University research ethics committee. The study was also subjected to appropriate research governance approval process in the local NHS Trust. Participants were provided with an information sheet explaining the study's aims, objectives and procedures and an informed consent was obtained prior to participation in an individual interview or FGD.

Data analysis

All interviews and FGDs were transcribed verbatim by independent transcribers. A thematic analysis as an iterative and interpretive technique (Spencer *et al.* 2003) was used. Each transcript was read and re-read to identify emerging themes. First, every line and sentence were given a code.

Table 1 Details of focus group discussions.

Focus	Focus group 1	Focus group 2	Focus group 3
Number of participants	13	11	9
Age of participants	28-40	30-52	25-45
Gender			
Male	9	08	0
Female	3	01	10

The initial code list was developed for six interviews. Similar codes were then clustered into sub-themes and themes. The process was then applied to rest of the interview and FGD transcripts. The data in each transcript were compared and contrasted with data from other transcripts.

First author conducted initial thematic analysis independently. The analysis was then shared with the second author who made minor moderation to the initial analysis. Following preliminary data analysis, a finding consolidation workshop was arranged. The workshop was arranged to 'piggyback' on an existing group consisting of Equality and Diversity (E&D) champions/representatives of various NHS organizations. The workshop was attended by 23 professionals, including nurses, managers, Human Resource representatives and other people responsible for E&D related issues in their organization. Using interactive group activities, participants were encouraged to discuss the relevance of findings to practice, ways through which findings of the study can be used to improve practices and strategies to overcome challenges to the provision of language concordant care to LEP patients. Participants' views facilitated consolidation of findings and recommendations.

Rigour

For a study to be ethical, it has to be rigorous and trustworthy (Denzin & Lincoln 1998). The trustworthiness of a qualitative study covers four elements which include: credibility; transferability; dependability and confirmability (Lincoln & Guba 1985, Denzin & Lincoln 2011). In this study, strategies used to ensure rigour included member checking, triangulation and peer debriefing (Lincoln & Guba 1985). In addition, appropriate information about the context in which the study was conducted, findings and context of findings is described.

Findings

Fifty-nine bilingual nurses (32 females and 27 males) participated in this study. Twenty-six participants contributed to individual interviews and the remainder contributed to three FGDs. Participants were aged between 23-52 years and completed their nursing education in Pakistan ($n = 40$), Italy ($n = 3$), Nigeria ($n = 3$), India ($n = 4$) and UK ($n = 9$). The job experience of the participants ranged from 2-23 years and the experience of working in the NHS acute hospital, for those qualified from other countries before joining the NMC register, ranged from 2-13 years. The experience of those who completed their nursing education in the UK ranged from 3-7 years. Examples of practice settings of the participants included medical, surgical, intensive care, cardiology, outpatient department and postoperative recovery units. Other than English, all participants were able to communicate proficiently in at least one language (Table 2).

Findings are presented in four themes, which are 'when we speak the same language' 'when I speak my patient's language', what facilitates provision of language concordant care and 'what hinders the provision of language concordant care'. To present data from individual interviews, numbers (e.g. Nurse 1) are used. Pseudonyms (e.g. P1-FGD 2) are used to present supporting quotes from FGDs.

When we speak the same language (Theme 1)

Participants talked about the impact of provision of language concordant care on patients. All participants felt

Table 2 Characteristics of the individual interview participants.

Characteristics	Number
Age	23-50 years
Gender	
Male	10
Female	16
Ethnicity	
Indian	2
Italy	3
Nigerian	3
Pakistani/British Pakistani	15
Polish	2
South Africa	1
Qualification	
Diploma in Nursing	10
BScN	16
Place of qualification	
India	2
Pakistan	15
Polish	2
Italy	3
Nigeria	1
UK	3
Language proficiency	
French	1
Gujrati	2
Hindko	2
Italian	3
Malayalam	2
Mirpuri	4
Polish	2
Pushto	1
Punjabi	7
Sindhi	5
Shona	1
Tamil	2
Urdu	14

comfortable and confident in providing language concordant care to patients, acknowledged using their language skills to communicate with patients in the past 6 months and articulated its usefulness for their patients with LEP, as one participant mentioned:

I am comfortable in speaking to patients in their own languages. I feel I can explain their care better. I make sure that they understand what is going to happen in theatre or in the procedure they are there for. They feel much relieved and it does enhance their recovery (Nurse 5).

Provision of language concordant care improves patient experience, increases their comfort, makes them feel listened to and enhances their satisfaction with the healthcare service. One participant illustrated this as:

I think a nurse's ability to communicate with the patient in their language reduces patient's anxiety as both the nurse and the patient may somehow have affiliation with the same culture, language or country of their origin (P1-FG 2).

Speaking to patients in their language facilitates development of trust and enables the patient to communicate their needs effectively as a participant stated:

I speak to patients in their language if I can. People come from all over the world with different cultures and languages, when you speak to them in their language, they feel most assured and would tell you their problems and needs comfortably (Nurse 6).

Participants mentioned that sometime, even those patients who can speak perfect English prefer to communicate in their primary language, as they find it reassuring and less stressful:

Once I met an Indian patient who could speak English very well, but wanted to would like to talk in Hindi. He was about 80-year old. He called me and asked me if I could speak Urdu or Hindi and when I said yes, he requested me to sit with him. He held my hand and started crying, he said that he was feeling lonely and he just wanted me to be there and speak to him in Hindi because he was just missing speaking his language (P2- FG1).

A perception was that communicating with a patient in their language helps with appropriate assessment of patients' needs and prompt treatment of their condition.

When I speak my patient's language (Theme 2)

Regarding the impact of language concordant communication on nurses, there was a mixed response. While, participants felt comfortable and willing to provide language concordant care to their patients, they said that in the absence of clear and supportive organizational policies and lack or appropriate recognition of their skills, their ability to speak another language results in extra pressure and increases their workload:

Sometimes it is hard to finish your jobs if you are going to interpret for another colleague. We are assigned five to six patients and if you are busy then it is not possible' (Nurse 10). Another participant articulated similar concern: 'if nurse started using their language skills, there is a danger that health team is going to abuse them by asking them to interpret for patients again and again and this would put this nurse in stressful position and staff will feel devalued for the purpose' (P3-FG2).

Some said that the use of their language skills puts them in a vulnerable position by making them accountable for issues not clearly articulated in their job description or organizational policies: 'you become more accountable and you are not paid for that job' (Nurse 15).

Some participants also said that communicating with LEP patients in their language might result in development of unrealistic expectations of favours by the patient who may ask nurses for preferential services and treatment. One participant while sharing her experience stated:

They would expect more from you when you speak to them in their own language. Patients try to engage you in their personal problems or drag you into irrelevant discussions and complain. Many expect from you to get them sick notes, etc. (Nurse 10).

Participants said that, although nurses know how to stay within professional boundaries, such situations are often difficult to manage.

What facilitate provision of language concordant care (Theme 3)

Participants identified various facilitating factors facilitating provision of language concordant care to LEP patients (Figure 2). Personal characteristics such as self-confidence, length of experience as a nurse, years of experience in the work setting, relationship with colleagues and line manager affected bilingual nurses' ability to provide language concordant care. Participants who believed that, as nurses, they were independent practitioners, responsible for their actions and decisions, felt comfortable in providing language concordant care. Years of experience as a nurse in the UK and in their present work setting appeared to be positively associated with bilingual nurses' willingness, confidence and comfort to provide language concordant care. Nurses working in settings [medical assessment unit (MAU), endoscopy unit and operation theatre] requiring one-to-one interaction with patients felt more confident and comfortable in providing language concordant care.

The majority of the participants stated that their colleagues, generally, are open, supportive and appreciative of their ability to communicate in more than one language. One participant stated:

> The multidisciplinary team appreciates my interpretation service and all doctors, physiotherapists, speech therapists and my nursing colleagues feel informed about the health needs of patients (Nurse 12).

Another mentioned that colleagues '... especially doctors are very grateful when I do interpret for them' (Nurse 17). While talking about other patients, participants mentioned that they are, generally, supportive and appreciate the nurses' efforts and abilities to speak to patients in another language. For instance, one participant mentioned: 'I find many English patients support and appreciate me when I speak to the patient in his or her own language who can't speak English' (Nurse 10). Participants highlighted that LEP patients and their family's positive reaction to nurses' ability to communicate in the same language encourages nurses to continue to use their skills.

Those who felt well supported and respected by their colleagues, were much more comfortable and willing to provide language concordant care and felt positive as one participant stated: 'I feel valued that I have been able to help patients as well as my colleagues using my language skills' (Nurse 6).

What hinders the provision of language concordant care (Theme 4)

Participants discussed many barriers to the provision of language concordant care (Figure 2). They talked about experiencing negative attitudes by English speaking patients. Participants said that some patients feel uncomfortable seeing nurses speaking to other patients in another language. One participant stated: 'I recall one patient who was making comments and later pulled the curtains while I was speaking to an elderly Asian woman with her language' (Nurse 7). Another participant recalled: 'one patient saying to us, if you can't speak English, then go outside and speak to each other whatever you like' (Nurse 2). However, such situations were seldom and the majority of the participants said that other patients are usually supportive of communicating with LEP patients in their own language.

Participants expressed facing conflicts and sometime arguments by some colleagues including managers who disapprove communicating in languages other than English. While talking about nurse colleagues' reaction to situations where bilingual nurses have to communicate in another language, some participants shared sensing scepticism, lack of trust and unlikeness:

> Not everyone, but the majority of our white colleagues are often sceptical. Many feel as when myself and a patient are talking in another language, we are probably talking against them or about them, which is never the case (Nurse 21).

Another participant, while talking about her colleagues' responses stated;

> They often do not say anything, but you could see from their non-verbal behaviour and expressions that they do not approve speaking with patient in a language other than English (Shona, FG3).

Another participant recalled a similar situation:

> Once I had and Asian patient who was speaking to me in Gujarati language and one nurse was working in the same ward. She [Nurse] did not understand what we were talking about and looked uncomfortable and sort of confused (P8-FG3).

In addition, some participants mentioned being questioned or discouraged by their line managers for speaking to patients in their language. Such experiences affected bilingual nurses' confidence to provide language concordant care to their patients.

Organizational language and interpretation policies remained central to the discussion in each interview and FGD. Not having clear guidelines and policies about what is (not) acceptable affected nurses' comfort and confidence in using their skills to provide language concordant care to their patients. The majority of participants had very little knowledge about language and interpretation policies of their organization and their impact on them: 'I have not seen any policy that allows or does not allow the nurse to talk to the patients in their own language' (P6-FG2). Participants considered that line managers and other colleagues have limited knowledge and awareness of interpretation policies and their reaction or decisions were based on their personal opinions and interpretations of the policy. For instance, one participant stated:

> It happened to me once, deputy manager objected when I was talking to a patient in Urdu. He stopped me and said that other people do not understand and would not like it. The other day, another patient who was stressed, wanted to talk to me in his language, I went to ask the deputy manager who objected first, then took me to regional manager who said I could communicate to the patient in his language and it is not a problem as it is the policy of the Trust. This clearly meant that my line manager was not aware of interpretation policies of the hospital (Nurse 6).

Figure 2 Factors affecting provision of language concordant care.

There was an implicit assumption that nurses were not allowed to speak to patients in their language, but this did not deter nurses communicating with patients in their language when required. All participants maintained that they were never approached or consulted during policy development or review process.

Discussion

This is the first study that explored nurses perspective about provision of language concordant care and factors affecting such provision. In multicultural and multilingual societies, for instance UK, bilingual nurses are an invaluable asset, particularly when their language skills can be effectively used to provide care to LEP patients. The aim of this study was to explore bilingual nurses' perspectives about provision of language concordant care to LEP patients and its impact on patients and nurses. The study also investigated nurses' perspective about barriers and facilitators to the provision of language concordant care to LEP patients. Nurses who contributed to this study came from diverse backgrounds, cultures, age, gender, years of experience and language skills. All participants had experience of providing care to LEP patients in their area of practice. This study is unique as research on bilingual nurses' experience of providing language concordant care remains scarce, though the impact of language barriers on provision of care have been explored (Bischoff & Denhaerynck 2010, Tay *et al.* 2012, McCarthy *et al.* 2013, Savio & George 2013). Consistent with existing research, the findings suggest that provision of language concordant care to enhance LEP patients' experience, comfort and satisfaction (Ngo-Metzger *et al.* 2007) with the healthcare services (Free 2005, Eamranond *et al.* 2009, Traylor *et al.* 2010, Gill *et al.* 2011). It makes them feel listened to and improves their understanding of and compliance with treatment regimens (Fernandez *et al.* 2004).

Findings suggest that nurses were comfortable and confident in using their language skills; however, their skills were not recognised or valued in their organization. Language skills were neither appreciated nor discussed in performance appraisals and there was no incentive attached to use of these skills. A lack of clear guidance and policies clarifying expectations affects bilingual nurses' confidence and ability to provide language concordant care. It also raises concern, among nurses, about increased workload and repercussions of using their language skills in case a patient or their family misunderstood something and complaint. However, there was a consensus that such issues can be easily managed by developing clear guidelines to allow nurses to use their language skill appropriately when needed. In addition, miscommunication or misunderstanding can occur in any situation and in the absence of language barriers. Nurses as registered practitioners are responsible, for providing safe and effective care to their patients (NMC 2015). As regulated practitioners, nurses are

expected to recognise and work within the limits of their competence. Nurses work collaboratively with other professionals, recognising their skills, expertise and contribution and refer matters to them when appropriate (Nursing and Midwifery Council 2015). Language skills, therefore, should be considered as any other skill and nurses should be trusted to use their judgement to decide when to use their language skills and or arrange an interpreter in the best interest of their patients. Ultimately, nurses are accountable for the decisions they make, and if a nurse makes a wrong decision because of interpretation errors, the nurse will still be accountable. Findings suggest that nurses are not consulted when developing or reviewing language and interpretation policies. This is probably the reason that the policies are not always relevant and applicable to their situation. While developing or reviewing language and interpretation polices, involving HCPs, such as doctors, nurses and other registered professionals, especially those capable of communicating in more than one language would be useful.

Findings also identified various factors that affect the nurses' ability to provide language concordant care. These include nurse's personal characteristics such as age, years of experience as a nurse and in the current work setting and relationship with colleagues and management. It may be that all of these factors contribute to the development of a nurse's confidence in their knowledge, skills and an ability to make and justify their decisions. Findings suggest that communicating with patients in their language might result in increasing their expectations of what a nurse can do for them. Patients may expect favours from a nurse because of their shared cultural linguistic background. However, nurses need to be able to maintain a professional relationship with their patients (Nursing and Midwifery Council 2015) regardless of the language they use to communicate with them. This issue needs to be explored further.

Other patients in the area and colleagues convey dislike of and unacceptance of bilingual nurses speaking to LEP patients in a language other than English. Such situations were more common when there was a lack of trust among colleagues or the bilingual nurse was either new or was not a regular member of the team (e.g. bank/agency staff). In some situations, bilingual nurses were reported to managers for communicating with patients in their language. It is important for bilingual nurses to develop their confidence, as provision of patient-centred care should always take precedence. Creating opportunities where nurses working in a department could discuss and reflect on such issues may be useful in supporting bilingual nurses develop their confidence in using their language skills. In addition, such opportunities may help other nurses to explore their attitudes, values and beliefs about provision of language concordant care.

Attitudes of colleagues and nurse managers and the support extended by them were identified as an important factor affecting nurses' practices of providing language concordant care. Findings suggest that managers and colleagues were generally unaware of organization's language and interpretation policies. Such unawareness contributed to variation in attitudes and practices of managers, with some being more receptive about provision language concordant care. Finding ways to increase staff awareness about interpretation and translation policies may help. As mentioned previously, it is also important to ensure that all staff members specially HCPs such as nurses, doctors and Allied Health Professionals (AHPs) are involved and consulted when developing policies.

Further research needs to be conducted to explore LEP patients' experiences of communicating via an interpreter. It may also be useful to explore non-BME patients' and nurses' perspective about provision of language concordant care to patients with LEP. It may also be useful to explore how non-minority nurses feel when their BME colleagues communicate with each other in a language other than English. Findings from this study could be used to develop questionnaires to conduct large scale studies to explore factors affecting the provision of language concordant care to LEP patients.

Limitations

The findings of the study need to be interpreted cautiously as it was only a small study. Use of snowball sampling may have resulted in the identification of the nurse participant with strong views about the issue and those who identify themselves as bilingual. The study only presents perspective of bilingual nurses and the perspective of patients, language and interpretation service managers/leads and nurse managers was not explored.

Implications

Bilingual nurses need to be competent and confident about their language skills. All nurses need to remember that they are required to act in their patient's best interest, as required by the Code of Professional Conduct (International Council of Nurses 2012, Nursing and Midwifery Council 2015). Strategies such as exploring the importance of effective communication and language concordant care and nurses' responsibilities in relation to the

provision of care to already marginalised or vulnerable patients such as those with LEP during organizational induction may be useful. Nurses need to be proactive in identifying ways to provide effective care to their patients; therefore, they need to be involved in policy making. Nurses should be encouraged to provide feedback about the usefulness or lack of usefulness of prevalent language and interpretation services in their organization. Language and interpretation policies should be revisited to assess their relevance to all staff members. All stakeholders, including nurses and other HCPs should be consulted when developing or reviewing policies. Bilingual nurses and other HCPs with a remit for clinical assessment should be allowed to use their language skills to provide care to patients they are directly responsible for. A register of bilingual nurses and other staff who are competent, confident and willing to use their language skills should be developed and kept in the clinical area. This may help in recognizing language skills of staff, but will be very useful in identifying appropriate people with a specific language in out of hours or when arranging an interpreter is no possible/difficult. Nurses should not be penalised for using their own language skills. Neither should they be pressurised to act as interpreters for patients for whom they are not responsible. Where possible, bilingual nurses should be assigned to provide care to those patients who cannot speak English but share same language. Bilingual nurses' language skills should be valued, recognised and remunerated.

Conclusion

Nurses are responsible for providing patient-centred care to their patients regardless of their personal characteristics including language skills. This necessitates effective communication between nurses and patients. Language barriers, however, can make it difficult for nurses to ascertain the needs of patients and consequently affect the quality of care provided. Providing language concordant care can enhance the healthcare experience of LEP patients and bilingual nurses' ability to speak another language can be invaluable in providing language concordant care to LEP patients.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/recommendations/)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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