

BRIDGING THE GAP

PARTNERSHIPS FOR CHANGE IN REFUGEE CHILD & FAMILY HEALTH

POLICY AND PRACTICE BRIEF #1

Engaging professional interpreters during labour A Bridging the Gap quality improvement initiative

Engaging interpreters during labour and birth is critically important for women with limited English proficiency. A Bridging the Gap initiative has dramatically increased the proportion of women having a professional interpreter during labour. This policy brief summarises the process to bring about change, lessons learnt and implications for policy and practice.

The policy-practice gap

The non-engagement of professional interpreters and use of a family member to interpret leads to errors in communication and adverse clinical outcomes.¹⁻⁵ In childbirth, low English proficiency severely limits a woman's capacity to ask questions, provide information to health professionals, understand what is happening, and make informed decisions.

In a study with Afghan families in Melbourne very few women who required language support during labour had access to a professional interpreter. Husbands frequently interpreted for their wives. Health professionals and women noted challenges with this, with many women on reflection preferring to have had a professional interpreter in labour.⁶



One in ten Afghan women had a professional interpreter in labour.

Source: *Having a baby in a new country study 2013*⁷

Dandenong Hospital in Melbourne's south east, the site of the interpreter initiative, is an area of high migrant and refugee settlement. Analysis of hospital language services data identified that interpreters were less frequently accessed in birth suite compared to outpatient clinics.

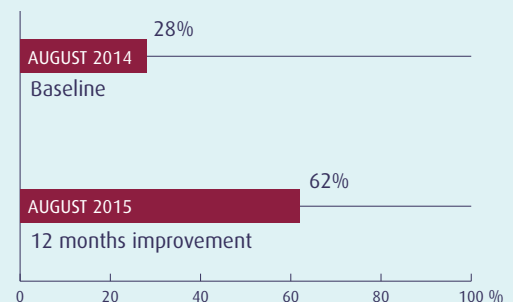
THE PRACTICE CHANGE

In the birth suite at the hospital, midwives tried out a new way of enabling women to have language support in labour.

This included:

- > Offering women a professional interpreter in **early labour**
- > Trying out different ways of offering an interpreter
- > Engaging an interpreter again if required
- > Encouraging staff to practice using the telephone interpreter service on speaker phones

What was achieved?



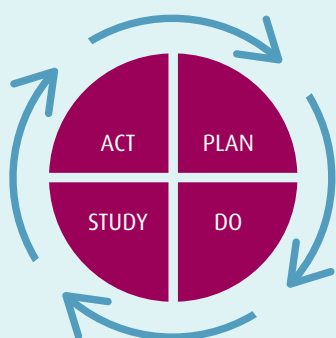
Women requiring an interpreter who had one in labour

The proportion of women identified as requiring an interpreter who went on to have one more than doubled from 28% at baseline to 62% following nine months of practice change.

How was this achieved?

A CO-DESIGNED SOLUTION

A working group comprising the managers of hospital maternity and language services, frontline staff, clinical midwives and researchers considered options to improve engagement of interpreters in labour. They decided to test a change in practice using iterative cycles of implementation adopting the Plan Do Study Act (PDSA) framework.⁸



STARTING SMALL WITH CYCLES OF CHANGE

Project implementation took place over nine months in 2015 with four PDSA quality improvement cycles where 2-3 midwives per cycle tried out offering an interpreter to women early in labour. The participating midwives recorded information on each occasion where the woman they were caring for required an interpreter. This included:

- > language spoken
- > offering women an interpreter
- > women's refusal of a professional interpreter and the reason
- > organising a face to face or telephone interpreter
- > stage/s of labour that the interpreter was used
- > the length of time of the interpreter mediated encounter.

This information was collated and the midwives shared their experiences with members of the working group after each cycle.

FLEXIBILITY FOR MODIFICATION

The process of using PDSA fostered reflective practice. Feedback from each cycle was used to make modifications to the following cycle.

A series of professional development sessions were available to all maternity practitioners to support practice change. Topics included: responding to family members who wish to act as interpreters; dispelling misconceptions including the number of times professional interpreters can be accessed in labour; and the use of the telephone interpreter service on speaker phone.

Information was made available for all staff in the birth suite, including a step by step guide for accessing interpreters. On advice from the midwives involved in the earlier PDSA cycles a notice reminding staff about engaging interpreters was developed:



- > Offer an interpreter early in labour
- > Gently insist if declined
- > Offer again

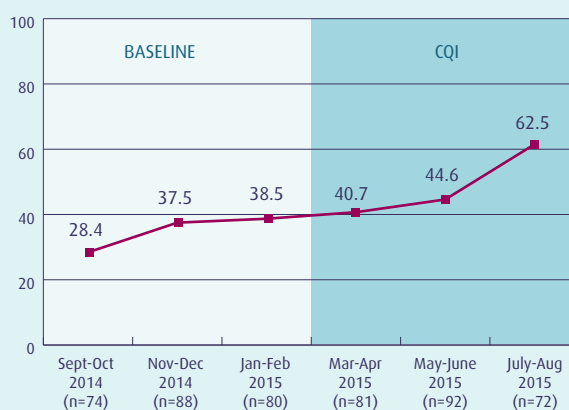
This was placed where staff would see it eg. on the doors of staff toilets.

Measuring change

The 'Study' component of the PDSA cycles enabled participating clinicians to share the data they had collected and reflect on successes and challenges.

Maternity and language services worked together to devise a way for data from each department to be linked on the Unit Record. This enabled measurement of an individual woman's requirement for an interpreter and language spoken with interpreter accessed in labour, either in person or via telephone.

Figure 1. Proportion of women who required an interpreter who received one in labour



Afghan women are the largest group of all refugee background women giving birth at Dandenong Hospital. Dari speaking Afghan women who had a baby at Dandenong Hospital in two months of 2015 were invited to participate in a brief telephone interview facilitated by an interpreter at 3-4 months postpartum.

Compared to the earlier study with Afghan women and men, women participating in the telephone interviews were four times more likely to have an interpreter in labour.



Four in ten Afghan women interviewed in late 2015 had a professional interpreter in labour.

A new approach to engaging interpreters in healthcare

The Language in Labour project illustrates that significant change in healthcare is possible within existing resources. It also illustrates the value of engaging 'consumers' in strengthening the responsiveness of health services to cultural diversity.

The perspectives of Afghan women and men were critical to informing the focus and design of the initiatives. Women's views and experiences of new systems were equally important to inform next steps. Women who had a professional interpreter were overwhelmingly positive about this commenting that it was easier to express themselves, ask questions and convey concerns. Of the women who declined an interpreter as they had a family member present, several commented that it would have been better to have had a professional interpreter.

A focus on sensitively negotiating the use of language services with women and their families will be important to sustainability of this initiative and replication elsewhere.

LOCAL MULTIDISCIPLINARY CO-DESIGN IS KEY TO SUCCESS

One of the key success factors is the preparedness of hospital staff to collaborate across internal hospital silos. The collaboration between service management and frontline staff in the design of a quality improvement initiative fostered relationships and enabled conversations about possibilities for change and 'doing things differently'.

Opportunities for the participating clinicians to meet together and share ideas for improvement and refinement built shared ownership of the project.

This approach to multi-disciplinary co-design requires shared responsibility for change.

Leadership at the hospital program and unit level facilitated collaboration and played a vital role in encouraging and supporting colleagues to try new approaches. The project had the support of the health service's program leaders and was registered as a maternity program quality improvement project at the participating hospital.

ADVANCING IMPLEMENTATION OF QUALITY IMPROVEMENT

The use of PDSA as a framework for implementation was central to this quality improvement initiative. The purpose of the PDSA method lies in learning as quickly as possible whether an intervention works in a particular setting, allowing adjustments to be made increasing the chances of delivering and sustaining the desired improvement.⁹

Considerations for policy and services

The process of change rarely progresses in a linear fashion. This initiative revealed many related issues that needed to be addressed in order to achieve the goal of enabling women who required a professional interpreter to have one in labour. Achieving change required identifying opportunities, addressing barriers and encouraging and supporting staff over the course of iterative cycles of quality improvement activity.

Key success factors were:

- > professional development to support clinicians in working with women and family members around language support
- > information available for clinicians and front of house staff on:
 - the new approach to interpreter engagement early in labour
 - identifying that an interpreter is required and language/s spoken
 - how to offer women an interpreter
 - how to access an interpreter (step by step guide).
- > reforms to data systems to enable maternity and language databases to link on the patient Unit Record
- > monthly data to identify whether individual women in labour who required an interpreter had one.
- > providing feedback loops to report achievements to managers and staff
- > the need for on-going and accessible measures of change including data, and consumer and provider perspectives.¹⁰

People with low English proficiency including people of refugee background, are often excluded from patient experience surveys and considered 'hard to engage' in patient participation endeavours. As such their voice is often missing in the design and evaluation of healthcare.

Expanding the interpreter initiative to other areas of maternity, postnatal and primary care has tremendous potential to improve quality and safety in health care and improve health outcomes for refugee and migrant families.

Bridging the Gap is a partnership program of system reform and quality improvement in maternity and early childhood healthcare with the aim of improving outcomes for women and families of refugee background.

FOR FURTHER INFORMATION ABOUT BRIDGING THE GAP:

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This policy and practice brief has been put together by the Healthy Mothers Healthy Families research group at the Murdoch Childrens Research Institute on behalf of the Bridging the Gap partnership. We acknowledge our many colleagues from the partnership and their contributions to the program. Bridging the Gap implementation sites include Monash Health, Western Health and the maternal and child health services of the City of Greater Dandenong and City of Wyndham.

REFERENCES

References used in the development of this policy brief are available from:
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