

# Importance and Promotion of Linguistic Safety in the Healthcare Setting

Desiree A. Diaz, PhD, RN-BC, CNE, CHSE, and Lynn Allchin, PhD, RN, CHPN, CNE

The United States has always been and will continue to be a nation of many cultures and languages. In the healthcare arena, this means safety will depend on clear, linguistically appropriate communication between the patient and family and the healthcare provider. Three obstacles exist to this type of essential communication: limited English proficiency, low health literacy, and cultural barriers.

Desiree A. Diaz, PhD, RN-BC, CNE, CHSE, is an associate clinical professor in the School of Nursing at the University of Connecticut in Storrs, and Lynn Allchin, PhD, RN, CHPN, CNE, is an associate clinical professor in the School of Nursing at Northern Arizona University in Flagstaff. The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the authors or editorial staff. Diaz can be reached at [desiree.diaz@uconn.edu](mailto:desiree.diaz@uconn.edu), with copy to editor at [CJONEditor@ons.org](mailto:CJONEditor@ons.org).

Digital Object Identifier: 10.1188/13.CJON.374-375

The Joint Commission, founded in 1951, accredits more than 18,000 healthcare organizations and programs and is the largest and oldest standards-setting and accrediting body in health care in the United States (Joint Commission, 2012a). They set the standards for and enforce high-quality care. The National Patient Safety Goals come directly from the Joint Commission (2013); however, none of those goals address communication between the patient and family and the healthcare provider. Barriers to safety in communication between the patient and family and the healthcare provider include limited English proficiency, low health literacy, and cultural barriers. More than 40 million immigrants in the United States are considered “linguistically isolated” (Joint Commission, 2012a; U.S. Census Bureau, 2010). Until each of these barriers is addressed throughout the United States in every healthcare setting, no healthcare agency will be able to fully comply with any of the Joint Commission’s National Patient Safety Goals (e.g., identify patient correctly, use medicine safely, identify patient safety risk). Although the Joint Commission’s (2012b) facts regarding patient-centered commu-

nications states that more than 300 languages are spoken in the United States and more than 90 million Americans have low health literacy, the National Patient Safety Goals do not address language, health literacy, or culture (Joint Commission, 2013). The U.S. Department of Health and Human Services (2010) defined health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (p. 1). As documented in the National Patient Safety Goals, none of the following sections address communication: home care, ambulatory care, behavioral health care, long-term care, and office-based surgery. Only the hospital, critical access hospital, and laboratory sections address communication at all, with each section stating to improve staff communication. Nothing in the goals is directed toward safety regarding linguistically appropriate communication with patients.

## Linguistically Appropriate Communication

The National Patient Safety Goals do not address linguistic safety as a way to

improve patient care and outcomes (Joint Commission, 2013). The U.S. Department of Health and Human Services (2010) Office of Minority Health developed National Standards on Culturally and Linguistically Appropriate Services in Health Care to encourage appropriate care and communication by healthcare providers for individuals with limited English proficiency. The standards were created in 2001 and updated in 2010 in an attempt to address proper verbal and written communication in a multilingual and multicultural society. However, no financial incentives exist for compliance or regulation of the standards. The standards serve as a guide and conceptually provide guidance. However, without funding and cost-effective strategies to enhance the application of the standards, they only rank with minimum importance in the healthcare setting.

The Joint Commission’s (2010) roadmap for hospitals defined communication as a “two-way process in which messages are negotiated until the information is correctly understood by both parties” (p. 1). The Joint Commission (2010) addresses communication between the patient and family and the healthcare provider in the roadmap for hospitals. The purpose of the roadmap is to “inspire hospitals to integrate concepts from communication, cultural competence, and patient- and family-centered care fields into their organizations” (Joint Commission, 2010, p. 3). Admission, assessment, treatment, end-of-life care, discharge or transfer, and organizational readiness are addressed in this document. The roadmap also contains information on how to ensure that each healthcare facility excels in communication between the patient and family and the healthcare provider.

However, the guidelines provided may not be working. In an account given by a nurse (L. Allchin, personal