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Original Article

Communicating with parents who have difficulty understanding and speaking Swedish: An interview study with health care professionals

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ABSTRACT

Background: Neonatal units care for sick and premature newborns, and staff meet the children's parents on a daily basis. Some parents are immigrants and do not speak or understand the local language, hampering both verbal communication and the parents' opportunity to be involved in their child's care and treatment.
Aim: To explore the experiences of health care professionals in Swedish neonatal care units regarding communication with parents of foreign origin who have difficulty understanding and speaking Swedish.
Methods: Individual open-ended interviews were conducted with 60 health care professionals at five neonatal care units in western Sweden: 10 physicians, 25 nurses, and 25 nursing assistants. The interviews were analysed using qualitative content analysis.
Results: The health care professionals' experiences were summarised in one main category: "Powerlessness in the face of inadequate care routines leading to failure to communicate." The main category was constructed through three categories. "*Inability to perform their work properly*" meant that staff experienced frustration when they could not convey important information to parents. "*Finding their own strategies*" meant that staff found their own ways to communicate using body language and assistive technology. "*Dependence on others*" meant that staff were dependent on others, primarily talking through an interpreter.
Conclusion: There is a need for organizational changes to increase parents' participation in their child's care in daily practice at neonatal care units. To ensure that parents who do not speak or understand the Swedish language are given sufficient time and possibilities, routines must be established in which interpreters are used more frequently.

Introduction

Of Sweden's 9.8 million inhabitants, 16% are of foreign origin and speak a range of languages (Central Bureau of Statistics; Swedish Migration Agency). Speaking and understanding the local language are important skills if the parents are to be able to take note of information concerning the child's care and treatment and to be involved in the care of their child. According to the Swedish Health Care Act, it is the responsibility of the staff to give parents the opportunity to attend and be involved in their child's care (Swedish Statute, 2017). Involvement here means actively participating in or having knowledge of something, and actively participating in decision-making (National Encyclopedia, 2014). The information should be adapted to the parents' linguistic background and individual circumstances (Patient Act, 2014). There should be opportunities for parents to be with their child, to receive detailed information so that they can get actively involved in or be aware of what is happening, and to be actively involved when decisions are made (United Nations Convention on the Rights of the

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Child, 1989). Healthcare model in neonatal care is usually family-centred, parental involvement in the care of the child is self-evident (Harrison, 2010). The parents learn to interpret their child's signals, which strengthens parental identity and promotes bonding between child and parent (Wigert et al., 2014). Language barriers can be an obstacle to the interaction between the medical staff and the family, which means that the cultural competence of health care personnel is important for a better understanding of the family (Hendson et al., 2015). Communication and chatting allow an important exchange of medical information and nursing care advice. When people cannot communicate with each other, their relationship is affected (Pergert et al., 2007). Furthermore, parents may misunderstand their child's condition and treatment (Wiebe and Young, 2011). Verbal communication affects people's understanding of the situation they find themselves in (Enke et al., 2017); in health care, this is often about giving and receiving information (Ng and Newbold, 2011).

The aim of this study was to explore the experiences of health care professionals in neonatal care regarding communication with parents of foreign origin who have difficulty understanding and speaking Swedish.

Methods

Design

The study was performed in western Sweden. Data were collected via interviews and analysed using inductive content analysis (Elo and Kyngäs, 2008). To get health care professionals' overall opinion, all three categories of staff working at the units were invited: physicians, nurses, and nursing assistants.

Settings

Interviewees were recruited from five hospitals with neonatal units, all based in a region in western Sweden. Neonatal units in Sweden are divided into three levels of care. Level I is basic neonatal care, and level II is specialist neonatal care. Level III is the subspecialty of neonatal intensive care, and is subdivided into A–D, where D is full intensive care for extremely preterm babies (Stark, 2004).

The care units were staffed by nursing assistants, nurses, and physicians. The number of staff at the units varied between 32 and 96 (mean 58), the number of beds ranged from 14 to 22 (mean 16.6), and the average period of inpatient care ranged from 8.3 to 13.8 days (mean 10.6); see Table 1.

Participants

The operational managers and unit managers at each unit were contacted by author (KP), who requested the participation of five nurses, five nursing assistants, and two physicians in the study. The nurses and nursing assistants were informed about the study at their workplace meeting and were able to declare their interest in participation to their unit manager. Physicians who showed an interest in the study were invited by the head of department. There was a predominance of women working at the units, and five of the participants were of foreign origin.

A total of 60 participants were interviewed, with a good distribution of age and experience within the profession. Of the nurses, two were midwives, one was a primary health nurse, three were general nurses, and 19 were paediatric nurses; their age range was 23–65 (mean 41) and they had worked in neonatal units for 1–26 years (mean 13). The assistant nurses were aged 25–63 (mean 47) and had worked in neonatal units for 1–44 years (mean 14). Of the physicians, seven were neonatologists and three were paediatricians; their age range was 28–62 (mean 45) and they had worked in neonatal units for 0.5–30 years (mean 7). Of all participants, 54 were women and six were men.

Table 1
The neonatal units.

Hospital n = 5	Level	Number of beds	Number of health care staff	Average days of inpatient care
1	II	22	32	13.8
2	II	14	44	11.7
3	III B	16	64	8.3
4	III B	16	54	10.4
5	III D	15	96	8.9

Data collection

Open-ended digitally recorded interviews were conducted by authors KP (n = 48) and HW (n = 12) from December 2014 to March 2015. The interviews took place in a separate room in each hospital, except for one, which was conducted in the interviewee's home; all interviews lasted between 14 and 59 min, with a mean of 32 min. All interviews started with the same question: “Can you tell me about your experiences of working at a neonatal unit and communicating with immigrant parents who don't speak and understand the Swedish language?” To get a deeper understanding, follow-up questions were posed, such as, “Can you give me an example?”, “How do you mean?”, and “What is your experience when you don't have a common language?”.

Data analysis

All interviews were transcribed verbatim. They were then analysed by the authors KP, HW, and MB using a qualitative inductive content analysis (Elo and Kyngäs, 2008) comprising three phases: *preparation*, *organization*, and *reporting*, to clarify and give an increased understanding of the phenomenon.

In the *preparation* phase, the transcribed text was carefully read several times to get an overall understanding of the data and a feeling for the whole material. In the *organization* phase, the text was organized by highlighting all the segments that were relevant to the study aim. Categorization was conducted by open coding. In further repeated readings of the marked text, several codes were combined and given tentative names, and headings were created with descriptive names to cover all aspects of the content and to group it into eight subcategories. For the continuing analysis, subcategories that covered the same subject were combined, giving three categories. Next, the categories and their content were read to provide a means of describing the phenomenon in a conceptual form, resulting in one main category (Table 2). Finally, in the *reporting* phase, the data were presented (Elo and Kyngäs, 2008).

Ethical considerations

Ethical approval was obtained from the Regional Research Ethics Committee in Gothenburg, Sweden (registration number T443-15). Information about the study was sent to the operation managers at each of the neonatal units, who gave their approval. Following this, information about the study was sent to the managers of all neonatal units. The health professionals were given oral and written information about the study, gave their written informed consent, and were informed about guaranteed confidentiality and the right to discontinue the interview at any time without having to specify the reason.

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