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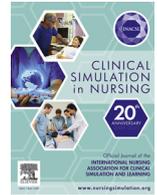
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# Addressing language barriers in maternity emergency care in the UK: A mixed methods quality improvement simulation study



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## ABSTRACT

**Background:** Language barriers in maternity care compromise patient safety and quality, with poorer maternal outcomes observed when communication between obstetric staff and women with limited English proficiency is hindered, especially during emergencies.

**Objective:** To explore obstetric and maternity staff understanding of language barriers when caring for women during obstetric emergencies.

**Methods:** A six-week mixed-methods quality improvement study in a UK National Health Service (NHS) Trust maternity unit. Forty maternity and obstetric clinicians were recruited. Participants engaged in postpartum hemorrhage simulations using a simulation mannikin programmed to speak a foreign language. Data collection involved presimulation Likert-scale questionnaires (five items) and postsimulation debriefs. Quantitative data were analyzed descriptively; qualitative data underwent thematic analysis.

**Findings:** Presimulation data revealed limited staff confidence: 52% were dissatisfied with interpretation services, 60% were very dissatisfied with communication support, and 57% were neutral about understanding communication in obstetric emergencies. Thematic analysis identified three key themes: (a) unavailability of interpreting services during emergencies, (b) undervaluing the importance of communication in urgent scenarios, and (c) opportunities for enhancing simulation-based communication training.

**Discussion:** Significant knowledge gaps and inadequate systems hinder effective communication with women facing language barriers during obstetric emergencies.

**Conclusion:** Urgent action is needed to strengthen training in interpretation services, enhance communication infrastructure, and raise awareness among maternity teams about the critical role of communication in emergency care.

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## Introduction

Communication forms the cornerstone of effective health-care delivery, serving as the critical bridge between healthcare providers and patients to ensure high-quality, safe care provision (Vermeir et al., 2015). Within maternity services, effective communication becomes particularly paramount given the complexity of care decisions, the emotional significance of childbirth experiences, and the potential for emergency situations requiring rapid decision-making and consent processes (Rock, 2021). The deliver-

ance of information through clear, comprehensible communication channels is essential not only for patient safety, but also for clinicians' understandings of the patient care journey and the provision of woman-centered care.

Language barriers represent a specific and significant communication challenge within healthcare settings, defined as barriers to communication between people who are unable to speak a common language (Oxford Dictionary, 2022). These barriers extend beyond simple linguistic differences to encompass cultural communication norms, medical terminology comprehension, and the ability to provide informed consent for medical procedures. Research has consistently identified that language barriers between obstetric and maternity staff and patients can result in poorer maternal and neonatal outcomes, with multiple reviews of maternal adverse

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outcomes finding that women are still not provided with interpreters even when there is clear evidence of lack of understanding (Healthcare Safety Investigation Branch [HSIB], 2021; Knight et al., 2021).

The complexity of communication barriers in healthcare encompasses multiple dimensions including linguistic, psychological, emotional, physical, cultural, organizational, attitudinal, and technological factors (Frydrychova & Semradova, 2012). Within maternity care, these barriers become particularly problematic during obstetric emergencies when time-sensitive decisions must be made rapidly, effective teamwork is essential, and patient cooperation and understanding are crucial for optimal outcomes. National reports have highlighted the benefits of human factors training surrounding communication with colleagues in obstetric emergencies, yet minimal attention has been given to communication with patients who have language barriers (Kirkup, 2022; Ockenden, 2022).

Current evidence suggests significant inadequacies in how maternity services address language barriers, with some women refusing interpreter services due to confidentiality concerns, staff using family members as translators instead of NHS-approved interpretation services, and women being denied their requests for interpreters (Bhatia and Wallace, 2007; HSIB, 2021; Thalassis, 2013). These practices can lead to misunderstanding of crucial medical information, inadequate informed consent processes, and negative impacts on maternal mental health and future care experiences. Furthermore, there is minimal teaching about communication with patients who have language barriers within current national maternity and obstetric training programs (PROMPT, 2022).

Despite growing recognition of healthcare inequalities, language barriers remain inadequately addressed in maternity care delivery, creating gaps in patient safety and care quality. This study addresses the critical need to understand current staff awareness and capabilities in managing language barriers during obstetric emergencies, representing a novel approach by utilizing simulation-based methodology to evaluate communication skills in emergency scenarios. The aim of this quality improvement project was to analyse the understanding of language barriers amongst obstetric and maternity staff when caring for women in maternity services, specifically during a simulated postpartum hemorrhage emergency. The objectives were to assess current staff awareness of interpretation services, evaluate communication approaches during obstetric emergencies involving language barriers, and identify training and system improvements needed to enhance care quality for women with limited English proficiency.

## Methods

### Study design

This quality improvement project utilized a sequential explanatory mixed-methods approach, combining quantitative and qualitative data collection methods to obtain comprehensive insight into the topic being studied. Quantitative data from presimulation questionnaires were first analyzed to identify patterns in staff confidence and satisfaction with interpretation services. These findings then informed the qualitative phase, where postsimulation debriefs were used to explore participants' reasoning and contextual experiences behind the quantitative results. This integration of numeric trends and thematic insights allowed for a comprehensive understanding of both the scope and meaning of communication barriers during obstetric emergencies (Creswell & Plano Clark, 2018). Mixed-methods research has been shown to be beneficial in healthcare research for obtaining information from multiple perspectives whilst allowing understanding of measurable data alongside contributing factors that may correlate with outcomes (Curry et al., 2006).

### Setting and participants

The study was conducted in a local NHS Trust maternity unit over a six-week period. The maternity unit consisted of inpatient and community midwifery services, delivering approximately 5,300 births annually with a level three neonatal unit. Delivery suite was chosen as the setting as this is where most obstetric emergencies occur due to high-risk cases being cared for in this area (King & Scrutton, 2011).

Forty clinicians participated in the study through convenience sampling. All maternity and obstetric staff working on delivery suite during the six-week study period were invited to participate via email invitation and in-person briefings during shift handovers. Participants included midwives (n = 18, 45%), student midwives (n = 4, 10%), delivery suite coordinators (n = 3, 8%), senior house officers (n = 5, 12%), registrars (n = 4, 10%), consultants (n = 3, 8%), anesthetists (n = 2, 5%), and maternity support workers (n = 1, 2%). Years of clinical experience ranged from less than one year (student midwives) to over 20 years (senior consultants and coordinators), with a mean experience of 8.3 years (SD = 6.7). Demographic data on gender, ethnicity, or language background were not collected to maintain participant anonymity. Participants were separated into groups of six per simulation to ensure realistic emergency response teams and facilitate effective team dynamics during the obstetric emergency scenario. To maintain anonymity throughout the process, no names or job roles were identified on questionnaires or debrief notes.

### Development and validation of presimulation questionnaire

The five-item Likert-scale questionnaire was developed specifically for this study based on a review of existing literature on language barriers in healthcare and consultation with senior maternity staff members. The questionnaire aimed to assess five key domains: (a) understanding of interpretation services, (b) confidence in communication during obstetric emergencies, (c) perception of simulation effectiveness for identifying knowledge gaps, (d) satisfaction with communication support services, and (e) ability to determine women's linguistic skills during emergencies. Each item used a five-point Likert scale (very dissatisfied, dissatisfied, neutral, satisfied, very satisfied) to allow measurement of satisfaction levels and attitudes (Bishop & Herron, 2015).

Face validity was established through review by three senior clinicians (one consultant obstetrician, one delivery suite coordinator, and one senior midwife) who confirmed that items were clear, relevant, and appropriate for the target population. Content validity was assessed by the same expert panel to ensure comprehensive coverage of key aspects related to language barriers in maternity emergencies. Minor wording adjustments were made based on their feedback to improve clarity. A pilot test was conducted with five maternity staff members not involved in the main study to assess questionnaire comprehension and completion time (approximately 3-5 minutes). No further modifications were required following the pilot.

Given the exploratory nature of this quality improvement project and the context-specific focus, formal psychometric testing (e.g., test-retest reliability, internal consistency) was not conducted. However, the questionnaire demonstrated adequate face and content validity for assessing staff perceptions within this specific maternity unit context.

### Simulation scenario

The simulation involved a postpartum hemorrhage scenario using a Gaumard simulation mannikin programmed to speak a foreign language. The scenario depicted a woman (named "Susie")

who was G1P0 at 39 + 3 weeks gestation, had a low-risk pregnancy with face-to-face Dutch interpreters at every appointment, and did not speak English. Following a precipitate labor and spontaneous vaginal delivery, the woman developed a postpartum hemorrhage with 500 mL estimated blood loss, requiring emergency management.

Consent was obtained from an individual to translate a prepared script, which was then programmed into the simulation mannikin. The script included phrases such as "why are there so many people in the room, please can you cover me," "what is happening, please help me," and "please tell me what is going on, I don't understand English." The simulation was conducted in actual delivery rooms with standard equipment and realistic blood loss simulation using fake blood-soaked incontinence sheets.

#### Data collection

##### Quantitative data collection

A presimulation questionnaire consisting of five questions using a Likert-scale format was administered to all participants. Questions assessed staff understanding of interpretation services, communication confidence in obstetric emergencies, simulation effectiveness for identifying knowledge gaps, satisfaction with communication support services, and ability to determine women's linguistic skills during emergencies. Response options included: very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied.

##### Qualitative data collection

Postsimulation debriefs were conducted with all participants following each simulation. The lead researcher posed the question: How do you feel the simulation went in regards to the communication with the woman (simulation mannikin)? Observational notes were taken during discussions to capture staff reflections on their communication approaches and experiences.

#### Data analysis

Quantitative data from Likert-scale questionnaires were analyzed descriptively and presented in graphical format. Qualitative data from postsimulation debriefs underwent thematic analysis using Braun and Clarke's (2006) six-phase framework. The process involved: (a) familiarizing with the data through repeated reading of transcribed debrief notes; (b) generating initial codes systematically across the dataset; (c) searching for themes by collating codes into potential patterns; (d) reviewing themes for coherence and validity; (e) defining and naming themes to capture their essence; and (f) producing the final analytical narrative with illustrative extracts.

To ensure analytic rigor, two researchers independently coded 20% of debrief transcripts (n = 8 debrief sessions) using Braun and Clarke's (2006) six-step framework. Coding discrepancies were discussed and resolved through consensus, resulting in a Cohen's kappa of 0.82, indicating strong interrater agreement. The lead researcher then coded the remaining 80% of transcripts and maintained a reflexive journal throughout to document analytical decisions and minimize interpretive bias. A third senior reviewer with expertise in qualitative methodology audited the final themes to confirm coherence and representativeness across the complete dataset. To ensure rigor and minimize interpretation bias, coding was conducted over three separate occasions spanning three weeks, allowing fresh analytical perspectives at each iteration. The researcher maintained a reflexive journal throughout to document analytical decisions and potential interpretative influences. Visualization methods including word clouds were utilized to identify key themes and patterns.

#### Ethical considerations

This project was registered and conducted as a quality improvement initiative within the NHS Trust. Permission and clearance for the quality improvement study was granted by the quality and compliance team at Medway NHS Foundation Trust with the reference number 2526.124. Ethical conduct was maintained throughout in accordance with the Declaration of Helsinki (2013), ensuring respect for participant autonomy, confidentiality, and psychological safety (Bibbins-Domingo et al., 2025). Although conducted as a quality improvement initiative, all procedures adhered to ethical standards applicable to research involving human participants. All participants provided informed consent, and anonymity was maintained throughout data collection and analysis. Wellbeing support services were made available to all participants, with signposting to counselling services and occupational health support if required.

#### Results

##### Participant demographics

Over the six-week implementation period, 40 participants were involved in the quality improvement project, participating in six simulation sessions with anonymized data collection throughout.

##### Quantitative results

As shown in Table 1, the results demonstrated significant gaps in staff confidence and satisfaction with current services. The mean satisfaction score across all five questions was 2.18 (SD = 0.94) on the five-point Likert scale, indicating overall dissatisfaction. Most notably, 52% of staff were dissatisfied with interpretation services (Q1; mean = 2.56, SD = 0.85), 60% were very dissatisfied with communication support services (Q4; mean = 1.40, SD = 0.49), and 57% felt neutral about communication understanding in obstetric emergencies (Q2; median = 3.0, IQR = 2.0-3.0). Question five showed the highest satisfaction, with 33% of staff satisfied with their ability to determine women's linguistic skills (mean = 3.13, SD = 0.78). These findings indicate substantial areas for improvement in both service provision and staff training.

##### Qualitative results

Thematic analysis of postsimulation debriefs revealed three main themes with supporting evidence from participant statements:

##### Theme 1: Interpreting services not available

Participants consistently reported difficulties accessing interpretation services:

*"Interpreting services are never available on shift." (Staff 1)*

*"There is no SOP/Guideline in place for me to follow to get a hold of the interpreting services." (Staff 2)*

*"There is no telephone available that we can use at the bedside so I have to use my own phone to access language service." (Staff 2)*

*"In one instance, a colleague tried to use our services and was told there is not an interpreter available for the next two hours." (Staff 12)*

This theme was supported by quantitative findings showing 52% dissatisfaction with interpretation services, highlighting systemic issues with service accessibility and infrastructure.

**Table 1**  
Presimulation Questionnaire Results (n = 40).

Question	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Mean (SD)	Median (IQR)
Q1: Understanding of interpretation services	2 (5%)	21 (52%)	10 (25%)	7 (18%)	0 (0%)	2.56 (0.85)	2.0 (2.0-3.0)
Q2: Communication in obstetric emergency	0 (0%)	4 (10%)	23 (57%)	10 (25%)	3 (8%)	3.31 (0.75)	3.0 (3.0-4.0)
Q3: Simulation highlighting knowledge gaps	0 (0%)	15 (38%)	20 (50%)	5 (12%)	0 (0%)	2.74 (0.67)	3.0 (2.0-3.0)
Q4: Communication support services	24 (60%)	16 (40%)	0 (0%)	0 (0%)	0 (0%)	1.40 (0.49)	1.0 (1.0-2.0)
Q5: Determining women's linguistic skills	1 (3%)	5 (12%)	21 (52%)	13 (33%)	0 (0%)	3.13 (0.78)	3.0 (3.0-4.0)

### Theme 2: Importance of communication in obstetric emergency

Staff demonstrated task-focused approaches that minimized communication importance:

*"When I am in an obstetric emergency, we are providing life-saving care, my priority would be to communicate, we need to deal with the emergency right now and we can talk to her later'." (Staff 4)*

*"During a PPH, I focus on the blood loss, I don't consider consent because I want to manage the blood loss firstly'." (Staff 6)*

*"I didn't even think about the communication with the woman because in simulation we usually focus on practicing communication with each other, and I just completely forgot about the woman." (Staff 8)*

*"I didn't realize we would be checked on how we talk to the woman, that's never been a thing." (Staff 19)*

### Theme 3: Simulation as a tool for communication awareness

Participants identified both the limitations and potential of simulation-based communication training:

*"The simulation mannequin is not realistic because when communicating with women there are nonverbal cues that can help with communication...such as her nodding or shaking her head or pulling away if we are doing something." (Staff 3)*

*"I think this has highlighted the importance of using sim more for communication than just practicing emergencies." (Staff 23)*

*"I didn't even think about the communication with the woman, we usually practice communication with each other, that's human factors right—us, I just completely forgot." (Staff 35)*

*"This simulation really made me aware of how we completely overlook patient communication during emergencies—it's opened my eyes to something we need to address." (Staff 16)*

*"Even though the mannequin can't respond like a real person, going through this has made me realize we need to be intentional about communication training, not just technical skills." (Staff 29)*

## Discussion

This mixed-methods quality improvement project revealed substantial dissatisfaction with interpreting services (52% dissatisfied) and communication support systems (60% very dissatisfied) among maternity staff. The mean satisfaction score of 2.18 across all domains indicates significant gaps in both staff confidence and system provision. Qualitative findings revealed that staff face systemic barriers to accessing interpretation services, tend to adopt task-focused approaches that deprioritize patient communication during emergencies, and recognize the need for enhanced communication training within simulation-based education.

### Comparison with recent studies

Our findings align with recent research demonstrating persistent challenges in addressing language barriers within maternity

services. Aldam and Purdie (2024) found that 74% of women requiring interpreting services faced issues around lack of availability, technical difficulties, and staff understanding, directly supporting our findings of interpretation service inadequacy. Similarly, Cull et al. (2022) identified clear evidential gaps in maternity care professionals receiving adequate training on accessing English language proficiency, leading to assumptions about women's linguistic abilities that mirror our participants' neutral responses regarding determining women's communication skills.

The task-focused approach observed in our study resonates with Sharp et al. (2018) findings that staff being task-focused within emergencies can impact patient experience and safety, with patients reporting lack of involvement in care planning. This suggests that the communication challenges we identified during simulated emergencies may reflect broader patterns in clinical practice.

Recent publications have emphasized the importance of interpretation services in maternity care. The Amma Birth Companions (2024) report on inequalities in maternity care specifically recognized that language barriers exacerbate communication issues, recording significant impacts from interpreting service problems in Scottish NHS trusts. Their findings of inadequate service provision and staff training deficits directly parallel our results, suggesting this is a systemic rather than localized problem.

### Implications for simulation practice

Consistent with the INACSL Healthcare Simulation Standards of Best Practice: Simulation Design (INACSL Standards Committee et al., 2021a) and Facilitation (INACSL Standards Committee et al., 2025b), our findings support integrating explicit communication objectives and interpreter-role engagement into obstetric simulation curricula. The INACSL Simulation Design Standard (INACSL Standards Committee et al., 2021a) emphasizes that learning objectives should align with program outcomes and participant needs, in this case, the critical need for effective communication with women experiencing language barriers during emergencies.

To enhance simulation fidelity and learning transfer, future training programs should consider incorporating standardized patients or multilingual role-play actors rather than relying solely on low-fidelity mannequins. This approach aligns with the INACSL standard of best practice: simulation-enhanced interprofessional education (INACSL Standards Committee et al., 2021b), which emphasizes the importance of realistic interactions that mirror clinical complexity. Additionally, debriefing sessions should explicitly address communication strategies, interpreter utilization, and patient-centered care principles, even during time-critical emergencies, as recommended by the INACSL debriefing standard (INACSL Standards Committee et al., 2025a).

The study findings have several important implications for maternity care delivery. Firstly, there is an urgent need for robust training in interpretation services, including clear standard operating procedures for accessing services and portable communication devices at bedsides. Secondly, simulation-based training programs should be enhanced to include communication skills with women experiencing language barriers, potentially utilizing high-

fidelity simulations or real-life actors to improve training effectiveness.

The task-focused approach identified suggests need for cultural change in emergency management, emphasizing that patient communication and consent remain priorities even during time-critical situations. This aligns with human factors principles highlighting that effective communication maintains situational awareness, which is paramount in obstetric emergencies (Fortune et al., 2013).

Based on study findings, several recommendations emerge: implementation of 24/7 accessible interpretation services with clear access protocols; development of bedside communication technology including video interpreting capabilities; enhanced staff training combining technical emergency skills with patient communication competencies aligned with INACSL Standards (INACSL Standards Committee et al., 2021a, 2021b, 2025a, 2025b); and regular audit of interpretation service effectiveness and staff satisfaction.

### Limitations

Several limitations must be acknowledged in this study. Firstly, the small sample size of 40 participants from a single NHS Trust limits generalizability of findings to other maternity units with different demographics, staffing models, or interpretation service arrangements. The findings represent a snapshot of one Trust's experience rather than a comprehensive national assessment.

Another limitation relates to voluntary participation, as staff who were more confident or interested in simulation-based education may have been more likely to participate, introducing potential self-selection bias. Staff who felt less competent in communication skills or who had negative views toward simulation may have been underrepresented in our sample, potentially affecting the generalizability of findings.

Researcher bias represents another significant limitation. The lead researcher's prior experience in maternity simulation and knowledge of existing literature on communication gaps may have influenced both data collection during postsimulation debriefs and subsequent thematic analysis. Although reflexive journaling and independent coding by a second researcher (Cohen's kappa = 0.82) were employed to minimize bias, the researcher's pre-existing awareness of communication challenges in maternity care may have shaped the interpretation of themes. The two-step mixed-methods approach meant the researcher was aware of quantitative findings when conducting qualitative analysis, potentially influencing interpretation of themes.

The use of low-fidelity simulation presented technical limitations, as the simulation mannikin could not provide nonverbal communication cues that are crucial in real-world patient interactions. Participants noted this limitation affected the realism of communication scenarios, potentially reducing the external validity of findings to actual clinical situations.

The six-week data collection period provided only a temporal snapshot of staff experiences and may not reflect variations in interpretation service availability, staffing pressures, or training initiatives that could influence results over longer timeframes. Additionally, the study focused specifically on postpartum hemorrhage scenarios and Dutch language barriers, limiting applicability to other obstetric emergencies or different language groups that may present unique communication challenges.

Finally, the study did not include patient perspectives or experiences, representing a significant gap in understanding the full impact of language barriers on care quality and maternal outcomes. Future research should incorporate women's voices and experiences to provide a more comprehensive understanding of communication challenges in maternity care. Future research should expand to multi-site studies incorporating patient perspectives and evaluating the long-term impact of communication-focused sim-

ulation training on both clinical practice and patient outcomes. The development and evaluation of enhanced training programs aligned with INACSL standards and service delivery models could provide valuable evidence for improving care quality and patient safety in diverse maternity populations.

### Conclusion

This mixed-methods quality improvement project has demonstrated substantial gaps in staff knowledge and inadequate systems supporting effective communication with women experiencing language barriers during obstetric emergencies. The combination of quantitative and qualitative data revealed that staff lack confidence in accessing interpretation services, tend to adopt task-focused approaches that deprioritize patient communication during emergencies, and require enhanced training in communication skills.

The findings highlight an urgent need for healthcare organizations to develop comprehensive strategies addressing language barriers in maternity care. This includes implementing reliable interpretation services with clear access protocols, enhancing simulation-based training to include patient communication competencies, and fostering cultural change that maintains patient-centered communication even during emergency situations. The study contributes to growing evidence that language barriers represent a significant patient safety concern requiring systematic attention within maternity services. Given the potential impact on maternal outcomes and patient experience, addressing these communication challenges should be considered a priority for quality improvement initiatives in maternity care.

Future research should expand to multi-site studies incorporating patient perspectives and evaluating the effectiveness of interventions designed to improve communication with women experiencing language barriers. The development and evaluation of enhanced training programs and service delivery models could provide valuable evidence for improving care quality and patient safety in diverse maternity populations.

### Conflicts of interest

None.

### CRediT authorship contribution statement

**Sorcha Magee:** Writing – review & editing, Writing – original draft, Validation, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **David B. Olawade:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation.

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