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Feature Article

Examining differences in nurses' language, accent, and comprehensibility in nursing home settings based on birth origin and country of education



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ABSTRACT

As nursing homes turn abroad to fill vacancies, the diverse linguistic backgrounds of nurse hires are creating new challenges in comprehensibility between nurses, providers, and residents. Accents are a natural part of spoken language that may present difficulty even when the parties involved are speaking the same language. We surveyed 1,629 nurses working in 98 nursing homes (NHs) in five U.S. states to determine if and how language difficulties were perceived by nurses and others (e.g. physicians, residents and family members). We found that when participants were asked how often other care team members and residents/families had difficulty understanding them due to language use or accent, foreign born nurses were significantly more likely to report that they experienced difficulty at least some of the time across all groups. This study supports an assessment of nurses' language, accents, and comprehensibility in these settings.

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Background

The Institute of Medicine's (IOM) "Retooling for an Aging America: Building the Health Care Workforce" projects that the U.S. will need an additional 3.5 million public health care workers by 2030 to maintain the current ratio of 220 workers per 10,000 older U.S. residents¹ The need for front-line health care workers, such as registered nurses (RNs), licensed practical/vocational nurses (LPVNs), and nurse aides (NAs) is especially critical for managing the complex care needs of the 1.4 million older adults residing in the nation's 16,000 nursing homes.²

With an estimated 40,000 nurse vacancies in nursing homes, many facilities are doing what they have done for decades – looking abroad to manage nurse shortfall.³ This practice has been

particularly notable since 1989, when nursing homes were able to secure foreign-born and foreign-educated (FB/FE) nurses through an "attestation" process stipulated in the Immigration Nursing Relief Act.⁴ Recruitment agencies have capitalized on the staffing crisis in nursing homes to provide nurses for this under resourced setting.

While the majority of FB/FE nurses work in acute care settings, 28% of FB/FE RNs and 74% of FB/FE LPVNs, in contrast to U.S. educated nurses, work outside the hospital setting.⁵ The percentage of FB/FE nurses working in nursing home/extended care settings has fluctuated between 6.1 and 11.7% of the total nursing workforce since 1992 (authors' calculation using data from the NSSRN 2008).^{4,6} As has been true for six decades, the Philippines contributes the highest number of FBNs to the U.S.—almost seven times that of South Korea, which ranks second.⁷ As has also been true for decades, FB/FE nurses entering the U.S. are still geographically clustered, practicing primarily in urban communities in California, Florida, New York, Texas, New Jersey, and Illinois.⁸

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Prior to licensure as a nurse in the U.S., FB/FE nurses in most states are required to have their credentials and qualifications verified through the Commission on Graduates of Foreign Nursing Schools (CGFNS). Part of this assessment entails certification of nurses' English language proficiency to establish linguistic competency among non-native English speakers⁹ through a variety of foreign language tests that focus on listening, reading, writing, or speaking. One major limitation of the CGFNS language assessment, however, is the lack of interpersonal communication assessment, a critical skill for nurses to possess.¹⁰ Further lacking is attention to sociocultural dimensions of language that may include how language is used and spoken by country or region.¹¹

Although FB/FE nurses working in the U.S. must speak English, only 5–6% of CGFNS applicants⁹ identify English as their primary language. Many FB/FE nurses report ongoing communication challenges such as problems with writing and documentation, misunderstanding jargon and slang,¹² and difficulty with conversational English.¹³ Heavy accents between nurses from different countries, and even among nurses from the U.S., can also make the communication process challenging.^{10,14} Indeed, the variation in word pronunciation and the comprehensibility of English among FB/FE nurses is a leading barrier to their successful integration in U.S. health care facilities.¹³

Effective communication is central to the nursing care process, whether it relates to relaying information to providers, interacting with patients and families, or working effectively with other nurses.^{15,16} The lack of clear and accurate communication has been reported as a key barrier to effective care with patients across institutions¹¹ as well as between staff in nursing homes. Furthermore, the nursing profession in the U.S. has its own vocabulary, abbreviations, and writing style that can challenge even nurses whose primary language is English.¹⁷

To date, most of the research on language barriers in nursing home settings has focused on communication between physicians and nurses. In 1999, Cadogen surveyed RNs and physicians and found that, while both reported difficulty understanding one another's spoken English, each group perceived that their own spoken English could be understood without difficulty.¹⁸ Tjia and colleagues also observed language barriers in nurse–physician relationships across long-term care facilities and reported that 12% of the surveyed nurses reported difficulty understanding the physician's language or accent or felt physicians had difficulty understanding them due to language or accent.¹⁹ There has been no research that examines nurse-to-nurse communication or nurse-to-resident or family in nursing homes.

Study aims

There is clear evidence that effective communication maximizes quality of care and patient outcomes in nursing homes.¹¹ There is also evidence that among the increasing numbers of international nurses working with older nursing home (NH) residents, communication issues persist.¹⁴ Given that FB/FE nurses are increasing in percentage in many nursing home settings and will likely continue to do so, it is critical to examine communication challenges experienced by FB/FE nurses with other care providers, nursing home residents, and residents' families as a foundation for understanding how these challenges translate into outcomes. Our study aim therefore, was to specifically examine communication challenges of FB/FE nurses (RNs and LPVNs) working in NHs, and determine how language comprehensibility (actual use of grammar and vocabulary) and accents (pronunciation) were perceived by others (e.g., physicians, other nurses, residents and family members) and whether nurses born and educated abroad faced different linguistic challenges.

Design

Using a cross-sectional, descriptive, comparative design, we collected data from RNs and LPVNs employed in NHs in five U.S. states with the highest proportion of FB/FE nurses. The study received ethics approval from the New York University Committee on Activities Involving Human Subjects (UCAIHS).

Sample selection

Inclusion criteria for participating NH included that they were Medicare and Medicaid certified facilities located in New York, Illinois, California, Texas, or Florida. The participating states were chosen based on data that showed internationally educated nurses were hyper-concentrated in these states, primarily in urban settings,¹⁴ and to achieve geographical diversity across regions (e.g., West, South, Southwest, Northeast, Midwest). New Jersey, ranked the fourth most populated state with FB/FE nurses, was not included based on its proximity to New York and instead, the sixth most populated state of FB/FE nurses, Illinois, was selected. To maximize sampling efforts to include FB/FE nurses, and given that less than 10% of FB/FE nurses are located in non-metropolitan areas,²⁰ we also selected nursing homes based on an "urban" code from the Center for Medicare and Medicaid Services' (CMS) Online Survey Certification and Reporting (OSCAR). We then selected a randomized sample of 849 urban NHs from these five states.

To elicit study participation, we first sent letters of introduction about the study to the Director of Nursing (DON) at each eligible nursing home. The DON was asked if he/she would be willing to distribute surveys to all full-time and part-time employed nurses (RNs and LPVNs) in the facility. In addition to a study description, each received an agreement form that included information on the number of full-time and part-time nursing staff, and a postage-paid return envelope. Two follow-up reminder mailings and phone calls were used as recommended by Dillman²¹ to increase response rate. Of the 849 NH contacted through the DON letter, 98 (11.5%) agreed to participate (20 in California, 13 in Florida, 19 in Illinois, 25 in New York, and 21 in Texas), with a fair distribution across geographic regions. Although there were no differences in facility-level characteristics, the remaining 734 NH declined to participate or were unable to be reached despite multiple attempts via phone and repeated mailings.

Upon receipt of a signed agreement form from the DON, survey packets were mailed for the DON to distribute to all nurses employed part or full time at greater than a 0.5 FTE. The number of surveys mailed was based on the DON's reported nursing staff count as indicated on the completed agreement form. For example, if the DON identified 10 nurses working in the nursing home, 10 survey packets with an enclosed \$5 cash incentive, letter explaining the study, the survey, and a self-addressed envelope were mailed. A total of 3539 surveys were sent to the 98 participating facilities. While the potential for sampling bias exists since the DON distributed the surveys, this method was deemed the most appropriate sampling approach to yield the highest response rate.

Once the participant completed the survey, she/he was asked to return it in a self-addressed stamped envelope to be mailed directly back to the research team. While the survey itself was anonymous, a facility ID code was included in the survey to gauge facility response rate. Two weeks after participants received the packets, reminder postcards were mailed to the facility for distribution.

Survey instruments

The surveys were pilot-tested by a sample of 45 nurses (both FBNs and U.S. educated) in a large non-profit nursing home in New

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