The number of non-English–speaking people in the United States is higher than ever before, and that number is expected to grow; the nation’s foreign-born or immigrant population reached a new record of more than 35 million in March 2005, according to the Center for Immigration Studies and the U.S. Census Bureau.

When non-English–speaking patients enter ERs, which are already facing maximum capacity, hospitals are faced with the serious dilemma of trying to diagnose medical conditions while successfully communicating with patients. In this environment, in which quick decisions and comprehension are crucial, the addition of a language barrier can be disastrous.

As a response, many cities are turning to technology to provide a communication tool. Recently, hospitals in some urban areas have installed interpretation technology from the Language Access Network (LAN), a live, two-way video interpretation tool that provides interpretation 24 hours per day in more than 150 languages, including Spanish, Portuguese, Italian, Thai, and even American Sign Language.

This technology can help doctors and nurses treat patients in their native language, says the company’s CEO, Michael Guirlinger.

“When a young boy comes to the hospital with his parents, and they don’t speak any English, the hospital is then confronted with a very serious situation,” says Guirlinger.

There is also a chance that doctors will prescribe medication that the patient does not understand how to take. “There is some real risk in not getting it right the first time,” he says.

Along with possible health risks, hospitals should also consider the additional cost of miscommunication, adds Guirlinger.

“If the hospital has trouble assessing what’s going on with an individual, they might be inclined, in light of liability, to assign a lot of tests,” he says. “Clearly, that can add up to a lot of money.”

How does it work?

LAN uses medically trained interpreters who are available to the hospitals through a wireless video unit. All that healthcare providers have to do, says Guirlinger, is walk up to the unit, push one button, and be connected to the network center in Columbus, OH.
Technology

In about 30 seconds, the hospital is connected, and about 20 seconds later, an interpreter is available on screen. Although nurses and other providers have very quick access to verbal translation, he says, LAN also puts a big emphasis on cultural awareness and comprehension, because 70% of communication is nonverbal. Interpreters are able to immediately assess the culture and environment from which a person is coming when he or she arrives at the hospital. Thus, the interpreters can pick up on and report cultural cues, increasing the patient’s ability to be understood. Right now, about 150 hospitals have been set up with LAN, including ones in Miami, Houston, Ohio, and Los Angeles. The transmission, says Guirlinger, is Health Insurance Portability and Accountability Act of 1996–compliant. “They can always be assured of privacy,” he says, adding that information transmitted over the video is never viewed by a third party.

To get connected, hospitals can buy packages from LAN that range from 1,000 to 10,000 minutes per month.

Where the magic happens

One of the hospitals equipped with LAN is the Boston Medical Center. Oscar Arocha, MD, director of the interpreter services department there, says that the hospital, which has more than 28,000 patient discharges and almost a million outpatient visits each year, treats people with a mix of language, ethnic, and cultural backgrounds.

Arocha, who himself is fluent in English, French, Portuguese, and Spanish, arrived at Boston Medical in 1996 to head interpreter services. Now, the hospital has the most extensive interpreter services program in New England, according to BusinessWire.com. Boston Medical has been using the LAN interpretation technology since January.

The technology assists the staff “in providing the best quality care for those with limited English proficiency and the deaf and hard-of-hearing patients whom we encounter every day,” says Arocha.

What the results say

The feedback on the network has been “absolutely delightful,” says Guirlinger. Healthcare providers who are on a quick schedule can get connected to an interpreter in under a minute, making it a very convenient and extremely valuable service that can be of use in many facilities.

“One of the terrific things about the business is that we help people get better because they’re understood,” says Guirlinger.

Editor’s note: For more information on interpretation technology, visit www.languageaccessnetwork.com or contact Guirlinger at mguirlinger@languageaccessnetwork.com.
Retention

Getting your new nurses past the hurdles

New Jersey ED successfully retains nurses with mentoring program

The horror stories abound: New nurses who enter an ED experience firsthand the “nurses eat their young” phenomenon. There are also those whose orientation leader throws them in at the deep end to see whether they will sink or swim. As a result of this lack of support and horizontal hostility, many new grads quickly flee the rough, fast-paced ED environment.

The Robert Wood Johnson University Hospital in New Brunswick, NJ, witnessed this snag in the system. The hospital’s ED, a Level 1 trauma center that sees more than 75,000 visits per year, found that about 50% of new nurses could not make it through the orientation program and left within a year. Instead of feeling ready to dive into the new work environment, the new grads reported feelings of helplessness and a lack of adequate support and preparation.

As the ED found itself continually recruiting new nurses, it wanted to find ways to help novice nurses through the rough start and retain their desire to stay in the field. Developed by Anthony Filippelli, BS, RN, CEN, head nurse in the ED, and Kathleen Evanovich Zavotsky, MS, RN, CCRN, CEN, APRN, BC, clinical nurse specialist, the department took off running with a new mentoring program that was geared toward staff development, aptly titled, “Be a Mentor, Not a Tormentor.”

Beginning the process

Filippelli and Zavotsky decided the best way to increase retention would be through mentoring. They began the program a year and a half ago as an additional step for the hospital’s training program.

“New grads kept asking for a mentoring program,” says Zavotsky. “They felt a little leery about ending their orientation. They were done with orientation, and boom, that was it. It was a little lacking.”

The new program pairs nurses with a mentor after they have completed the original preceptor training program. The mentors, who volunteer their time and are unpaid, are nurses who have been at the hospital for at least three years and have ED experience.

After deciding to become a mentor—defined in the program as “a colleague who is willing to guide, teach, and support during the growth of a novice’s practice”—the experienced nurse filled out an application for Filippelli and Zavotsky. The mentors then were prepared for their role with a training session. The group learned several techniques to help the new nurses “navigate the waters.”

There are 10 steps, the experienced nurses learned, to mastering the mentor role:
1. Remember what it was like to be a novice
2. Acknowledge the presence of the new nurse
3. Openly discuss a plan with him or her
4. Remain with the novice through thick and thin
5. Assist in critical-thinking development
6. Provide insight into the chain of command
7. Remain positive
8. Remain aware of your influence and behave accordingly

> continued on p. 4
9. Befriend the new nurse
10. Be a good listener

The mentors were then equipped with navy-blue T-shirts with white letters that read, “Mentor, Not a Tormentor,” and each of the experienced nurses was linked with a novice nurse who had gone through the original preceptor training program. Each new nurse was paired with two mentors, with the expectation that at least one of the mentors would be around each time the mentee worked.

Staff members and nurses collaborated to find the best fit for each person involved, says Zavotsky.

“Primarily, we looked at personality and matched people that we felt would get along fairly well for whatever reason,” she says.

For the first two weeks, the mentee followed the mentor’s schedule within the department. Additionally, during the first three months, the mentor and the mentee met for about 15 minutes every two weeks to talk about everything that was going on, from educational opportunities within the field to any difficult cases either one was facing.

From three to six months, the pair met every three weeks, and from six months to a year, they met once per month.

One of the biggest results of the program was that new nurses reported not experiencing the nervousness and anxiety often associated with approaching an older nurse with questions—evidence that the techniques had accomplished the goal of ending horizontal hostility within the group, says Filippelli.

“That person was there for them because they knew they could go up to them and say, ‘Could you help me out with this?’ And that person had already volunteered to help that person, so the apprehension was eliminated,” he says.

Getting results

After the first year of Be a Mentor, Not a Tormentor, Filippelli says he retained nine out of the 10 nurses involved with the program, showing evidence that its goal of nurse retention has also been reached. The nurse who left only did so because she was relocated to another trauma center in Boston.

Mentors and mentees completed evaluations (see a sample evaluation form on p. 5), and Zavotsky says the feedback has been phenomenal.

“Mentees and mentors have nothing but positive things to say about it,” she says. “I have so many people that want to be mentors now . . . Every time I hire a new person, they say, ‘If you need a mentor, I’ll be a mentor.’ ”

So how do you do it?

A mentoring program is not something that takes a particularly long time to get up and running in a facility, says Filippelli, making it an effective, quick method to increase nurse retention and job satisfaction. He also believes that mentoring programs should be strictly voluntary.

“I don’t know if nurses should be compensated for it,” he says, “because there might be another motive more than just to mentor that person.”

Filippelli and Zavotsky view the program as a big success in their attempt to prevent nurses from “eating their young.” They also hope to see housewide duplication of the program in the near future.

“I’ve been a nurse for 10 years, and you see how the older nurses are a bit rough to the newer nurses,” says Filippelli. “But they were newer nurses, too, once. And the whole attitude went away with this program.”
**Sample mentor/mentee evaluation form**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you find the mentor program helpful to your practice?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Would you add anything to the mentor program? (If yes, please explain.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you think the mentor program should continue to be offered to all new ED nurses?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Did you feel that the relationship that you have with your mentor/mentee will last longer than the scheduled year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you think the mentor program impacted your ED Nursing practice?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what area/areas?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please include any additional comments:

*Source: Robert Wood Johnson University Hospital, New Brunswick, NJ. Used with permission.*
**Book excerpt**

**The shock of a new environment**

*How to help your preceptees confront and overcome reality shock*

Editor’s note: The following is adapted from HCPro’s new book *The Nurse Preceptor Training System, Second Edition*, by Diana Swihart, PhD, DMin, MSN, CS, RN-BC. To purchase this book or any other from our library, visit www.hcmarketplace.com.

New nurses enter their assigned practice settings eager to begin their new jobs, meet their new colleagues, and accept their new challenges. They complete orientation and their initial competency verifications without difficulty. Their preceptors ease the transition into practice and teach them everything they need to be successful. Then, six months to a year later, disillusionment sets in. The preceptee realizes that the reality of the new healthcare environment is flawed.

Preceptees may then experience reality shock when they encounter the change, conflict, and chaos associated with their new responsibilities. Reality shock is the reaction that newly graduated nurses and students, as well as newly hired employees, experience when they find that the careers for which they have just been prepared do not operate with the same values and ideals that they have learned.

There are four phases to reality shock:

1. **Honeymoon phase.** Preceptees are happy to be in their clinical rotations, finished with school, and starting a new job. They perceive the setting and their new coworkers positively, or through “rose-colored glasses.” When asked, they may say, “Everything is wonderful!”

   Preceptees are actively focused on developing their skills, mastering work routines, and meeting new people.

2. **Shock phase.** Preceptees begin to encounter weaknesses, discrepancies, and inconsistencies in the work environment and their new colleagues, such as coworkers with weaknesses (e.g., disorganized or often tardy), a lack of supplies, or any situation that can cause frustration, anger, embarrassment, or disillusionment.

   To help preceptees through the shock phase, one technique is to ask them to list on an index card the weaknesses, obstacles, and inconsistent practices that they have encountered on their nursing units. Discuss the list by asking:
   - What can be done on the nursing unit to change the situation you listed?
   - Who needs to be involved in the change process?
   - What action plan would you use to address these suggestions for change with the appropriate personnel?

3. **Recovery phase.** Preceptees begin to perceive the realities of the professional practice environment with a balanced view of both negative and positive aspects. They establish expectations that are consistent for all coworkers. The perspective that not all healthcare providers have uniform conformity to the professional or organizational standards for conduct must evolve from within the work setting. Once this is achieved, preceptees recognize their own fallibility. Their sense of humor may return.

4. **Resolution phase.** Preceptees may adopt less than ideal values or beliefs to resolve the conflicts of values and find ways to fit in. Preceptors must help them to see the positive aspects of both belief systems—those taught at school and those held by practicing nurses.

   Sometimes, preceptors are scheduled to work other shifts, and preceptees are thrown into the practice setting before they are ready. This can cause such anxiety that preceptees feel unable to perform their duties and thus resign to resolve the stress.

   When reality sets in and preceptees begin to react to the disparities they encounter, preceptors have the opportunity to step in and help them through the process (see the chart on p. 7). Develop an action plan early to help them complete the transition and celebrate their successful journey through the phases of reality shock and realize their potential.
Helping preceptees complete the transition

<table>
<thead>
<tr>
<th>Phase</th>
<th>Ways to assist preceptees</th>
</tr>
</thead>
</table>
| 1. Honeymoon | ➤ Develop the initial bonds between preceptors and preceptees, created by a mutual sense of trust, respect, and honor.  
➤ Harness preceptees’ enthusiasm for learning new skills and routines.  
➤ Be realistic, but do not stifle their enthusiasm.  
➤ Introduce them to new staff and coworkers. |
| 2. Shock | ➤ Anticipate that preceptees may experience some dissatisfaction with new positions, peers, or employers.  
➤ Listen attentively.  
➤ Model the ideals of professional nurses.  
➤ Help preceptees find appropriate supplies and functional equipment when needed.  
➤ Provide opportunities to vent frustrations in a constructive manner. |
| 3. Recovery | ➤ Always treat preceptees kindly.  
➤ Help them view situations realistically.  
➤ Ask them to keep a journal of improvements they would like to suggest and outcomes they expect or would like to see.  
➤ Help them recognize positive aspects of their current work settings, as well as areas where improvements might be made.  
➤ Ease them into their roles and responsibilities. Do not release preceptees to take full patient assignments until they are ready.  
➤ Protect them in times of adversity.  
➤ Always speak kindly about nurses and other healthcare providers.  
➤ Help preceptees regain their sense of humor. |
| 4. Resolution | ➤ Identify and manage any conflicts and confusions that persist.  
➤ Assist them in constructive and creative problem-solving.  
➤ Describe mechanisms and processes available to resolve perceived problems or confusion.  
➤ Give simple, easy-to-follow directions for tasks.  
➤ Help them combine the best aspects of their prior school or work expectations with their current work situations.  
➤ Help preceptees see the positive aspects of the nursing values/belief systems they learned at school, as well as those that they have learned from practicing nurses. |

Adapted from American Association of Critical Care Nurses, A Preceptor Training Program (2000). Used with permission.
On call
Sitting down for a conversation with . . .

Christine Varner, MSN, RN, CCRN, staff nurse in the ICU at Cayuga Medical Center in Ithaca, NY. This month, Christine took some time from her busy schedule to talk to us about being a team player, the importance of patient safety, and her quest for a good book.

The best orientation exercise that I’ve ever been a part of . . . consisted of a lecture about being a team player. It focused on the different types of personalities that we encounter at work. It was presented in a fun way, and everyone had to take a little personality test to start.

One exercise I use to help my staff members think critically is . . . constantly asking questions. Sometimes they don’t even realize that they already know the answer. A mentor once told me that if you can explain something to a child you truly understand it. So I make them explain it to me.

My fondest memory of nursing school is . . . taking care of a dying patient. I just sat by her bedside and held her hand. She thought I was her granddaughter. I guess we looked a lot alike. Her granddaughter couldn’t fly in, but it was comforting to both of them to know that I was there.

The one thing I remember about my first day as a nurse is . . . I didn’t know half of what I thought I did. I started out in a very busy cardiovascular ICU. It was intimidating, full of technology and chaos.

The best thing a preceptor can do to help new nurses is . . . support them in the learning process. Encourage critical thinking, ask questions, give new nurses autonomy when they have earned it, step back when they are ready, and watch them fly.

One tip I’d give to anyone entering the nursing profession would be . . . go for it. I have seen and done many things. You see people at their worst and encourage them at their best. You will never be bored.

The best way to combat the nursing shortage facing us today is . . . to put patient safety first. If our patients are safe, we will be more productive and efficient. I don’t think nurses enter the profession thinking that they will make millions. They do it because they care.

One thing I wish I had more time for each week is . . . to read for fun. I read a lot of nursing books, journals, and online information. I wish I had time for a juicy novel about something other than what I live every day.

The idea of shared governance is important because . . . it puts nurses in the driver’s seat. They feel empowered to make decisions and hold each other accountable because they are vested. It is a wonderful thing that can improve patient safety and nursing turnover rates.

Editor’s note: To get more information from Christine, e-mail her at cvaner@cayugamed.org.