Centre for
Canadian Language
Benchmarks

Benchmarking the English Language Demands of the Nursing Profession Across Canada

July 2002

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RESEARCH TEAM

The Research Team from the Red River College Language Training Centre (Winnipeg, Manitoba):

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- individuals in the five provinces who provided assistance in arranging the observations of nurses in the workplace

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Marianne Kayed, CCLB Project Manager

Executive Summary

A growing shortage of nursing professionals in Canada is projected in the next ten years. Internationally-educated nurses entering the profession in Canada could ease this projected shortage. However, one of the issues involved in licensing these nurses is language competence and how it is measured. Stakeholders have indicated the need for a nursing-specific assessment tool to facilitate integration of nurses into the profession. Based on this need, the Centre for Canadian Language Benchmarks (CCLB) has initiated a two-phase project. The results of the first phase, *Benchmarking the English Language Demands of the Nursing Profession across Canada*, are presented in this report. The purpose of this study was to determine the real-life English language demands of the nursing profession in Canada, and to assign appropriate Canadian Language Benchmark (CLB) levels to the four skill areas (speaking, listening, reading, and writing). To establish the language demands of the nursing profession, we: (1) sent survey questionnaires to 1000 randomly-selected nurses across Canada, asking them to rate the importance of language tasks described by the CLB document; (2) administered 10 CanTESTs to internationally-educated nurses in 5 provinces; (3) held focus groups with a range of stakeholders in 5 provinces; (4) interviewed 23 nurses across the country; and (5) observed a sample of nurses on the job in 5 provinces, noting the language tasks they carried out.

Based on analysis of the data gathered, the English language demands of the nursing profession were determined to be:

SKILL	CLB LEVEL
SPEAKING	8
LISTENING	9
READING	8
WRITING	7

We recommend that the CCLB proceed with Phase II of the project, in which an English language assessment tool specific to the nursing profession in Canada will be developed.

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1. Project Background

The Centre for Canadian Language Benchmarks (CCLB) initiated the project, *Benchmarking the Language Demands of the Nursing Profession across Canada.* This project is designed to address the critical shortage of nursing professionals in Canada. Statistics Canada anticipates that over the next five years, a large percentage of nurses will retire. With enrollment in nursing programs in colleges and universities decreasing and the aging population of Canada increasing, the demand for health care providers may exceed the supply by as many as 113,000 nurses by the year 2011. The Ontario Ministry of Health and Long Term Care, in a recent report, *Ensuring the Care Will be There* (Registered Nursing Association of Ontario with Registered Practical Nurses Association of Ontario, 2000), stated that unless solutions are found, and found soon, the country's health care system will suffer significantly. This view extends across the country among members of the health care profession and members of the general public.

Internationally-educated nurses entering the profession in Canada could help to ease the projected shortage. However, one of the issues involved in licensing these nurses is language competence and how it is measured. In 2000-2001, with funding from the Ontario Government, the CCLB completed a feasibility study entitled, "Benchmarking the Nursing Profession and Developing an Occupational Specific Assessment Instrument". This study included a survey of over 50 professional nursing stakeholder organizations across Canada, who were contacted to explore interest in a nursing-specific English language assessment instrument. This survey focused on occupational groups and regulatory bodies. One of the key questions posed was whether stakeholders believed the nursing language assessment tool would be of benefit. Ninety-two percent of respondents responded YES, which led the CCLB to undertake this project.

The results of the feasibility study were even more encouraging. Stakeholders generally indicated that existing assessment instruments such as the Test of English as a Foreign Language (TOEFL) and the Test of Spoken English (TSE) were too general to adequately evaluate the ability of internationally-educated nurses to communicate effectively in the profession in Canada. The benefits of a nursing-specific assessment instrument expressed in Canadian Language Benchmarks, as cited by stakeholders, are summarized as follows:

- To help internationally-educated nurses who are not presently working as nurses in Canada to enter the profession.

- To provide a standard means of assessing English language competence for internationally-educated nurses.

- To alleviate the need for a national centre for the assessment of applicants to the nursing profession educated outside Canada.

Based on the data gathered, there is clearly a need for a nursing-specific assessment tool. However, before such a tool can be developed, it is necessary to do an in-depth analysis of the English language demands of the nursing profession in Canada.

The CCLB is a national, not-for-profit organization, primarily serving the adult English as a Second Language (ESL) community in Canada including learners, teachers, program administrators, and materials, curriculum and test developers. A Canada-wide combination of language training specialists, assessment service providers and both federal and provincial government members forms the CCLB Board of Directors. The Board of Directors and staff of the CCLB are committed to maintaining and promoting language proficiency standards based on the Canadian Language Benchmarks (CLB).

The CLB is a descriptive scale of communicative proficiency in ESL, expressed as benchmarks or reference points. They provide a framework of reference for learning, teaching, programming and assessing adult ESL in Canada, and a national standard for planning second language curricula for a variety of contexts, a common "yardstick" for assessing the outcomes. The CLB descriptors are available in the document, *Canadian Language Benchmarks 2000*, which can be ordered at the Website www.language.ca at no charge. The CLB provides descriptors for four language skills: speaking, listening, reading and writing on a scale from CLB Level 1 to CLB Level 12. These twelve levels are divided into three stages: Stage I, Basic Proficiency (Levels 1 to 4); Stage II, Intermediate Proficiency (Levels 5 to 8); and Stage III, Advanced Proficiency (Levels 9 to 12).

The CLB was developed in response to a 1992 consultation undertaken by the Government of Canada through the department now called Citizenship and Immigration Canada (CIC). This consultation with experts in second language teaching and training, testing and measurement confirmed that no one instrument, tool or set of "benchmarks" was widely used or appropriate to Canadian newcomers' needs. A national working group on language benchmarks was established by CIC in 1993 to oversee and guide the development of benchmarks. Field testing of a draft document was implemented in 1995, and in 1996 the CLB Working Document was ready for distribution and use in English. In 1999 revisions were made to the CLB Working Document based on feedback from stakeholders across the country. Based on this feedback, the Canadian Language Benchmarks 2000 was published.

The CLB is presently used in English language training programs across the country to determine content and curricula of ESL programs. According to the CLB 2000 (p. IX),

> …the CLB standards can help to articulate ESL needs, practices and accomplishments. They can also facilitate clear communication throughout the ESL community, and between it and other community/national organizations and agendas (e.g., instructors, learners, educational programs, assessors and counsellors, language education funding bodies, labour market associations, licensing bodies, and employers).

Because the CLB provides a common language to discuss levels of language proficiency, it has the potential to be useful for a wider range of applications. It has been used to benchmark academic programs, occupations, and assessment tools. An assessment tool, Canadian Language Benchmarks Assessment (CLBA) has been developed to measure English language proficiency based on the CLB. This tool is used primarily to assist in placing ESL learners in appropriate ESL classes.

2. Project Overview

The CCLB is undertaking this project as the first phase of a two-phase project. Phase I, *Benchmarking the English Language Demands of the Nursing Profession across Canada*, is being funded by the Ontario and Alberta Governments, and is being carried out by the Language Training Centre, Red River College, Winnipeg, Manitoba. The goal of the project is to conduct an English language occupational analysis of the Nursing Profession in Canada, expressed in Canadian Language Benchmarks. The project includes registered nurses (RNs), registered practical nurses (RPNs), registered nursing assistants (RNAs) and licensed practical nurses (LPNs).

The project outcomes are:

- Increased access by internationally-educated nurses to the nursing profession by clearly defining the required level of English language competency.
- Identification of the specific English language skills still needed by an applicant in order to be eligible to work as a nurse in Canada.
- A basis for the development of "English for Nursing" bridging programs for internationally-educated nurses.

Subsequently, the CCLB plans to pursue Phase II, which would involve the development of a CLB task-based assessment instrument for nursing, as an alternative to language tests that merely evaluate a candidate's academic knowledge of the English language.

The project is expected to benefit nursing colleges, licensing bodies, health care employers and internationally-educated nurses. It will offer them an accurate picture of the English language ability needed by nurses to practise in the profession effectively in Canada. This information will contribute to the development of a nursing-specific language assessment tool.

3. Project Methodology

Research approval was applied for and received from the Research Approval Committee at Red River College. This committee operates according to the Tri-Council Policy Statement on the Ethical Conduct for research involving humans. It ensures that research proposals are coordinated, follow ethical guidelines, and serve the wider purpose of educational knowledge. Application requires a summary of the proposed research and a detailed description of research procedures. Samples of research materials including the survey, the protocol for the administration of the CanTEST, the focus group agenda, the interview format, and the observation protocol were submitted. Also included were covering letters, consent forms used with participants, and details regarding the use and reporting of results and findings.

A National Advisory Committee (NAC) was initially set up, using as a starting point a list of contacts supplied by the CCLB. We (Epp and Stawychny) also consulted directly with the CCLB regarding other possible contacts. Stakeholders who had expressed interest in the project were contacted. In addition, we identified stakeholders not on the list (additional nursing associations, regulatory bodies, nurses' training programs, employers, health and social services agencies, immigrant-serving agencies, nursing union representatives, and nurses, some of them internationally-educated).

Based on the contacts made, we made a recommendation to the CCLB regarding the composition of the NAC. It was agreed that a wide range of stakeholders should be represented, and that NAC members should be chosen in locations across the country. A profile was sent to prospective NAC members to fill out (see **Appendix A).**

The following stakeholders agreed to participate as members of the NAC:

- **Jean Barry**, Registration Advisor - Initial Registration, Registered Nurses Association of British Columbia (also representing Canadian Nurses Association)
- **Carolyn Sams**, Executive Director/Registrar, College of Licensed Practical Nurses of British Columbia
- **Rob Boldt**, Manager, Program Design and Evaluation, Settlement and Multicultural Branch, Government of British Columbia (CCLB Board Member)
- **June Rock**, Registrar, Alberta Association of Registered Nurses (also representing Canadian Nurses Association)
- **Laura Schnieder**, Manager of Health Programs, Alberta Learning
- **Bula Ghosh**, Past President/Instructor, Immigrant Refugee and Visible Minority Women of Saskatchewan/Cypress Hills Regional College
- **Debbie Carey**, Acute Care Coordinator, Meadow Lake Hospital (Saskatchewan)
- **Susan Neilson**, Executive Director, College of Registered Nurses of Manitoba
- **Lydia Nowicka** (internationally-educated nurse), sub-acute care nurse, Concordia Hospital, Winnipeg
- **Brenda Lewis**, Coordinator of Assessment, College of Nurses of Ontario
- **Ricki Grushcow**, Director, Ontario Hospital Association
- **Ana Maria Revilla**, CARE for Nurses Project, Toronto
- **Peggy Frederikse**, Senior Policy and Project Consultant, Ministry of Training, Colleges and Universities, Access to Professions and Trade, Toronto (CCLB Board Member)
- **Tracy Kuder**, Instructional Designer, Nova Scotia Community College

A summary of the role of members of the NAC was also developed. The main function of the NAC was to give feedback at various stages of the project, and to provide the names of contacts for various aspects of the research (see **Appendix B).**

Data was gathered in five different ways. First, **a survey of language tasks** was sent to 1000 nurses practising in Canada. Second, **the CanTEST was administered** to a total of ten internationally-educated nurses presently working in the profession. In addition, five **focus groups** were conducted with a range of stakeholders. **An interview format** for individuals who were not able to attend focus groups was established to gather data from nurses and others who work closely with nurses. Finally, **observations of nurses** were carried out in the workplace. We thought that using a range of methods to gather data would provide balance and help to confirm and interpret the final results.

The administration of the CanTEST, the meetings with focus groups, and the observations of nurses in the workplace were carried out in five provinces (British Columbia, Alberta, Manitoba, Ontario, and Nova Scotia). Two criteria were used in determining locations: (1) A range of locations across the country needed to be represented; and (2) It was important that NAC members be available in each location to assist with arrangements. We spent three full days in each location in order to gather data.

3.1. Survey

A survey form was developed by selecting relevant CLB descriptors at levels ranging from CLB Level 6 to CLB Level 12. These descriptors of English language tasks were arranged according to language skill areas. Nurses were requested to rate the descriptors (on a scale of 1 to 5) in terms of their importance as reflected in the position the nurses presently held. The first draft of the survey was sent to Alister Cumming, consultant for the project. It was suggested that the survey be field-tested. A feedback form was developed, and the survey was filled out and returned by six participants including a nurse/nurse educator, other nurses (RNs, an LPN), and an acute care coordinator. It was recommended that the survey be shortened and that the wording be simplified. Appropriate changes were made to the survey, and the final version was drafted (see **Appendix C**). A cover letter explaining the project was included. Directions about how to fill out the survey were also enclosed, as was a pre-paid, addressed return envelope. The responses were to be indicated on bubble sheets, which were also supplied. Prior to the mailing, we identified the province/territory and nursing designation of the participant.

Surveys were sent to the specified designations of nurses in all provinces (except Quebec)[*] and territories. Surveys were sent to 1000 nurses across Canada, based on a ratio proportionate to the number of nurses represented by each licensing body. Table 1 lists the names of the provincial licensing bodies that participated by supplying names and addresses of randomly-selected nurses to whom the surveys were sent by mail. The table also indicates the number of surveys sent through each organization.

[*] Quebec was not involved because French, not English, is the dominant and official language of the province.

Table 1.

Association	Number Sent	Association	Number Sent
College of Licensed Practical Nurses of British Columbia	21	Registered Nurses Association of British Columbia	120
College of Licensed Practical Nurses of Alberta	20	Alberta Association of Registered Nurses	96
Saskatchewan Association of Licensed Practical Nurses	9	Saskatchewan Registered Nurses Association	37
College of Licensed Practical Nurses of Manitoba	10	College of Registered Nurses of Manitoba	43
College of Nurses of Ontario [includes RPNs (Registered Practical Nurses) and RNs (Registered Nurses)]	RPN 148 RN 353 Total 501	College of Registered Nurses of Nova Scotia	38
Nova Scotia Practical Nurses Licensing Board	15	Registered Nurses Association of New Brunswick	32
Association of New Brunswick Registered Nursing Assistants	11	Nursing Association of Prince Edward Island	5
Licensed Nursing Assistant Association of Prince Edward Island	3	Registered Nurses Association of Newfoundland	23
Council for Licensed Practical Nurses of Newfoundland	13	Northwest Territories Licensed Practical Nurses	1
Northwest Nurses Association of the Northwest Territories	1	Yukon Licensed Practical Nurses	1
Yukon Registered Nurses Association	1		

In addition, we (Epp and Stawychny) independently identified the language tasks on the survey that we considered most important, based on an overview of all the other data that had been gathered. These results were compared.

3.2. CanTEST

It was important that some evidence of English language competence of internationally-educated nurses presently practising in Canada be available to assist in verifying the CLB levels needed. The Canadian Language Benchmarks Assessment (CLBA) could have been used; however, the CLBA was developed primarily to assess language levels for ESL programs, and tests only to CLB Level 8. It was decided that the CanTEST would be a more appropriate assessment tool for the benchmarking of nurses.

The CanTEST is used by an increasing number of Canadian post-secondary institutions to ensure that candidates meet the language requirements for admission into programs. It is available through the CanTEST Project Office at the University of Ottawa, and measures all four skill areas: speaking, listening, reading, and writing. It was originally developed as a tool for screening the preparedness, in terms of English proficiency, of Chinese scholars coming to Canada for work-study or academic programs at university.

The CanTEST has been analyzed using the CLB in two separate projects, one undertaken by the CanTEST Project Office at the University of Ottawa (U of O) (2001), and one undertaken by the Language Training Centre at Red River College (RRC) (1999). Although the U of O and RRC used different methodologies in benchmarking the CanTEST, the results were very similar (see **Appendix D**). Epp and Stawychny were trained to administer the test by CanTEST trainers at the University of Winnipeg. RRC has access to two versions of the Institutional Version of the test. Institutional Version A was used for this project.

The CanTEST was administered to ten internationally-educated nurses who were presently practising in Canada. Contacts were asked to identify nurses who had recently begun to work. An effort was made to test two nurses in each of the five provinces being visited. Two nurses in each of the provinces of British Columbia and Alberta were tested. One nurse in each of the provinces of Nova Scotia and Ontario was tested. To make up the difference, four nurses were tested in Manitoba. Eight of the nurses tested were RNs, and two were LPNs. Honoraria of $75.00 were paid to the nurses taking the CanTEST. A letter of explanation was given to each participant, and each participant signed a letter of consent (see **Appendix E**).

3.3. Focus Groups

Focus groups were held in Vancouver, Edmonton, Winnipeg, Toronto, and Halifax. A wide range of stakeholders was invited to each focus group. Feedback was received from the NAC regarding the make-up of the focus groups. Stakeholders contacted included representatives of nursing regulatory bodies and nursing associations, clinical nursing instructors, representatives of immigrant-serving agencies, employers, members of the NAC, nurses (including internationally-educated nurses), board members of the CCLB, and representatives of nursing unions. Although it was not possible to have representation of all categories of stakeholders at every focus group, every group of stakeholders was represented in at least one focus group. The number of participants in each group ranged from six to eleven (not including us). Each group met for 2 to 2 ½ hours. We led the focus groups and recorded minutes. The minutes were later sent to all participants in each focus group, with participants having the opportunity to suggest revisions.

The agenda for the focus groups was approved by the NAC. At the beginning of each focus group meeting, participants were asked to read and sign a consent form (see **Appendix F**). Participants introduced themselves and the groups they represented. An introduction to the CLB, the rationale for the project, and the process of the research were presented, allowing time for feedback from the group. Three questions were then addressed by participants: (1) Why are you/your organization interested in the project? What are you concerns/suggestions? (2) What are the greatest language challenges for internationally-educated nurses in your province? (3) In your province, what are the differences in the language demands of the two designations addressed by this project?

3.4. Profile Information Interviews

An interview protocol (see **Appendix G**) was developed to gather data from individuals who were not able to attend the focus groups. The purpose of the interview format was to rate CLB language tasks in terms of importance for nurses, to find examples of nursing tasks that represent the language descriptors in the CLB document, and to address the following three questions: (1) Identify what you would consider the three main differences between the tasks

carried out by the different nursing designations (e.g., RN/LPN/RNA/RPN) in your province? (2) How would these differences be reflected in the language tasks required of nurses in each designation? (3) What do you see as the three greatest challenges related to the language demands of the nursing profession in Canada?

The interview format was field tested with two executive directors of nursing regulatory bodies, three clinical nursing instructors, and a practicing internationally-educated RN. The interview format was edited, based on the field testing. The changes involved mostly the rewording and combining of language tasks to avoid repetition. A cover letter and a consent form were developed for use with the interview. For telephone interviews, consent was verbal.

Interviewees were given descriptions of language tasks (e.g., talk to other health care professionals face to face) and asked to rate their importance on a scale of 1 to 4 in terms of the practices of nursing in Canada. They were then asked to give examples of the types of nursing tasks that would require these language tasks. The interview format was used with 23 participants. Participants included nurses (some of them internationally-educated), nurse educators, and others who worked closely with nurses. Interview participants were given information about the research, and asked to give consent to the use of the information gathered for the project. Most interviews were carried out in person or by phone. In a few cases, participants wrote responses and returned them by fax. In some cases, one or both of us held group interviews in person.

3.5. Observations

The observation of nurses on-the-job was a key element in the establishment of the English language demands of the nursing profession as defined by the project. In British Columbia, Alberta, Manitoba, Ontario, and Nova Scotia, contacts were made with individuals who agreed to assist in identifying appropriate settings for the observation of nurses. Based on interviews already carried out, it was clear that nursing tasks varied widely from one health facility/setting to another, and from one unit to another. As a result, the importance of observing at a range of facilities was noted.

Letters were composed to send to contacts explaining the project and requesting assistance in arranging for observations. Also, letters to inform nurses of the project and their role in it were written (see **Appendix H**). These letters varied based on the requirements of the facility and/or province to which they were sent. Consent forms were also developed for participating nurses (see **Appendix I**). In Edmonton, ethics approval required an additional form (to obtain permission from clients to view their charts) and two scripts explaining our presence (one for nurses to read to other professionals, and one for nurses to read to clients) and asking for verbal consent. Ethics protocol, letters and scripts required the approval of the Health Research Ethics Board in Edmonton. In other provinces permission to observe was given on an adhoc basis depending on the requirements of each facility/organization.

In each province visited, we asked NAC members to identify contact persons to arrange for the observation of six nurses in a range of settings. An effort was made to observe nurses in all the professional designations addressed by the project. During most observations, one of us observed one nurse on the job for three consecutive hours. During this time, the language used by the nurse was noted. In speaking and listening, the focus was on interactions between

nurses and other professionals, clients, and clients' families. In reading, the focus was on charts and other informational text, and in writing it was on filling out charts and other forms. Wherever possible, samples of reading and writing were obtained for further analysis. If possible, a 20- to 30-minute interview was carried out with the nurse's supervisor. It was important to remain flexible in carrying out the observations, based on the constraints of the workplace. For example, supervisors seldom had time for a 20- to 30-minute interview. We made it clear that we did not wish to impose on the nurses and their clients, and were willing to step out of the room at any time when our presence was inappropriate. There were also times when it was possible to observe for more than three hours, and conversely, when a shorter amount of time was available for observation.

The process for arranging observations of nurses differed in each province. No one involved in the project anticipated the amount of time that would be required to gain official approval to observe nurses in the workplace. In Alberta and Nova Scotia, specific ethical review processes were required by Health Authorities, and application deadlines had to be met. Furthermore, review committees only met once a month. In other provinces, each facility had its own regulations that had to be met. Another challenge was the political climate at the time of observations in each location. For example, in Manitoba we were advised not to make contacts to arrange observations until labour negotiations between nurses and the provincial government were settled. In British Columbia, arrangements to observe at a hospital had to be cancelled at the last minute because of the timing of a political announcement. Based on the time constraints of the project and the challenges involved in arranging the observations, we adapted our plans according to the realities of the situation. In spite of the difficulties, observations were carried out in every location, although not as many as had been anticipated in each of the locations. More observations were carried out in Manitoba to provide a wider representation of facilities and settings.

In all, 20 nurses were observed 80 ¼ hours, with 56 ¼ hours of that time being spent observing RNs, and the balance, 24 hours, observing LPNs. It was not always possible to choose the range of healthcare settings originally proposed, because of the constraints experienced in making the arrangements. However, a wide range of settings were observed including:

- Hospital medicine units (Alberta and Manitoba)
- Hospital surgery units (Alberta and Manitoba)
- Hospital sub-acute units (Alberta and Manitoba)
- A hospital emergency unit (Ontario)
- A hospital intensive care unit (Manitoba)
- A hospital acute unit (Alberta)
- A hospital maternity unit (Manitoba)
- A long-term care facility (British Columbia)
- VON (Victoria Order of Nurses) home visits (Nova Scotia)
- A VON foot clinic at a community centre (Nova Scotia)
- A community health centre (Ontario)
- A public health educational presentation (Manitoba)

To analyse the data gathered during observations, we developed a chart to record the types of interactions observed during observations (see **Appendix J**). Together we reviewed all notes that had been taken, and recorded the following data: (1) the number of times each task was observed; (2) with whom the nurse interacted; (3) the samples of reading and writing collected; (4) any additional comments noted. Such a chart was filled out for each observation, and the results were analyzed in terms of frequency of interactions with clients and their families, and with other professionals, as well as frequency of types of speaking and listening interactions.

Observations of the different nursing designations were compared. Also, CLB global descriptors were assigned to the language tasks observed, and CLB descriptors of tasks that reflected those observed on-the-job were listed for each skill and sub-skill. In addition, workplace tasks considered to be representative of the nursing profession were identified (Pawlikowska-Smith, 2001).

Flesch-Kincaid readabilities were done on unformatted (text in sentence/paragraph form) texts. Each readability score bases its rating on the average number of syllables per word and words per sentence. The Flesch Reading Ease score rates text on a 100-point scale; the higher the score, the easier it is to understand the document. The Flesch-Kincaid Grade Level scores rate text on a U.S. grade-school level. For example, a score of 8.0 means that an eighth grader can comprehend the document. It should be noted that this measure, although conventional in reading research, only provides an indicator of certain dimensions of reading texts, and may not address various aspects of text that are integral to nursing practices.

Finally, CLB levels were assigned to formatted (text not in sentence/paragraph form) text. Forms and charts were analyzed in terms of the CLB reading and/or writing levels that would be required to fill them out. We assigned CLB levels to samples separately, and then compared results. These results were recorded.

4. Project Results

4.1. Survey

Of the 1000 surveys sent out, 158 were returned, with 4 of these being unreadable. Analyses below are based on the results of 154 responses. Even though the response rate to our survey was quite low, the survey data were analyzed in various ways. Table 2 indicates the frequency of response from each province, and the percentage of the total responses from each province. Over half of the responses came from Ontario, but surveys were received from each province and territory.

Table 2.

PROVINCE	FREQUENCY	PERCENT	VALID PERCENT	CUMULATIVE PERCENT
BC	21	13.6	13.6	13.6
AB	15	9.7	9.7	23.4
SK	11	7.1	7.1	30.5
MB	4	2.6	2.6	33.1
ON	87	56.5	56.5	89.6
NB	2	1.3	1.3	90.9
NS	4	2.6	2.6	93.5
PI	4	2.6	2.6	96.1
NF	4	2.6	2.6	98.7
YK	1	.6	.6	99.4
NT	1	.6	.6	100.0
Total	154	100.0	100.0	

Table 3 indicates the frequency of response according to the professional designations of nursing. Most respondents were Registered Nurses.

Table 3.

DESIGNATION	FREQUENCY	PERCENT	VALID PERCENT	CUMULATIVE PERCENT
RN (Registered Nurse)	109	70.8	72.2	72.2
LPN (Licensed Practical Nurse)	16	10.4	10.6	82.8
RPN (Registered Practical Nurse)	26	16.9	17.2	100.0
TOTAL	151	98.1	100.0	
NO DESIGNATION AVAILABLE	3	1.9		
TOTAL	154	100.0		

Table 4 indicates the responses of survey participants to each category of language skill addressed in the survey. The shaded skills received mean scores of 3.00 or higher. This would indicate that these skills are considered "important" to "extremely important" by most nurses who responded to our survey.

Table 4.

LANGUAGE SKILL	TOTAL RESPONSES	MINIMUM	MAXIMUM	MEAN SCORE	STANDARD DEVIATION
INTERPERSONAL COMPETENCIES	154	2.33	5.00	3.98	.70
CONVERSATION MANAGEMENT	154	1.00	5.00	3.70	.76
PHONE COMPETENCIES	154	.00	5.00	4.00	.94
SPEAKING: INSTRUCTIONS	154	1.00	5.00	4.01	1.05
SPEAKING: SUASION	154	1.50	5.00	3.56	.86
SPEAKING: PRESENTATIONS	154	.57	5.00	3.08	1.21
INTERACTION ONE-ON-ONE	154	1.20	5.00	4.09	.77
INTERACTION IN A GROUP	154	1.00	5.00	3.17	1.05
LISTENING: INSTRUCTIONS	154	1.60	5.00	4.09	.84
LISTENING: SUASION	154	.00	5.00	3.63	1.09
LISTENING: INFORMATION	154	.00	5.00	3.27	1.15
READING: SOCIAL INTERACTION	154	.60	5.00	3.01	1.07
READING: INSTRUCTIONS	154	.60	5.00	3.93	.97
READING: BUSINESS/ SERVICE TEXTS	154	.67	5.00	3.26	1.08
READING: INFORMATION (UNFORMATTED)	154	.00	5.00	2.90	1.27
READING: INFORMATION (FORMATTED)	154	.75	5.00	3.06	1.09
READING: STUDY	154	.00	5.00	2.88	1.37
WRITING: SOCIAL INTERACITON	154	.00	5.00	3.26	1.14
WRITING: REPRODUCING INFORMATION	154	.00	5.00	2.96	1.18
WRITING: BUSINESS/SER-VICE MESSGES	154	.00	5.00	3.33	1.04
WRITING: PRESENTING INFORMATION	154	.00	5.00	2.74	1.29
VALID N (listwise)	154				

For a table of descriptive statistics for each individual question in the survey, see **Appendix K** (and for survey items see **Appendix C**).

The survey results are helpful in indicating the language skills and tasks viewed as most important by all or most respondents. These results correspond well with other observations. It is interesting to note that shaded descriptors (with mean rating 3.00 or higher) include all of the speaking and listening skills, two of the reading skills, and two of the writing skills. These results are consistent with other findings in this project. Respondents tended to rate oral abilities in English as more important than literate abilities in English for the nursing profession in Canada. The table in Appendix K indicates the score for each individual descriptor on the survey. These results will be helpful for the development of an assessment

tool. They indicate possible content for assessment in terms of skills and tasks. The lower scores could also indicate skills that need not be included in an assessment tool.

However, there are some obvious limitations to the survey results. Of the 1000 surveys that were sent out, only 154 were returned. The length and complexity of the survey was probably a deterring factor for some, and there was no particular incentive to motivate respondents to complete the survey. Also, because representatives of associations in each province distributed the survey, there was no way to send reminders to those who had received the survey, but had not yet completed it.

Another concern was that some respondents marked all of the descriptors as 5 ("extremely important"), leading us to question these results, especially because some of the descriptors represented tasks that, based on all the other data gathered, seemed to be seldom or never required of nurses (e.g., write a report to interpret extensive complex information using conventions for academic writing in nursing). As has been observed in previous experiences with surveys of this type in the benchmarking of programs and occupations/professions, there may be a tendency to check off most descriptors as "very" or "extremely important". Another concern was that the respondents were asked to fill out the questionnaire based on the nursing position with which they were most familiar, rather than on the position of a nurse entering the profession. All these factors would suggest that the survey would probably indicate CLB levels that were unrealistically high.

Based on all the data gathered in this project, we (Epp and Stawychny) separately identified language descriptors on the survey that we considered most important for nurses. Table 5 notes the CLB levels that were identified, and the number of times that level was identified in each language skill category. For example, in speaking and listening, CLB Level 7 descriptors were identified nine times by Researcher 1, and eight times by Researcher 2. The levels most frequently identified are shaded.

Table 5.

SKILL	**CLB RANGE/ RESEARCHER 1**		**CLB RANGE RESEARCHER 2**	
	CLB LEVEL	**FREQUENCY**	**CLB LEVEL**	**FREQUENCY**
SPEAKING/LISTENING	**7**	**9**	**7**	**8**
	8	**12**	**8**	**12**
	9	**8**	**9**	**6**
	10	**1**	**10**	**1**
READING	**7**	**5**	**7**	**4**
	8	**4**	**8**	**3**
	9	**3**	**9**	**3**
	10	**N/A**	**10**	**1**
WRITING	**6**	**1**	**6**	**1**
	7	**3**	**7**	**3**
	8	**2**	**8**	**3**
	9	**1**	**9**	**2**

Based on our analysis of the descriptors used on the survey, language tasks most frequently required of nurses fall mostly in the following ranges: Speaking and Listening: CLB Levels 7-9; Reading: CLB Levels 7-9; Writing: CLB Levels 7-8.

4.2. CanTEST

Table 6 shows the results of the CanTEST. The first bolded score indicates the CanTEST band level score for each participant, and the bolded score in parenthesis indicates the CLB Level as indicated by the two benchmarking projects carried out by the U of O CanTEST Project Office and RRC (see **Appendix D**).

Table 6.

Participant Number	Speaking	Listening		Reading		Writing
	CanTEST (CLB)	Raw Score	**CanTEST (CLB)**	Raw Score	**CanTEST (CLB)**	**CanTEST (CLB)**
1	**4.0 (7)**	31/40	**5.0 (10)**	64/80	**5.0 (10)**	**4.0 (8)**
2	**5.0 (9)**	36/40	**5.0 (10)**	70/80	**5.0 (10)**	**3.5 (7)**
3	**4.0 (7)**	30/40	**4.5 (9)**	55/80	**4.0 (8)**	**3.5 (7)**
4	**4.5 (8)**	26/40	**4.0 (8)**	54/80	**4.0 (8)**	**3.5 (7)**
5 (LPN)	**4.5 (8)**	27/40	**4.5 (9)**	52/80	**4.0 (8)**	**3.5 (7)**
6 (LPN)	**4.5 (8)**	22/40	**3.5 (7)**	57/80	**4.5 (9)**	**3.5 (7)**
7	**4.5 (8)**	39/40	**5.0 (10)**	56/80	**4.0 (8)**	**4.0 (8)**
8	**5.0 (9)**	35/40	**5.0 (10)**	72/80	**5.0 (10)**	**4.0 (8)**
9	**4.0 (7)**	30.40	**4.5 (9)**	49/80	**3.5 (7)**	**3.5 (7)**
10	**5.0 (9)**	36/40	**5.0 (10)**	64/80	**5.0 (10)**	**4.0 (8)**

Table 7 reports scores on the CanTEST in terms of minimum, maximum, mean, and standard deviations for the 10 people who took the test for us.

Table 7.

Skill Area	Minimum Score	Maximum Score	Mean Score	Standard Deviation
Speaking	4.0	5.0	4.50	.41
Listening	3.5	5.0	4.60	.52
Reading	3.5	5.0	4.40	.57
Writing	3.5	4.0	3.70	.26

Table 8 indicates the mean score on the CanTEST for each skill area, and the corresponding CLB level (when the mean score is rounded off to the nearest CanTEST Band Score), as determined by the two benchmarking projects carried out by the U of O CanTEST Project Office and RRC (see **Appendix D**).

Table 8.

Skill Area	Mean	Closest CanTEST Band Score	Corresponding CLB Level
Speaking	4.50	4.5	8
Listening	4.60	4.5	9
Reading	4.40	4.5	9
Writing	3.70	3.5	7

Table 9 is a comparison of scores of nurses with less than half a year of experience in Canada, and those with more than half a year of experience in Canada. The results for participants who have been working as nurses in Canada for less than 6 months are shaded. The nurses with more working experience in Canada had slightly higher scores on the CanTEST.

Table 9.

Skill Area	– = less than 6 mo + = more than 6 mo	Number of Participants	Mean Score	Standard Deviation
Speaking	–	5	4.4	.41
	+	5	4.6	.41
Listening	–	5	4.5	.35
	+	5	4.7	.67
Reading	–	5	4.1	.55
	+	5	4.7	.45
Writing	–	5	3.6	.22
	+	5	3.8	.27

While the sample here is small, it is interesting to note that mean scores are very similar to the language proficiency levels indicated by other data as appropriate for the nursing profession. There also seems to be an indication that language proficiency may improve slightly on the job. Further study is needed to confirm these indications.

Several factors must be considered in using the CanTEST results for the purposes of this project. First of all, it cannot be assumed that all ESL nurses who are practising in the profession actually have the language skills needed for the job. Therefore, we cannot conclude that all of these results indicate appropriate English language levels for the job. Also, candidates were not writing under high stakes conditions, and may not have had any test preparation. Most commented that they had never seen a CanTEST before. These factors would probably result in scores being slightly lower.

At the same time, we might expect that, generally, nurses who feel more confident about their English language skills are more willing to be tested. There were cases in which nurses were not willing to be assessed because they were uneasy about their language ability. Also, the candidates being paid a $75.00 honorarium may have increased the seriousness with which they wrote the test.

While the CanTEST comparisons may be an indication of general CLB levels, the language skills reflected in the assessment tool do not necessarily reflect language ability in certain sub-skills addressed by the CLB descriptors. This is most evident in the writing section of the CanTEST, in which test takers are required to write an essay on a given topic. In terms of the CLB, this writing task reflects the sub-skill, *Presenting information and ideas*. An essay requires effective use of sentence structure and the ability to organize text coherently into paragraphs. The writing demands of the nursing profession, on the other hand, fall mostly in the sub-skills, *Business/Service texts* (e.g., charting and filling out forms). In fact, it was frequently noted in our study that practicing nurses were seldom required to write text in complete sentences, much less paragraphs or essays.

Taking all of these issues into consideration, it is important that the CanTEST be seen as an indication of general fluency in English, but not as the deciding factor for CLB levels needed for the nursing profession.

4.3. Focus Groups

In every focus group there was a lively exchange of ideas, with many stakeholders raising similar issues from different perspectives. Each focus group provided an opportunity not only for us to gather data, but also for stakeholders to network.

Feedback was given during the focus groups regarding the research process. It was suggested that the interview format be e-mailed to participants in advance so that they would have time to preview the categories. Participants were concerned that the data gathered using the survey might be limited for a range of reasons. It was suggested that there would be a tendency for nurses to over-use the "very important" or "extremely important" categories in the survey. Based on experience with other research projects, it was pointed out that the qualitative interview, observation, or discussion data would probably be more informative than the quantitative survey data for this type of research. The fact that survey instructions did not instruct survey participants to indicate the language tasks required of entry-level nurses was also observed to be a drawback. In addition, the fact that the survey was sent to nurses at random could result in biased feedback, for example, from mostly nurses whose first language was English. There was concern expressed about the close link between culture and the CLB descriptors. At the same time there was a suggestion that data needed to be put in the context in which nursing occurs. It was noted that the need for nurses to work as part of a team should be reflected in both the interview protocol and the survey. There was a general observation acknowledging the difficulty of developing a framework to analyze the pragmatics of communication. Not only a particular speech act must be considered, but also the intention of the interaction must be clear. This aspect of language usage should be considered in assigning CLB levels.

Three questions were addressed by the focus groups:

4.3.1. QUESTION ONE: Why are you/your organization or group interested in the project? What are your concerns/suggestions?

Participants in all the focus groups indicated two basic reasons for participation. Stakeholders anticipated the opportunity to voice their perspective as it related to the English language competency of nurses in Canada. At the same time, they saw this as an opportunity to listen to the views of other stakeholders, and to participate in a discussion of relevant issues.

The importance of English language competency for internationally-educated nurses was most frequently cited as a reason for participation in the focus groups. Many participants mentioned the importance of having some process to ensure that nurses who were registered could communicate in the workplace. It is important to maintain standards, and there is a need for evidence of competency. For employers, it is important that all employees have the ability to communicate. Public perception and public safety were also mentioned as important issues. It is essential to take responsibility for safe, ethical care. Language skills have to meet professional standards. It was mentioned that a nurse might be the only nurse in the building in certain settings, requiring a high level of responsibility. It is important that

nurses understand not only the language to accomplish the task, but also the language needed in the context of the task. For these reasons it was seen as important that CLB levels established by the project not be set unrealistically low.

The need to maximize the recruitment and retention of nurses was also a common theme. Participants were concerned about a nursing shortage, which is already being experienced, and is projected to become more critical in the next ten years. Many examples were given of trained nurses who were unable to access the profession in Canada, and were working in survival jobs. It is frustrating to see resources wasted in this way, and participants expressed the need for a mechanism to fast-track nurses into the profession. Without this type of mechanism, many qualified people may never access the profession and valuable human resources are wasted.

Many participants voiced concerns that the language levels established should not be too high or too low. Standards should not be lowered, as it is important that nurses demonstrate communicative proficiency. Nurses entering the profession with inadequate English language skills could jeopardize the health and safety of clients. At the same time, there is the danger that levels established could increase barriers to employment if they are set unrealistically high. It was emphasized that the levels established should be fair and balanced.

Related to this, the need to address the barriers that internationally-educated nurses face in accessing the profession was discussed. People who work with immigrants want to assist clients in finding satisfying, sustainable careers. Participants expressed the hope that the present project could help to enable and empower immigrants. Examples were cited of internationally-educated nurses struggling to survive, often doing demeaning work, in spite of their background and experience. It was noted that many second language immigrants are often not speaking English comfortably initially upon arrival in Canada. While working in lower level jobs in the health system can introduce them to the workplace culture and can provide an opportunity for them to improve their English language skills, a better system is needed to help them move up. The longer they are not working directly in the profession, the more erosion of skills occurs. These immigrants sometimes face more barriers than encouragement. Participants suggested that nurses already in Canada be seen as a potential resource, rather than as a drain on the system.

Wide concern was expressed that the system to become licensed was too fragmented. Many gaps were identified. There was concern expressed that discrepancies related to access into the profession exist within provinces, as well as between provinces. In some cases, nurses are actively encouraged to immigrate offshore, but when they arrive in Canada there are access issues that were not anticipated. Credentialing is a frustrating process. There is very little information on how to have credentials recognized. Participants expressed a need for people to know how to get through the system. While licensing bodies are perceived as setting up barriers, they also struggle to be fair while assuring that licensed nurses have the skills needed in the workplace. This is a national issue that needs to be articulated throughout the country. The suggestion was made that it would be an advantage to have one regulatory body Canada-wide with a consistent language standard to facilitate access into the profession. This would help to address the lack of consistency across the country.

The present system of English language assessment was seen by many participants as a barrier. Because there is no English language assessment instrument that is related to nursing in Canada, the assessment process is considered questionable. In some cases, people who pass existing assessments do not function successfully in terms of their use of the English language in the workplace. In other cases, people who could function successfully in terms of their use of English cannot meet the requirements. Five English language assessment tools are presently recognised for access to the nursing profession: (1) Test of English as a Foreign Language (TOEFL)/Test of Spoken English (TSE); (2) Test of English for International Communication (TOEIC); (3) International English Language Testing System (IELTS); (4) Michigan English Language Assessment Battery (MELAB); and (5) Canadian Assessment of English Language (CAEL). Some of these tests cost less than others, and are more accessible. While the proliferation of tests offers more choices, it also adds to the confusion. Different provinces recognise different tests. One participant reported that some people have taken 10 different tests. This was considered an issue of both discrimination and cost. The test-taking environment itself was considered a barrier by some. It was suggested that how the test is administered needs to be considered. Time limits and test format can be intimidating. The multiple choice format of tests was also questioned.

Participants were most familiar with the TOEFL/TSE assessment option, and shared several concerns related to it. There was an observation that some nurses pass the test, but still have communication problems, especially with pronunciation and terminology. Passing the TOEFL was not seen by some participants as an indication of fluency in the workplace. The length of the TOEFL was cited as problematic. The TOEFL is considered frustrating to many, and an example was given of one nurse that flew to Toronto from another province to take another exam. The TSE was singled out by some as a barrier. Some very fluent speakers from certain cultures find the format of speaking into a tape recorder uncomfortable; furthermore, there is some concern that the TSE raters are not as used to some accents as others. It was suggested that there should be an alternative method for assessing speaking.

There is a concern that, while the labour market says there is a shortage of nurses, specific English programs are not available to help internationally-educated nurses access the profession. This lack of availability of bridging program was also seen as a barrier. Addressing English needs early is seen to increase the chances of success for ESL nurses. The need for more high level ESL/English for Specific Purposes (ESP) programs was frequently reiterated. Many ESL classes focus mainly on settlement issues, leaving a gap in English language training. In some provinces there are no ESL classes available at the higher levels. In some cases, ESL classes only serve clients up to CLB Level 5. However, most nursing programs require proficiency of at least CLB Level 7 or 8. As a result, internationally-educated nurses who need English language training are not able to get it, and, cannot access training programs. In addition, participants expressed a need for more materials to teach English for Nursing Purposes. There is a need for contextualized programming, with a focus on content. Internationally-educated professionals lack technical language, and need opportunities to practice it. At the same time, there are a number of initiatives across the country which offer bridging programs, and could serve as models. Concern was expressed about lack of support for nurses in accessing appropriate programs. In terms of admission into nursing refresher programs and nursing programs, it was felt that those being admitted should have the potential to succeed. It is important to be able to measure whether a student has the English language to be successful in a program.

Participants gave examples of a variety of prejudices faced by internationally-educated nurses. For example, in the workplace, others sometimes perceive accent as a problem, even when language is comprehensible. Applicants with accents are sometimes excluded from programs and employment. At the same time, it was pointed out that accent requires more work on the part of the listener. Sometimes it is difficult to determine when ability to comprehend is related to accent. It was suggested that barriers that stem from racism and discrimination, while they are highly charged issues, need to be addressed. One participant emphasized that systemic challenges must be illuminated, and that language is just the prerequisite step. Another participant cautioned that the establishment of CLB levels for nurses could potentially become just an added systemic barrier.

The need for greater internal support for internationally-educated nurses entering the workforce was also voiced. There is a need for a framework of community support in the workplace. Nurses already have heavy loads, and need to be compensated for time spent supporting nurses entering the workforce. Resources to provide this kind of support would help to keep nurses in the workplace. It was also suggested that it is important to provide mentorship opportunities, and to educate existing staff. Another participant suggested internship programs and/or a probation period. Resources allocated to these types of support should be seen as resulting in long-term benefits and savings for the system. These measures would also help to avoid setting internationally-educated nurses up for failure.

In addition, it was felt that the project could give direction to nursing programs. There is a need for the development of realistic curricula in terms of outcomes. For ESL providers, this project could help provide data for the development of materials for tailoring courses to bridge the language gap for internationally-educated nurses. For nursing training programs, it could provide appropriate content/competencies as required by the industry.

The project was also seen as an important step in getting stakeholders involved in the process of setting English language standards for internationally-educated nurses. Employers and management need to buy in to the standards, and it is important to consider their needs, expectations and issues. The perspective of internationally-educated nurses must also be heard. Professional bodies and ESL organizations need to represent their points of view. Participants saw the focus groups as an opportunity for a range of stakeholders to get together and have a deeper conversation at the table.

It was pointed out that some nursing programs are moving toward a more content-based and problem-based approach that is more holistic. This has implications for the type of language needed to be successful in programs. There is more group work based on case studies, and interaction on the team is evaluated. Also, theory and clinical components of programs may be integrated. Some participants expressed concern that there were few supports available to second language nurses in programs. It was noted that not only language support, but also financial support was needed.

It was mentioned that nursing is a good focus for the project, as the aging population in Canada has long-term implications for the profession. Interest was also expressed in the potential of the project to provide a model to be explored, modifed and used in other fields. There are projected shortages in many professions across the country. Perhaps research such as this could assist the facilitation of access into these fields.

There was wide support for the development of an appropriate English language assessment tool for the nursing profession in Canada. Participants definitely recognized the need for an occupation-specific language assessment tool to measure English language proficiency of internationally-educated nurses. Concern was expressed that the present system does not indicate that a person is able to function in the workplace (in terms of language). A great many wide-ranging suggestions were made regarding the development of an English language assessment tool. It was suggested that key indicators for predicting success be identified and used in the test development. There is a need for an instrument which determines comprehension and ability to converse with other professionals, clients, and clients' families. Currently such an assessment tool is not available. Such a tool would need to have occupational validity and conformity. Also, it would have to be realistic and reliable. It was also hoped that such a test would provide some diagnostic feedback to test-takers, indicating their language strengths and weaknesses. This type of feedback would be helpful in redirecting internationally-educated nurses to appropriate programs. Also, it was mentioned that an assessment tool which accurately verified a person's language skills, could also help to address some of the myths and assumptions often associated with second language nurses. The need for cost effectiveness was also addressed. Some participants made the suggestion that there would need to be support mechanisms to prepare for the test, and that there should be a standardized way to prepare for it.

It was proposed that all nurses, not just second language nurses, be required to take a test in language communication skills. It was also suggested that an assessment tool be field-tested with a large control group of both first and second language nurses. Some participants mentioned that it is also important to know how first language nurses function under similar test conditions. In developing an assessment tool, it was suggested that a blind study on first and second language nurses in the system would help to prevent the benchmark levels from being set unrealistically high.

Some participants felt that experience should be considered as well as language. It was also suggested that if nurses had been trained and/or had practised in the English language, this should be an advantage for them in accessing the profession. Also, it should be noted that if internationally-educated nurses had already spent time working in lower level positions in the Canadian health system, they would have built up their fluency.

There was some discussion regarding the Canadian Registered Nurses Exam (CRNE). Some wondered if the CLB could be used to benchmark the exam itself. Because of security issues, it was considered unlikely that researchers would be able to gain access to the exam for benchmarking purposes. It was thought that there was a need for an initiative to provide preparation for the CRNE. Some preparatory programs are available, and there is a plan to put some CRNE preparation information on the Internet. There is research available to identify nurses who fail the CRNE by country of graduation. It was suggested that this data would be helpful to agencies that deal with internationally-educated nurses in the process of accessing the profession.

The issue of reaching out to nurses internationally was raised. Health Canada has been asked to participate in a non-raiding agreement. At the same time, there will be nurses seeking to immigrate to Canada. Interest was expressed in setting up partnerships with other countries. There was some suspicion regarding partnerships with brokers. External credentialing was raised as a possibility.

Other suggestions included the need for monitoring of assimilation and recruitment needs on a regular basis. Also, it would be helpful to establish links with organizations that represent people who are under-employed.

Broader applications of the model presented by this project were encouraged. Many participants expressed the hope that this project be seen as a potential model to be explored, modified and used in other fields to address shortages in other professions. Collaboration with professionals, colleges and universities across Canada was suggested.

4.3.2. QUESTION TWO: What are the greatest language challenges for internationally-educated nurses in your province?

Although it was recognised that, in general, areas of language weakness depend on the individual, by far the majority of language challenges identified fell into the categories of speaking and listening. Pronunciation was a major concern. It was noted that in the fast pace of the workplace, the ability to speak clearly and also the ability to comprehend sometimes deteriorate. Second language speakers often need more time to process an interaction when they are developing fluency. Finding the right words for communication while concentrating on what is being done is more of a challenge for second language speakers. If nurses know the theory in their own language, they may need time to think of the English translation. Interactions on the phone were also seen as challenging. Sometimes there was difficulty in articulating why the call was being made. Understanding orders over the phone was not easy, and difficulty understanding physicians' orders was specifically identified. Furthermore, the condition of patients influences how they communicate. For a variety of reasons, a patient might not speak clearly, or might not be able to speak at all. This complicates the listening task for the nurse.

Terminology and jargon were mentioned as difficult for some second language nurses. Even nurses from English-speaking countries can encounter differences in terminology, equipment, medication, and dosages. Even within one province, terminology can vary from one setting to another, as can abbreviations and acronyms. Also, terminology that is appropriate with other professionals may not be equally appropriate with clients or their families. Sometimes different words are used in other languages to describe conditions, and direct translation does not communicate. The example was given of hemorrhoids being referred to as "strawberries" in another language. Sometimes second language nurses master the more technical terminology, but have difficulty with the everyday idioms used by patients. One nurse gave the example of a patient saying, "I want to go to the 'john"; the nurse had no idea what the 'john' was. The challenge of "dangerous" English was also mentioned. The use of swearing, for example, is not usually included in ESL classes, and second language nurses may not understand swearing, or may use it inappropriately, not realizing the connotation.

The ability and willingness to ask for clarification was seen as essential. Obviously it is of utmost importance that nurses understand what they hear in the workplace. One example given was as basic as knowing the names of body parts. If a patient says, "I have pain in my chest," it is important that this not be reported as stomach pain. It was also pointed out that patients do not always use correct terminology, and may point to their chest and say they have pain in their stomach. It was agreed that the important thing was that nurses be able to explore what a patient is saying, and clarify it. Misunderstandings can occur, and the ability to ask for clarification and to make sure the other person understands is critical.

The ability to communicate using appropriate register was an issue. It is not always easy to know when to be formal, and when to be informal. For some there was difficulty with small talk, and determining which topics were appropriate with others. A process is described one way when speaking with other professionals, and another way when informing patients who may not be familiar with medical terminology. Nurses may understand a physician's orders, but have difficulty communicating those orders to clients in plain language. Clients and their families come with a wide range of backgrounds. Their age, level of education, and cultural background all play a part in determining the type of language that is appropriate when interactions occur. Sometimes it is difficult for second language nurses to "read" the signals that indicate appropriateness, and they may not have the ability to communicate in a wide range of registers.

Interactions which required assertiveness were frequently mentioned as challenging. It is often difficult for second language nurses to express disagreement, for example, to challenge a physician's order. At the same time, it was recognised that this type of assertiveness is often difficult for first language nurses as well, and depends on personality as well as language ability. Other challenges mentioned included resolving conflict, advocating for clients and for themselves, and delegating tasks to others.

Responding to negativity is a challenge even in first language interactions. Second language nurses may need to respond to negativity from clients and/or their families who are dealing with their own frustration and stress. Internationally-educated nurses spoke of having to respond to negative comments about their accents, and of being unfairly blamed when mistakes were made. In some cases they were even told to go back to their countries. It is always awkward to respond to this type of prejudice, and even more difficult when the response must be made in a second language.

Writing was identified as a challenge in that proper written English does not apply in charting. Also, reading handwriting in charts was frequently mentioned, but again, this is a constant challenge for first language nurses as well.

It was also recognised that nonverbal communication plays a role in the interactions of nurses. Since nonverbal communication is usually unconscious, it may be more difficult to master. Tone of voice can change the meaning of words. Miscommunication and/or disbelief can be read in a person's facial expressions. A client who cannot speak may have to use gestures to indicate answers to questions.

Culture was seen by some participants as a greater challenge than language. It definitely was recognised as an important aspect of communication. Many communication issues are also cultural issues. Nonverbal messages carry different meanings in different cultures. Under stress, it is easy to unconsciously revert to body language of one's native culture. The example was given of a nurse who bowed to another professional. In the Canadian workplace, this is an unusual gesture, and can be seen as an indication of subservience. In some other cultures it has a more positive connotation, indicating agreement or greeting.

The culture of the workplace is a challenge in itself. The role of the nurse in the workplace varies from culture to culture. It was observed that internationally-educated nurses sometimes underestimate the participatory aspect of nursing in Canada. The emphasis on working as a team member may not be familiar. Client care differences exist; in some cultures nurses are

trained to do everything for the client, whereas in Canada, a client's independence is generally encouraged. Clients' involvement and expectations related to their own care varies between cultures as well.

The roles of males and females in Canada were frequently mentioned as a cultural challenge for nurses. In some cultures, a male caring for a female may be taboo. Assertiveness with authority figures, especially men, may be frowned on in some cultures. A nurse coming from such a culture may find it very difficult to question a physician's order, especially if the nurse is female and the physician is male.

In some cultures, asking for help may be considered an indication of weakness. As a result, some nurses may fail to ask for assistance when it is called for. Saying "yes" when one means "no" can also be a cultural response. It is important for nurses to be aware that these cultural differences exist.

In many interactions, an understanding of cultural reference points is needed to follow the conversation. For example, idioms referring to baseball (e.g., "to strike out") may have no meaning to someone who is not familiar with the game. Food items may be unfamiliar. One second language nurse had never heard of "shepherd's pie", and told a client that "shepherd's pea" was on the menu for lunch. Although this miscommunication probably did not have serious consequences, others might.

Another challenge discussed was the difficulty of understanding the complexity of the workplace. Nurses must be familiar with the Canadian health system, as well as the provincial health system. Workplace protocol, labour conditions, and policies must be understood. Internationally-educated nurses may be faced with the need to learn new techniques and technologies. Nurses entering the workplace may not be familiar with what is expected. They may also face a lack of cross-cultural awareness on the part of Canadians.

Accessing education was noted as another challenge for internationally-educated nurses. It was felt that there was a need for really focused pronunciation in nursing education. There was also a concern that internationally-educated nurses often did not have the money to pay for the programs.

The immigration process itself was considered to be a barrier. Immigrants are given points for English language skills, which help to qualify them to immigrate, and yet these points have no relevance once they arrive in the country. As a result, immigrants receive mixed messages. The integration system is fragmented, and accreditation is becoming a political issue. There have been discussions about the development of a pre-screening process to predict success and to give advice to professionals before they come to Canada.

The issue of access to the profession was again discussed. It was noted once more that it is a challenge to know the regulatory requirements. Some internationally-educated nurses are not even aware that there is a licensing process. It is a challenge to know how to get information regarding this process to the persons who need it.

Because only 50% of internationally-educated nurses pass the CRNE, it was also cited as one of the challenges. There was uncertainty as to the reason for this. Possible factors discussed included the interpretation of questions, the multiple choice format, and the cultural issues

that might be reflected in the exam. Critical thinking is an important aspect of the CRNE. It was pointed out that there are factors that influence the chances of success on the CRNE. There is a relationship between early language success (qualifying at the beginning of a refresher program) and success on the CRNE. Some participants observed that nurses who take a refresher program have a higher rate of success.

Emotional challenges were cited as well. When internationally-educated nurses come with unrealistic expectations, they experience a great deal of stress. They get the message that nurses are needed, but at the same time face many barriers. It is discouraging to them when they do not feel listened to; they feel they want to give up and go home.

The present English language assessment process was also seen as a challenge. Many of the same points stated earlier were discussed again. Most of the feedback once more referred to the TOEFL/TSE. Again, it was noted that passing the test does not guarantee fluency in the workplace. The test topics were seen as unrelated to the profession. The test procedure was described as time-consuming and costly. It was observed that some nursing students had a good knowledge base, but were unable to pass the test. There were some participants who considered passing the language test the biggest challenge for internationally-educated nurses.

It was recognised that internationally-educated nurses themselves have been expected to bear much of the burden in overcoming barriers in accessing the profession in Canada. It was suggested that there was a need to shift the systemic burden. Internationally-educated nurses must be viewed as a valuable human resource rather than as a drain on the system. In an increasingly multicultural country, there are benefits to having a nursing workforce that reflects and understands other cultures. Other employees and/or other professionals, as well as patients and their families, may come from a range of cultural backgrounds. More resources allocated to provide support for these nurses as they enter the Canadian workforce will result in many long-term benefits to the system.

4.3.3. QUESTION THREE: In your province, what are the differences in the language demands of the two designations addressed by this project?

The four designations addressed by this project are Registered Nurse (RN), Licensed Practical Nurse (LPN), Registered Practical Nurse (RPN), and Registered Nurse Assistant (RNA). All of the provinces have the same RN designation, but the other three designations (LPN, RPN, and RNA) are similar positions with different names in different provinces.

In Ontario, the designations are RN and RPN. Most participants agreed that there was not necessarily a difference in the language demands of the two designations. It would depend on how fully nurses were practising to their scope. It was mentioned that RNs are expected to have more knowledge. They might need to articulate analysis and critical thinking to a greater extent, and would be expected to apply research findings to nursing care. It was also noted that the entrance reading requirements for RN programs were higher.

In British Columbia, the designations are RN and LPN. In general practice and at entry level, participants stated that there would be no substantial differences in language demands between the two designations. In higher RN positions, more articulation would be required, as would more interdisciplinary team interaction. RNs were seen as more likely to delegate tasks to others. One participant stated that language cannot be separated from context, and

that narrower contexts require fewer language skills. It was pointed out that differences might be more pronounced in certain settings (e.g., institution versus community). It was also noted that expectations are different because of power issues.

In Nova Scotia, the designations are RN and LPN. There was general agreement that the language demands of the two designations were similar. Language tasks would depend on the context of practice. In a long term-care setting there would be no difference, while in a setting such as an intensive care unit (ICU), an RN would be expected to have a higher level of technical knowledge. LPNs might have to report to RNs. RNs have more to do with the planning of care, and have to be able to synthesize information. In the education setting, it was noted that the writing demands are higher for RNs in terms of the types of academic papers they must write.

In Alberta, the designations are RN and LPN. Participants stated that differences would depend on the setting. At the direct care level, there would be no difference in language demands. The scopes of practise are similar, and it depends where the practice setting is. It was pointed out that RNs had the education to do evidence-based practice, and needed to know how to utilize it. As a result, they need to synthesize information from a broader knowledge base when analyzing issues. It was also mentioned that case managers had greater writing requirements.

In Manitoba, the designations are RN and LPN. It was generally felt that there would be very few language-related differences in the level of care and level of expectations. Participants listed the following points to illustrate: (1) They read the same charts; (2) They read the same physicians' orders; (3) They take directions from physicians; (4) They provide the same care in the operating room; (5) They are expected to think critically and articulate; (6) They must work independently (are sometimes left alone); (7) They must document care. It was mentioned that reading and writing skills for RNs would need to be higher in relation to evidence-based practice (e.g., interpreting research findings, dealing with statistical data/trends, interpreting algorithms). At the same time, it was stated that this is a difficult area to quantify, especially in relation to how their (RN/LPN) different knowledge bases are used.

Based on the input received, it would be difficult to justify a different English language requirement for the different designations. In most of the groups, discussion indicated that differences between the tasks expected of the two designations in each province were growing smaller rather than larger. RNs at the higher end of practice might have greater language demands, but it was not felt that internationally-educated nurses should be required to meet those higher demands upon entry into the profession in Canada. Rather, it was generally agreed that English language competence needed for an entry level nursing position should be expected.

The focus group feedback was helpful in providing a broad perspective on issues, but it was less helpful in actually identifying specific language tasks as they relate to the CLB descriptors. The information gathered was very helpful in providing information about typical nursing tasks, and the language required to carry out these tasks. It also helped to clarify which language tasks were considered most important and most challenging for nurses. Finally, the focus groups were very helpful in providing perspective regarding the comparison of the various nursing designations addressed by this study.

4.4. Profile Information Interviews

Twenty-three people were interviewed using the Profile Information Interview form (see **Appendix G**). Participants were interviewed in person and on the phone. Three participants were e-mailed forms, which were later returned by fax. Participants were from British Columbia (6), Saskatchewan (3), Manitoba (9), Ontario (2), Nova Scotia (2), and the Yukon Territories (1). Many of the participants (14) were clinical instructors in Degree Nursing Programs, Diploma Nursing Programs and LPN Programs. These clinical instructors work with nursing students in a variety of health settings such as pediatrics, sub acute care, orthopedic surgical, long-term care (assessment and rehabilitation), and acute care. Two participants were internationally-educated nurses; one worked on an ear, nose and throat post-operative unit, and one worked on a medicine unit. The remainder of the participants were nurse managers, nurse educators, LPNs and RNs, working in a variety of settings such as rehab geriatrics, medicine, surgery, acute care, and intensive care.

4.4.1. Feedback regarding Language Tasks

Out of the 37 language tasks on the Profile Information Interview form, 34 were rated as "important" or "very important". Interviewees cited numerous examples of these tasks. These included:

- interacting with physicians (important because physicians may not see patients but rely on nurses' observations and assessments)
- interacting with other professionals (important because clients' health may be jeopardized if unit problems are not articulated with other staff)
- following physicians' orders, may be written or oral, face-to-face or by phone (e.g., comprehending orders for medications, treatments)
- giving instructions (e.g., teaching clients how to take medication/how to change dressings, catheter care, instructions to co-workers)
- using commands in emergency situations such as fire drills, cardiac arrest, codes
- making requests (e.g., asking for help, phoning pharmacy/rehab therapist/dietician with a request)
- asking for detailed information (e.g., receiving information from ambulance attendant/other staff/new client/physician)
- analyzing or expressing opinions about work (e.g., being assertive when necessary, advocating for clients, participating in interdisciplinary meetings)
- clarifying/elaborating (e.g., making sure physicians' orders are understood, clarifying instructions to make sure clients understand, clarifying lab values over the phone)
- explaining (e.g., explaining procedures to clients and their families)
- attracting attention (e.g., attracting attention in emergency situations when help is needed)
- providing detailed complex information in order to coordinate teamwork (e.g., meeting with multi-disciplinary teams to discuss discharge planning, brainstorming to solve problems, delegating, reporting to next shift)
- asking for permission (e.g., requesting permission from patients before certain procedures)
- indicating solutions to problems (e.g., offering a variety of solutions to client)

- giving advice/making suggestions (e.g., providing information and options to clients and their families regarding discharge planning)
- dealing with communication problems (e.g., interacting with clients who have language barriers/accents, dealing with frustrated clients)
- following audio tapes or videos (e.g., comprehending taped shift reports, following lectures/demonstrations when participating in continuing education)
- scanning text quickly to find specific information (e.g., scanning charts, lab results)
- recalling what has been read (e.g., recalling information on care maps)
- interpreting formatted text (e.g., interpreting lab values, Kardex)
- interpreting unformatted text (e.g., interpreting policy/procedure manuals)
- asking for assistance from colleagues when reading is required (e.g., asking for help to interpret chart entries)
- filling out forms (e.g., filling out transfer orders, charts)
- keeping a record/log book (e.g., writing progress notes, keeping a Medication Administration Record)
- writing reports (e.g., writing incident reports)
- writing messages (e.g., noting telephone orders)
- assisting each other when writing is involved (e.g., helping to write an incident report)
- deciphering handwriting on charts and forms

Two language tasks were rated as less important than the others. For Task 14, *"Facilitate a discussion, seminar, formal meeting; help participants clarify issues and reach set goals"*, 50% of respondents said that this task would be "not important" or "somewhat important", and 50% said that it would be "important" or "very important". One interviewee said that if a nurse could not perform this skill, it did not necessarily mean that he or she was a poor nurse. Another said that it was important to be familiar with the group process, but that it was not crucial to be able to facilitate a group discussion. Some stated that a nurse manager or a unit manager would more commonly carry out this type of task, although one interviewee stated that an entry level nurse in charge of patient care would facilitate a discussion on patient care.

For Task 35, *"Take notes in point form from an oral presentation"*, 50% of the participants stated that it was "not important" or "somewhat important" and 50% stated that it was "very important" or "important". Educational in-services were cited most often as examples of this type of task. Other examples of situations in which nurses would take notes were: (a) participating in interdisciplinary meetings, (b) listening to taped reports, (c) learning something on a new piece of equipment, and (e) participating in seminars on procedures such as treating frost bite.

In addition, for Task 32, *"Write reports. What is the length of these reports?"*, 78% answered "important" or very important". The most common example of a report cited was an incident report. However, interviewees' responses regarding the length of the report varied. The responses ranged from one paragraph in point form, to one to two paragraphs written in complete sentences, to a page written in complete sentences. One interviewee stated that the length of the report depended on the incident. It was also stated that the incident report was set up in a chart format using a check off system, with a space provided on the form for a one-paragraph description of the incident. Other types of report writing cited were consults, discharge reports, and Worker's Compensation reports.

Three questions were addressed by the Profile Information Interview:

4.4.2. QUESTION ONE: Identify what you would consider the three main differences between the tasks carried out by the different nursing designations (e.g., RN/LPN/RNA/RPN) in your province.

Participants in the Profile Information Interview identified differences between the tasks carried out by the different nursing designations. Respondents agreed that LPNs, RNAs, and RPNs are able to do more now than they had done in the past. Many stated that these three designations do not administer certain medications. A common response was that RNs start intravenous lines (IVs), and LPNs, RNAs and RPNs maintain them. However, many respondents stated that the tasks carried out by LPNs, RNAs, and RPNs would depend on the facility in which the nurse was working. An example would be talking to physicians. In some facilities, LPNs, RNAs, and RPNs would not take physicians' orders on the phone or face-to-face, whereas in other facilities they would. Participants stated that RNs interpret physicians' orders, do more advanced assessment, are responsible for coordination of care and discharge planning, have a greater depth and breadth of knowledge, integrate health care members, especially in acute care settings, and have more formal education in leadership/management. The feeling was that there are some nursing tasks that require more critical thinking by RNs. Five participants said that the cognitive reference for RNs and LPNs, RNAs, and RPNs is different. Two participants stated that generally the RN is the nurse in charge; however, on the night shift, an LPN may be in charge.

4.4.3. QUESTION TWO: How would these differences be reflected in the language tasks required of nurses in each designation?

Seventy-three percent (16/22 participants) stated that there would be no difference in the language tasks required of RNs and LPNs, RNAs, and RPNs. One participant could not comment because there were no LPNs working on her unit. One respondent stated that even though there were some tasks carried out by RNs that required more critical thinking, there would be no difference in the language tasks. In terms of differences in specific language tasks, it was stated by some respondents that, in certain facilities, LPNs, RNAs, and RPNs would not take physicians orders on the phone or face-to-face, and they would not write consults. Two participants said that the language tasks would be reflected in the nurse's area of expertise. One participant said that LPNs could have a lower language level because they did not communicate with physicians, and another participant said that the differences would be slight.

The data collected from the Profile Information Interview form indicates that the English language demands for RNs and the other designations addressed by this project (LPNs, RNAs, RPNs) are within similar ranges.

4.4.4. QUESTION THREE: What do you see as the greatest challenges related to the language demands of the nursing profession in Canada?

Speaking and listening comprehension were two of the greatest challenges mentioned by participants.

For speaking, specific examples included:

- speaking with clients, particularly ESL clients
- interacting with all health care professionals

- having discussions about a client's care with the client's family
- not being understood by others because of accent
- pronouncing medical terminology
- asking questions
- asking for clarification
- asking for assistance
- using slang and/or idioms.

For listening, specific examples included:

- understanding slang and/or idioms
- understanding physicians on the phone
- understanding confused patients
- understanding clients whose first language was not English.

Other challenges mentioned were reading a client's body language, reading charts, and using the correct abbreviations, descriptions and terminology when recording information in charts. One participant said that writing in charts was an area in which a nurse could receive assistance.

Report writing, specifically incident report writing, requires the nurse to write a paragraph or two to describe what happened. Often this is written in point form. Only 50% of participants reported that it would be necessary to take notes from an oral presentation, and this was a task that was not performed on a regular basis.

Unfortunately, feedback was not received from as many areas across the country as had been hoped. An effort was made to contact individuals in other locations, but it was not possible to arrange the interviews for various reasons. Nevertheless, feedback that was received confirms the results of the other data gathered in this project.

4.5. Observations

The observation of nurses in the workplace provided an opportunity to gain first-hand knowledge of the English language demands of the nursing profession. We were able to record interactions, and to see the reading and writing that nurses actually did on the job. This data could then be compared directly with the descriptors of the CLB document. Certain language tasks dominated in many of the observations, while some settings presented unique language challenges.

Interactions were recorded and the data was analyzed using the chart developed for this purpose (see **Appendix J**). The total number of language tasks analyzed was 1,591.

Chart 1 illustrates the situational use of language by nurses during the observations.

Chart 1.

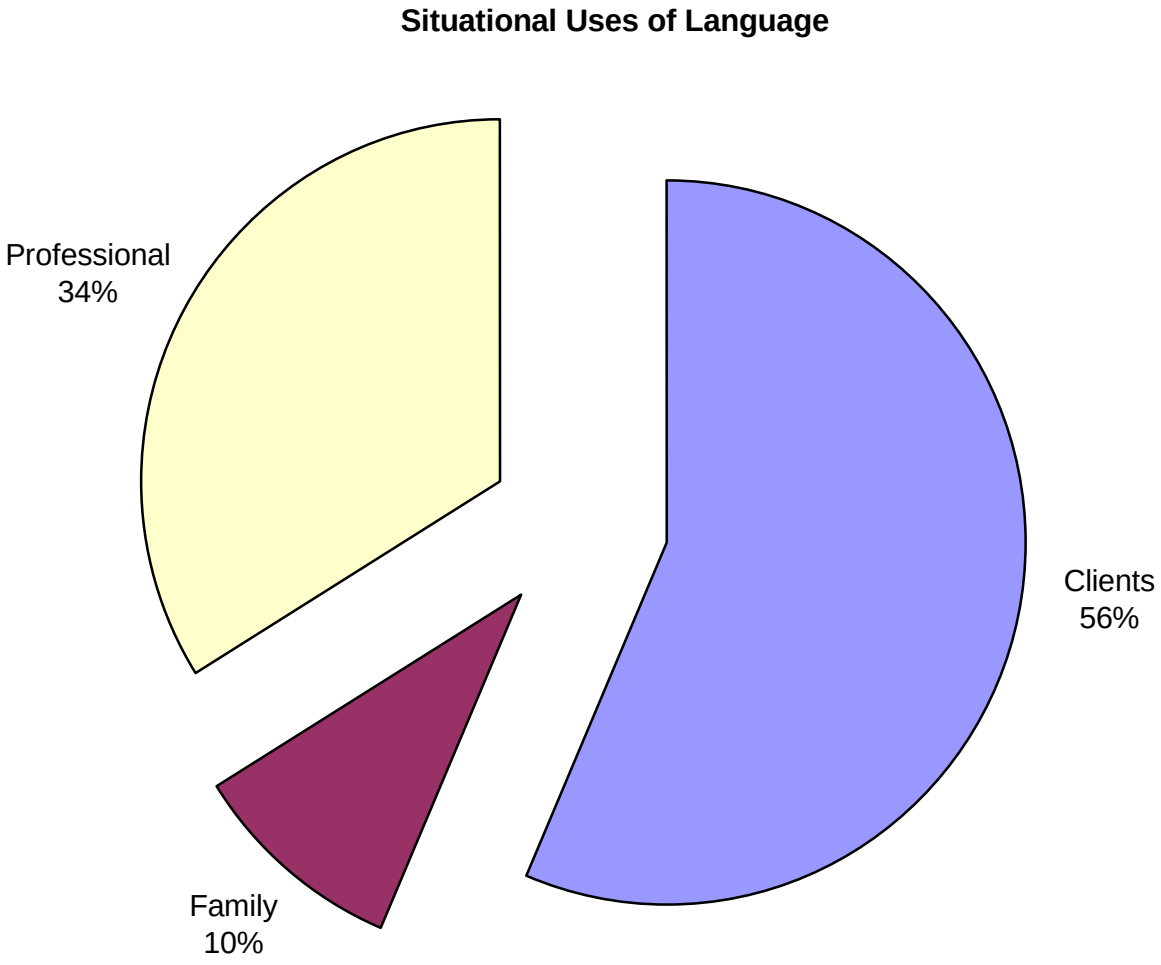
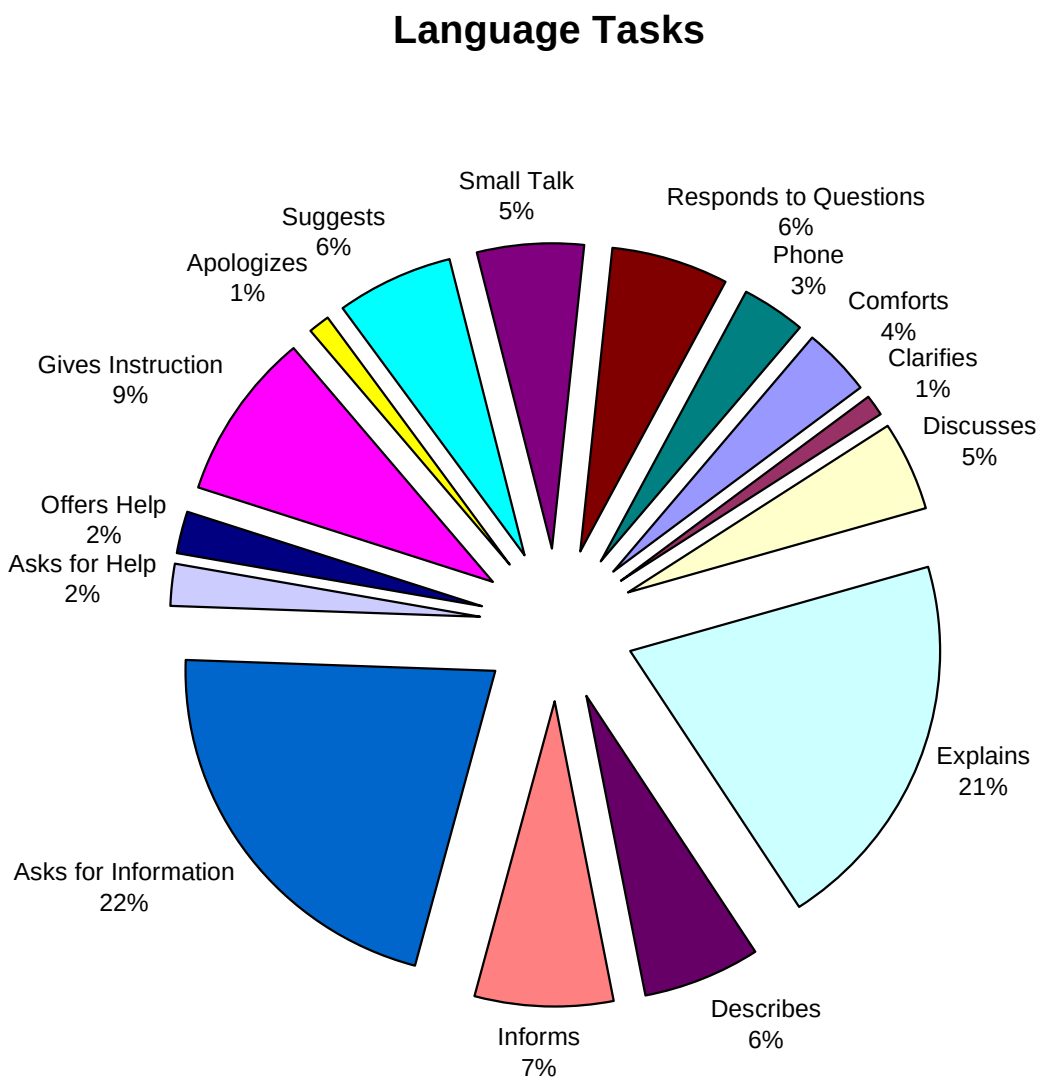


Chart 2 illustrates the types of tasks observed, and the percentage of time that was spent on each task, based on all the observations.

Chart 2.



4.5.1. Interactions with Clients and their Families

Most interactions observed were between nurses and clients. Often nurses would explain what they were doing, and why they were doing it. They would answer questions clients had about their condition or treatment. Nurses were responsible for explaining discharge instructions to clients. These instructions were also given to the clients in written form.

Nurses were often observed using persuasive language with clients. For example, in some cases, clients did not want to take medication; in others, they did not want to limit or increase their intake of fluids. In these types of situations, it was important for nurses to have established rapport with clients so that they could convince them to comply without becoming confrontational. For this reason, joking and small talk were observed as important language skills in developing relationships with clients.

Clients were sometimes very difficult to understand. In some cases, English was not their first language; in others, cognitive and/or physical impairment interfered with speech. Nurses had to have good listening skills and often needed to ask for clarification to ensure that they understood what clients were communicating. Sometimes clients were unable to speak because of oxygen masks. Nurses then had to read clients' body language and gestures.

At the same time, it was important for nurses to speak clearly and appropriately. Again, clients whose first language was not English had more difficulty understanding nurses. Some clients were hearing impaired. In addition, nurses needed to be aware of appropriate register in relation to clients' age and education level. Nurses were observed adjusting their tone and vocabulary based on the needs of their clients.

Nurses also had a great deal of contact with clients' families and friends. Sometimes they asked families questions regarding the client to get information. Nurses also answered the questions that families had regarding the condition of the client. Families were often under a great deal of stress, and nurses were observed providing empathy and support. Nurses reported that, in some situations, they had to help resolve conflict between family members.

4.5.2. Interactions with Other Professionals

Interactions with other professionals were frequent in most observations. Other professionals included physicians, physiotherapists, occupational therapists, social workers, spiritual care workers, paramedics, and other nurses. In most of these interactions, nurses were observed describing a client's condition, and explaining what had been done or what should be done. For example, before a nurse went on a break, she/he would describe the situation of her/his clients to the nurse taking over. Many of these interactions also included small talk and joking.

Shift-to-shift reports are an important part of a nurse's responsibility. On many of the units visited, these reports were done by tape recorder. This required the nurse to report briefly on the condition of each client, explaining special situations when necessary. The use of the tape recorder requires clear pronunciation. When listening to the report, it is not possible to ask for clarification, but it is possible to rewind the tape and listen again when something is not clear. In some cases, shift-to-shift reports were done in person.

Interactions with physicians were not often observed, but they were of vital importance. When physicians visited units, nurses would give information and ask questions. Nurses are on the front line of care, and they are most familiar with the condition of their clients; therefore, it is very important that they have the language to convey this knowledge to the physician. At times, nurses were observed advocating for their clients. Taking physician's orders over the phone was not frequently observed, but often referred to as a language challenge. Some nurses reported that phoning physicians who were on call was one of their responsibilities.

Nurses also participated in interdisciplinary meetings with other professionals to discuss issues related to client care. Although not many of these meetings were observed, it was reported that they frequently involved discharge planning. Here it was important for nurses to share their knowledge and perspective regarding the clients, so that appropriate plans could be made. Again, nurses might well be in a position to advocate for clients at these meetings. Nurses also participated in family conferences, where both a client's family and other professionals were present.

Asking for the assistance of another professional was also observed. For example, sometimes help was needed in moving a client. Nurses were frequently observed asking for and giving assistance in deciphering handwriting on charts.

4.5.3. Interactions with Other Staff

Some interactions with other staff were also observed. Health Care Aides (known by different titles in different provinces) reported requests of clients or concerns about clients to nurses. In some cases, nurses were responsible for student nurses doing practicums. In these interactions, the role of the nurse tended to be more supervisory. There was also limited interaction observed with other staff such as janitorial staff.

4.5.4. Phone Interactions

Nurses were often observed using the telephone. The phone was used to make arrangements (e.g., for tests, to get equipment), to get lab results, to give and get information from other professionals (e.g., physicians), and to give and get information from clients' families. Nurses also answered the phone and took messages.

4.5.5. Reading and Writing Tasks

The reading task most frequently observed was the reading of charts. Examples included client care plans, team notes, physician's orders, integrated progress notes, various assessments, and neurological records. The greatest reading challenge was often deciphering the handwriting on these charts. Much of the vocabulary on these charts was field-specific terminology. Drug compatibility charts were also referred to for specific information. Nurses also read lab reports (e.g., bloodwork, diagnostic imaging reports). Some reading tasks involved reading data from a computer screen (e.g., vital signs). They also needed to understand the instructions written for clients (e.g., discharge instructions) and explain them. Policy manuals and textbooks were accessible, but nurses were observed referring to them only once. Samples of reading text were collected and then matched with the CLB descriptors (see *4.5.10*).

A great deal of the writing required of nurses was the filling out of charts and forms. These included the charts listed above. Generally the nurse was required to check off items, or to record information in point form. In some cases, anecdotal records were made, but usually these were in point form rather than in complete sentences. It was necessary for nurses to use appropriate terminology when entering information. Descriptive vocabulary was especially important. The format of incident reports obtained was generally checklists and point form, although in a few cases, sentences were required. Nurses reported that they were able to get help in filling out incident reports if they needed it. Again, samples of forms and charts were collected and matched with the CLB descriptors (see *4.5.10).*

4.5.6. Settings with Unique Language Challenges

In a few cases, observations were done in settings with unique language challenges. These settings included the emergency unit, the intensive care unit, the long-term care setting, the Victoria Order of Nurses (VON) setting, the community health centre, and the public health presentation.

In the emergency unit, interactions were very fast-paced. One nurse observed that in the trauma room, a nurse who did not understand what was being said would pose a high risk. It was also more common for nurses in emergency situations to deal with clients who could not communicate for a range of reasons (e.g., oxygen masks, cognitive impairment). In addition, clients and their families who are experiencing an emergency are under a great deal of stress. Nurses need the language skills to reassure and empathize, while carrying out their other duties.

In the intensive care unit, a great deal of time was spent in discussion with other professionals regarding clients. Nurses were constantly updating other professionals on the condition of patients, and the information shared was detailed. Nurses also interacted with clients frequently and at length, especially asking for information, informing, and explaining. At the same time, clients were generally not able to communicate well because their condition was more serious than in some other settings.

At the long-term care facility, it was noted that some residents had difficulty communicating, due to issues such as hearing impairment, strokes, and dementia. Also, for many residents, English was not their first language. Because of this, it was very important that nurses used simple language with clients, and that they spoke clearly. At the same time, they had to explain each resident's condition in detail to the physicians. Another language skill observed more frequently in this setting was persuasion. On one hand, nurses had to convince clients to take medication. On the other hand, they needed to know calming techniques when clients or their families became agitated.

In observing VONs, it was noted that the context of interactions was less predictable than in a hospital setting. In home visits, VONs had to adjust to the environment of the client's home, often without the presence of other professionals. This increased the need for cultural awareness, and required more independence on the part of the nurse. The nurse had to take responsibility for many arrangements, often by phone. An example was given of an internationally-educated nurse who tried to work as a VON and found it too difficult. She then found a position in a hospital setting, where she was able to function successfully.

At the community health centre, nurses followed a holistic approach. The nurses observed collaborated a great deal with physicians. Because care was tailored to individual clients, there was a high need for flexibility. In addition, constant interruptions were observed. Nurses had to deal with a wide range of clients and their families. The facility served a large immigrant population; as a result, cultural awareness was essential. Part of the nurses' responsibility was to facilitate groups and to teach (e.g., lifestyle changes, breastfeeding, hospital procedure, pain management, fetal development). It was important that they used simplified language and concepts in order to communicate with clients appropriately. It was also important that nurses in this setting had the ability to persuade and counsel clients (e.g., to persuade a pregnant client to get an HIV test by explaining consequences and assuring anonymity). Many interactions with other professionals, clients and their families were carried out by telephone. Also, a great deal of reporting was done by computer.

The public health presentation observed was on the topic of sexually-transmitted diseases. It was a one-hour presentation for a group of about 50 ESL students. It was unique in that it did not demonstrate any one-on-one or small group interactions. The nurse explained and described the topic, using overhead transparencies and a video. During the presentation she encouraged questions and facilitated some discussion.

4.5.7. Nursing Designations

In observing RNs and LPNs, few differences in language demands were observed. In some cases, but not in all, RNs demonstrated synthesis of a broader knowledge base in analyzing issues. In one case, an LPN was observed to take charge of a discussion with an RN, probably because she had more experience. RNs were more likely to be working in the more specialized positions, although it was noted that LPNs were beginning to be allowed to do more specialized work by taking special courses.

4.5.8. Language Tasks Observed and Corresponding CLB Descriptors

Based on the observation of nurses we conducted in the workplace, the following CLB descriptors apply. (These descriptors are taken from the document, *Canadian Language Benchmarks 2000,* as well as the companion document, *Canadian Language Benchmarks 2000*: *Additional Sample Task Ideas.)*

4.5.8.1. SPEAKING

Global Performance Descriptors (Speaking)

The global performance descriptors for speaking ranged from CLB Level 7 to CLB Level 9, with **most global performance descriptors for speaking falling in the CLB Level 7-8 range.**

- **CLB Level 7**
  - Can communicate comfortably in most common daily situations.
  - Can participate in formal and informal conversations, involving problem solving and decision making.
  - Can present a detailed analysis or comparison.

- Can use a variety of sentence structures (including compound and complex sentences) and an expanded inventory of concrete and common idiomatic language.

- **CLB Level 8**
  - Can communicate effectively in most daily practical and social situations, and in familiar routine work situations.
  - Can participate in conversations with confidence.
  - Can provide descriptions, opinions and explanations; can synthesize abstract complex ideas, can hypothesize.
  - In social interaction, learner demonstrates increased ability to respond appropriately to the formality level of the situation.
  - Can use a variety of sentence structures, including embedded and report structures, and an expanded inventory of concrete, idiomatic and conceptual language.
  - Grammar and pronunciation errors rarely impede communication.
  - Discourse is reasonably fluent.
  - Uses phone on less familiar and some non-routine matters.
- **CLB Level 9**
  - Can independently, through oral discourse, obtain, provide and exchange key information for important tasks (work, academic, personal) in complex routine and a few non-routine situations in some demanding contexts of language use.
  - Can interact to coordinate tasks with others, to advise or persuade, to reassure others and to deal with complaints in one-on-one situations.

What a Person Can Do (Speaking)

Although speaking tasks range from CLB Level 6-9, **the majority of speaking tasks fall in the CLB Level 7-8 range.**

I. Social Interaction

Interpersonal Competencies

- Make or cancel an appointment or arrangement. (6)
- Express/respond to apology, regrets, and excuses. (6)
- Express and respond to gratitude, appreciation, complaint, disappointment, dissatisfaction, satisfaction and hope. (7)
- Confirm own comprehension. (7)
- Respond to a minor conflict or complaint (e.g., acknowledge and/or clarify a problem, apologize, suggest a solution.) (8)
- Comfort and reassure a person in distress. (8)
- Express and respond to expressions of respect, friendliness, distance and indifference. (9)

Conversation Management

- Indicate partial comprehension. (6)
- Encourage conversation by adding supportive comments. (6)
- Avoid answering a question. (6)
- Change topic. (7)
- Manage conversation. Check comprehension. (8)
- Use a variety of strategies to keep conversation going. (8)
- Encourage others to participate. (8)
- Contribute to/co-manage a discussion or debate in a small formal group (work meeting, seminar). (9)

Phone Competencies

- Take live phone messages with five to seven details. (7)
- Carry on a brief phone conversation in a professional manner. (8)

II. Instructions

- Give a set of instructions dealing with simple daily actions and routines where the steps are not presented as a point-form sequence of single clauses. (6)
- Give clear instructions and directions related to moderately complex technical and non-technical tasks (e.g., explain how to handle a household emergency). (7)
- Give and respond to a warning; discourage others (e.g., discourage a person from … dangerous actions). (7)
- Give/pass on instructions about an established familiar process or procedure (technical and non-technical) (e.g., give instructions on how to administer first aid). (8)
- Give clear, detailed oral information to someone to carry out complex multi-step instructions for a familiar technical/non-technical process (e.g., give complex instructions on familiar first aid and emergency procedures in the workplace). (9)

III. Suasion (Getting Things Done)

- Make a simple formal suggestion; provide a reason. (6)
- Make a simple prediction of consequences. (6)
- Make a verbal request for an item. (6)
- Request a word. Ask for and respond to recommendations or advice. (7)
- Make an extended suggestion on how to solve an immediate problem or make an improvement. (7)
- Indicate problems and solutions in a familiar area. (8)
- Propose/recommend that certain changes be made in a familiar area. (8)

IV. Information

Presentations

- Relate a detailed sequence of events from the past; tell a detailed story, including reasons and consequences. (6)
- Describe and compare people, places, etc. (6)
- Describe a simple process. (6)
- Tell a story, including a future scenario. (7)
- Describe, compare and contrast in detail two events, jobs or procedures. (7)
- Describe a moderately complex process. (7)

Interaction One-on-one

- Ask for and provide information in an interview related to daily activities. (6)
- Ask for and provide detailed information related to personal needs, varied daily activities and routine work requirements (e.g., call to request information about very specific services or products, or to discuss a very specific need). (7)
- Ask for and/or provide detailed information related to personal needs, varied daily activities and routine work requirements (e.g., obtain multiple opinions about a medical condition, treatment options, prognosis). (8)
- Discuss options. (8)

Interaction in a Group

- Participate in a small group discussion/meeting on non-personal familiar topics and issues: express opinions, feelings, obligation, ability, certainty. (6)
- Participate in a small group discussion/meeting: express opinions and feelings; qualify opinion, express reservations, approval and disapproval. (7)
- Express or ask about possibility, probability. (7)
- Participate in a debate/discussion/meeting on an abstract familiar topic or issue. (8)
- Express and analyse opinions and feelings. (8)
- Express doubts and concerns; oppose or support a stand or a proposed solution. (8)

V. Workplace Tasks* (Speaking)

- Provide work-related feedback/opinion when asked by the supervisor in a small informal team meeting. (6)
- Make a request to borrow tools or to have tools fixed. (6)
- Explain a sequence of events leading up to a situation. (6)
- Suggest to someone to try a product. (6)
- Call on the phone to request a meeting. (6)
- Speak briefly on routine matters with familiar suppliers of goods and services (e.g., discuss the content and timing of routine deliveries). (6)
- Speak briefly with customers to clarify routine orders. (6)
- Explain to a new worker how to do a familiar routine task: explain sequence, procedure, method, materials. (6)
- Give or withhold permission to borrow tools; give reasons. (6)
- Engage in small talk during breaks. (6)
- Explain why things are not working. (6)
- Report errors in operations. (6)
- Make a simple suggestion on an element that should be changed; give reason; make a simple prediction of consequences. (6)
- Speak with co-workers and supervisors to clarify schedules and coordinate activities. (7)
- Respond to minor client complaints by apologizing and addressing the problem; refer serious complaints to the supervisor. (7)
- Consult with supervisor and get approval on direction and co-ordination of work.
- Interact with others to share stories and knowledge of a subject area. (7)
- Summarize simple information on routine company policies and procedures for customers. (7)
- Make an extended suggestion on how to solve an immediate single problem or how to improve a procedure or outcome; give reason; predict consequences/effect of certain actions. (7)
- Evaluate/question the validity of a suggestion/proposed solution to an immediate single problem; warn co-worker or supervisor of negative results or effects of proposed changes/lack of action. (7)
- Negotiate time taken on particular tasks. (7)
- Describe to a customer the features of two similar items. (7)

* *Workplace Tasks* taken from *Canadian Language Benchmarks 2000: Additional Sample Task Ideas*

- Handle a complaint or dissatisfaction from a customer in an initial stage; refer him/her to the supervisor. (7)
- Approach supervisor to report a workplace problem and possible consequences. (7)
- Answer the phone with a set phrase and answer basic questions. (7)
- Make work-related suggestions in staff meetings. (7)
- Answer the phone in a professional manner (identify organization and yourself; greet and connect a caller; give routine information; hold a conversation, close. (8)
- Present a complaint to a person and work with her/him towards resolving the conflict. (8)
- Speak with suppliers to determine availability of material, to purchase goods and exchange information on products. (8)
- Report to colleagues/co-workers, supervisors on work progress. (8)
- Participate in a performance review with a supervisor. (8)
- Participate actively in group work or a brainstorming meeting. (8)
- Explain a problem with a new program, machine, procedure; present a possible detailed solution. (8)
- Respond to client complaints and make suggestions for a resolution. (8)
- Respond to a complaint over the phone by empathizing and referring the caller to management. (8)
- Actively participate in a meeting. (9)

4.5.8.2. LISTENING

Global Performance Descriptors (Listening)

The global performance descriptors for listening ranged from CLB Level 7 to CLB Level 9, with **most global performance descriptors for listening falling in the CLB Level 7-8 range.**

- **CLB Level 7**
  - Can comprehend main points and most important details in oral discourse in moderately demanding contexts of language.
  - Can follow most formal and informal conversations on familiar topics at a descriptive level, at a normal rate of speech, especially as a participant.
  - Can understand an expanded inventory of concrete and idiomatic language.
  - Can understand more complex indirect questions about personal experience, familiar topics and general knowledge.
  - Can understand routine work-related conversation.
- **CLB Level 8**
  - Can comprehend main points, details, speaker's purpose, attitudes, levels of formality and styles on oral discourse in moderately demanding contexts.
  - Can follow most formal and informal conversations, and some technical work-related discourse in own field at a normal rate of speech.
  - Can follow discourse about abstract and complex ideas on a familiar topic.
  - Can determine mood, attitudes and feelings.
  - Can understand sufficient vocabulary, idioms and colloquial expressions to follow detailed stories of general popular interest.
  - Can follow clear and coherent extended instructional texts and directions.

- Can follow clear and coherent phone messages on unfamiliar and non-routine matters.
- Often has difficulty following rapid, colloquial/idiomatic or regionally accented speech between native speakers.

- **CLB Level 9**
  - Can obtain key information for important tasks (work, academic, personal) by listening to 15- to 30-minute complex authentic exchanges and presentations in some demanding contexts of language use.
  - Sometimes may miss some details or transition signals and is temporarily lost.
  - Often has difficulty with interpreting verbal humour, low-frequency idioms and cultural references.
  - Able to infer speaker's bias and purpose, and some other attitudinal and sociocultural information.

What a Person Can Do (Listening)

Although listening tasks range from CLB Level 6-9, **the majority of listening tasks fall in the CLB Level 7-8 range.**

I. Social Interaction

- Identify specific factual details and inferred meanings in dialogues containing openings and closings, making and cancelling of appointments, apologies, regrets, excuses, problems in reception and communication. (6)
- Identify mood/attitude of participants. (6)
- Identify stated and unspecified details, facts and opinions about situation and relationship of participants containing expression of and response to gratitude and appreciation, complaint, hope, disappointment, satisfaction, dissatisfaction, approval and disapproval. (7)
- Identify stated and unspecified details about mood, attitude, situation and formality in discourse containing expression of and response to formal welcomes, farewells, toasts, congratulations on achievements and awards, sympathy and condolences. (8)
- In complex formal social interaction dialogues, identify social roles, relationships and relative status of speakers (where obvious from the text from stated and unstated clues). (9)

II Instructions

- Understand a set of instructions when not presented completely in point form; sequence/order must be inferred from the text. (6)
- Understand sets of instructions related to simple technical and non-technical tasks. (7)
- Understand simple directions given on the phone. (7)
- Understand simple messages left on voice-mail (with five to seven details). (7)
- Follow an extended set of multistep instructions on technical and non-technical tasks for familiar processes or procedures (e.g., follow first aid or other emergency instructions by phone). (8)
- Integrate several detailed and extensive pieces of oral information to carry out multistep complex instructions for a familiar process or procedure. (9)

III. Suasion (Getting Things Done)

- Demonstrate comprehension of details and speaker's purpose in suggestions, advice, encouragement and requests. (6)
- Demonstrate comprehension of details and speaker's purpose in directive requests, reminders, orders and pleas. (7)
- Identify stated and unspecified meanings in extended warnings, threats, suggestions and recommendations. (8)
- Evaluate the validity of a suggestion or proposed solution. (8)
- Evaluate extended oral suggestions for solutions to problems, recommendations and proposals in relation to their purpose and audience. (9)

IV. Information

- Identify main ideas, supporting details, statements and examples in a descriptive or narrative presentation, or in a group interaction (e.g., meeting, discussion). (6)
- Demonstrate comprehension of mostly factual details and some inferred meanings in an extended description, report or narration when events (or stages) are reported out of sequence. (7)
- Identify facts, opinions and attitudes in conversations about abstract and complex ideas on a familiar topic. (8)

V. Workplace Tasks* (Listening)

- Follow instructions from the supervisor on what to do next, changes in scheduling or assembly procedure. (6)
- Follow comments on what is wrong and must be corrected. (6)
- Follow instructions and details in coordinating teamwork. (6)
- Identify main ideas and essential details presented in a meeting of a familiar small group or team at work. (6)
- Listen to information on what training is available. (6)
- Take detailed telephone messages/voice-mail messages for others and pass them on orally/repeat them back. (7)
- Take detailed orders and delivery/shipping instructions by phone. (7)
- Listen to details when talking to suppliers and customers face-to-face or over the phone. (7)
- Evaluate the factual accuracy of oral directions/instructions by checking details on a diagram or map. (7)
- Follow simple directions given over the phone. (7)
- Get information from an oral report detailing handling procedures for delicate material. (7)
- Listen to detailed oral instructions and directions from supervisor about a familiar but complex process. (8)
- Follow simple directions on non-routine procedures. (8)
- Listen to co-workers and supervised workers to determine the root of a problem or conflict in a team. (8)
- Listen to reports about daily operation…. (8)

* *Workplace Tasks* taken from *Canadian Language Benchmarks 2000: Additional Sample Task Ideas*

- Listen to and follow a report in a meeting where ... problems are discussed. (8)
- Listen to and follow a progress report on orders, projects, etc. (8)
- Obtain specific extensive information (literal and inferred) by listening to presentations, discussions, or interviews. (9)

4.5.8.3. READING

Global Performance Descriptors (Reading)

The global performance descriptors for reading ranged from CLB Levels 7-9, with **most global descriptors for reading falling in the CLB Level 7-8 range.**

- **CLB Level 7**
  - Can follow main ideas, key words and important details in an authentic one- or two-page text on a familiar topic within a predictable, practical and relevant context.
- **CLB Level 8**
  - Can follow main ideas, key words and important details in an authentic two- to three-page text on a familiar topic, but within an only partially predictable context.
  - Can locate and integrate several specific pieces of information in visually complex texts (e.g., tables, directories) or across paragraphs or sections of text.
  - Text can be on abstract, conceptual or technical topics, containing facts, attitudes and opinion. Inference may be required to identify the writer's bias and the purpose/function of text.
  - Reads in English for information, to learn the language, to develop reading skills.
- **CLB Level 9**
  - Can read authentic multipurpose texts: daily newspaper items, short stories and popular novels; academic materials, sections of textbooks, manuals; simple routine business letters and documents.
  - Some topics may be only partially familiar, or unfamiliar, but are relevant to the learner.
  - Can use inference to locate and integrate several specific pieces of abstract information across paragraphs or sections of visually complex or dense text.

What a Person Can Do (Reading)

Although reading tasks range from CLB Level 5-9, **the majority of reading tasks fall in the CLB Level 7-8 range.**

I. Social Interaction Texts

- Identify factual details in moderately complex notes, e-mail messages, letters and announcements containing cancellations of arrangements, apologies. (6)
- Identify factual details and inferred meanings in moderately complex notes, e-mail messages and letters expressing appreciation, complaint, hope satisfaction, dissatisfaction. (7)

II. Instructions

- Follow a set of common everyday instructions (up to 10 steps) when not presented completely in point form: sequence/order must be inferred. (6)
- Follow a set of written instructions on 10- to 13-step everyday procedures related to simple technical and non-technical tasks (e.g., follow written instructions, including diagrams, on how to apply the Heimlich Manoeuvre). (7)
- Follow everyday instructional texts. (7)
- Follow an extended set of multistep instructions for established process (e.g., explain how to assemble a simple object, according to written instructions and diagrams). (8)
- Follow coherent extended instructional directions (e.g., follow instructions for CPR and what to do in case of a serious injury in a car accident). (8)
- Follow formal instructions of advisory, instructional texts, and instructions for a familiar process or procedure that require integration of several pieces of information (e.g., read policy and procedure manuals; equipment installation/manuals; user product guides and health and safety advisories). (9)

III. Business/Service Texts

- Identify factual details and some inferred meanings in moderately complex business/service texts, including formatted texts. (5)
- Identify factual details and some inferred meanings in moderately complex texts containing advice, requests, specifications (e.g., explain details in notices, announcements and newspaper coverage of public health issues (e.g., such as a disease). (6)
- Identify factual details and some inferred meanings in moderately complex texts containing assessments, evaluation, advice (e.g., obtain information from public health advisories …).
- Locate three or four pieces of information in moderately complex formatted text.
- Locate and integrate three or four pieces of information contained in moderately complex formatted texts (e.g., interpret selection from texts about safety precautions at a workplace by locating and integrating three to four pieces of information from the text. (8)
- Obtain information for key work/business tasks by locating and integrating several pieces of information in complex prose texts and formatted texts (e.g., read extensive and visually complex formatted texts). (9)

IV. Informational Text

- Show comprehension of a one-page moderately complex descriptive/narrative text on a familiar topic. (6)
- Demonstrate comprehension of a cycle diagram, flow chart and a time line/schedule. (6)
- Demonstrate comprehension of a one- or two-page moderately complex extended description, report or narration on a familiar topic (e.g., predict how a machine would work based on information in text). (7)
- Demonstrate comprehension of moderately complex tables, graphs, diagrams, and flow charts (e.g., interpret/explain information in a moderately complex diagram in a basic science text). (7)

- Demonstrate comprehension of factual details and inferred meanings in an extended description, report or narration when events are reported out of sequence. Draw conclusions (e.g., interpret orally or in written text a process flow chart related to basic science or social science). (8)

Information literacy/reference and study skills competencies

- Access/locate/compare two or three pieces of information in a CD-ROM electronic reference source. (6)
- Access and locate three or four pieces of information in on-line electronic reference sources (e.g., World Wide Web, library databases), if available, or from print reference sources. (7)

V. Workplace Tasks* (Reading)

- Scan basic charts, tables, maps or schedules for information. (5)
- Find routine information on the computer screen/scanner screen/computerized display screen, if available. (6)
- Read information in the reception/appointment book to find available openings for a new appointment. (6)
- Read a checklist to verify if all the steps in the procedure have been completed. (6)
- Follow one page of clear familiar task instructions. (7)
- Read a reminder or complaint letter/memo-take appropriate action. (7)
- Scan complex charts, tables and schedules for several specific pieces of information for comparison/contrast. (7)
- Follow instructions on evacuation procedures, fire drills, or on using simple machinery/equipment.(7)
- Use plain language manual with familiar topic and content in own field of knowledge to find specific information. (8)
- Follow 1-2 pages of clear task instructions. (8)
- Follow instructions on how to operate a piece of equipment. (8)
- Read to understand clear language instructions and diagrams to assemble or process something. (8)
- Read to understand information on protective measures/precautions against exposure to toxic chemicals. (8)
- Get information from a process flow chart (e.g., a hiring process flow chart or a flow chart for handling procedures of dangerous goods or chemicals). (8)
- Read an incident report left by workers on a previous shift. (8)
- Read multiple short workplace activity reports (shift or daily reports); intake assessment or client interview reports; short routine formatted evaluation reports; technician's reports or routine formatted lab reports. (9)
- Follow instructions in technical manuals, which may contain some unfamiliar terminology. (9)
- Read workplace and/or government bulletins on policies or procedures to modify own documentation or practices. (9)
- Complete or check complex forms. (9)

* *Workplace Tasks* taken from *Canadian Language Benchmarks 2000: Additional Sample Task Ideas*

4.5.8.4. WRITING

Global Performance Descriptors (Writing)

The global performance descriptors for writing from CLB Levels 6-8, with **most global descriptors for writing falling in the CLB Level 6-7 range.**

- **CLB Level 6**
  - Can effectively convey familiar information in familiar standard formats.
  - Can reproduce information received orally or visually, and can take simple notes from short oral presentations or from reference materials.
  - Can write down everyday phone messages.
  - Demonstrates good control over simple structures, but has difficulty with some complex structures and produces some awkward sounding phrases (word combinations).
- **CLB Level 7**
  - Demonstrates adequate ability in performing moderately complex writing tasks.
  - Demonstrates mostly satisfactory control over complex structures, spelling and mechanics.
  - Can take notes from clear pre-recorded phone messages.
- **CLB Level 8**
  - Can fill out complex formatted documents.

What a Person Can Do (Writing)

Although writing tasks range from CLB Level 5-9, **the majority of writing tasks fall in the CLB Level 6-7 range.**

I. Social Interaction

- Convey a personal message in a formal short letter or note, or through e-mail, expressing or responding to invitations, quick updates, feelings. (5)
- Convey a personal message in a formal short letter or note, or through e-mail, expressing or responding to congratulations, thanks, apology or offer of assistance. (6)
- Convey a personal message in a formal short letter or note, or through e-mail, expressing or responding to appreciation, complaint, disappointment, satisfaction, dissatisfaction and hope. (7)

II. Reproducing Information

- Take live phone messages, voice mail messages or pre-recorded information with five to seven details. (5)
- Take notes from pre-recorded longer phone messages on public information lines or voice mail messages with seven to 10 details. (7)

III. Business/Service Messages

- Convey business messages as written notes. (5)
- Fill out forms (e.g., fill out a worker's accident report form). (5)
- Fill out moderately complex forms (e.g., fill out a short medical history form). (6)
- Fill out moderately complex forms (e.g., fill out an application for training). (7)

- Convey business messages as written notes, memoranda, letters of request, or work record log entries, to indicate a problem, to request a change, or to request information. (8)
- Fill out forms and other materials in pre-set formats with required brief texts. (8)

IV. Presenting Information and Ideas

- Write a paragraph to relate/narrate a sequence of events; to describe a person, object, scene, picture, procedure or routine; or to explain reasons. (5)
- Write one or two paragraphs to: relate a familiar sequence of events, tell a story; provide a detailed description and comparison of people, places, objects and animals, plans, materials or routines; or to describe a simple process. (6)

V. Workplace Tasks[*] (Writing)

- Take a simple routine phone message (5-7 details). (5)
- Write a short note to a co-worker to let him/her know when there is a problem (e.g., comments about equipment operation in a "problem book"/daily log). (5)
- Write a short incident/accident report. (6)
- Fill out a form to record and report a weekly workload. (6)
- Write brief information/short entries on patient care in card files (e.g., temperature, weight, etc.). (6)
- Using single words and short phrases, write brief comments in daily logs to describe condition of the machines/equipment. (6)
- Keep a daily/weekly work record/log book. (7)
- Transcribe a short voice-mail message on a familiar topic. (7)
- Write down phone messages freehand (7-10 details). (7)
- Fill out a medical procedure consent form…. (8)
- Appropriately record on a special form information from a structured oral interview.
- Compete a detailed incident report; include cause and effect analysis. (8)
- Write short workplace activity reports (shift or daily reports); intake assessment or client interview reports ….(9)

[*] *Workplace Tasks* taken from *Canadian Language Benchmarks 2000: Additional Sample Task Ideas*

4.5.9. Flesch Kincaid Readability Scores Computed for Unformatted° Text

The texts used for the readability analysis were collected at work sites at which we observed nurses. Some facilities requested confidentiality regarding their documents; as a result, texts are identified by title, but not by source. The results are recorded in Table 10.

Please note that these scores reflect grade levels, not CLB levels.

Table 10.

TEXT	Flesch Ease Score (100-point scale, with 100 representing easier text, and 0 representing more difficult text.)	Flesch-Kincaid Grade Level Score ***(Not CLB Levels)***
Appendectomy Discharge Teaching/Instructions	**74.6**	**6.0**
Bowel Resection Discharge (read and explained to patients being discharged)	**72.1**	**6.1**
Unit Dose--Self-Learning Pkg.	**60.7**	**9.2**
Emergency Department Instructions	**47.2**	**9.9**
Clinical History (written by a physician)	**41.2**	**10.5**
HIV Testing Guidelines	**44.8**	**10.6**
Clinical Lab Tests: Values and Implications	**41.6**	**11.0**
Newsletter	**46.6**	**11.1**
Functional Assessment	**27.5**	**11.3**
Nursing Drug Handbook	**27.5**	**11.5**
Dosages and Calculations	**39.2**	**11.9**
Transferring of Patient Procedures	**31**	**12.0**
Diabetes Management	**28.8**	**12.0**
Procedures Manual	**18.7**	**12.0**
Policy Manual	**18.7**	**12.0**
Governance Standards Manual	**18.4**	**12.0**
Total Parentral: Nutrition Lipid Complications	**14.3**	**12.0**
Learning Package: Standing Orders	**5.8**	**12.0**

It should be noted that Flesch Kincaid Readability Scores are computed based mainly on the syntax of text. Aspects of language such as terminology, vocabulary, abbreviations, and context are not taken into consideration, and these features are perhaps the most challenging for workplace reading tasks. Therefore, these results should not be regarded as the main criteria for determining language levels of reading text.

4.5.10. CLB Levels Assigned to Samples of Formatted+ Text Collected

A great deal of text used by nurses in the workplace consists of forms and charts. Some of these texts require mostly reading skills, while others require mostly writing skills. In some cases, both are required. Each of us independently analyzed the samples collected by

° Unformatted text refers to text in sentence/paragraph format.
+ Formatted text refers to text **not** in sentence/paragraph format.

assigning reading and/or writing CLB levels separately. There was never more that a one-level discrepancy in the two results assigned. The results are recorded in Table 11.

Table 11.

TEXT	CLB Reading Level/s Assigned	CLB Writing Level/s Assigned
CLB READING LEVELS ASSIGNED		
Work Schedule	**6**	
Client Bill of Rights and Responsibilities (Client Service Standards)	**6**	
Health Records	**6-7**	
Memo: Communication with the Schedulers	**7**	
Memo: Things to Do	**6-7**	
Physician's Order 1	**7**	
Physician's Order 2	**7**	
Medical Orders	**7**	
Physician's Treatment Orders	**7**	
Assessment-Arterial Ulcers (from *Evidence Based Wound Management Protocol*)	**8**	
Memo re. T4 and tax-related items	**8**	
In Motion (Newsletter)	**8**	
Resuscitation Level Record (filled out by physician; read by nurse)	**8**	
Government Standards Manual (Risk Management-Conflict of Interest)	**8-9**	
Pressure Ulcer Flow Chart (from *Evidence Based Wound Management Protocol*)	**8-9**	
Intravenous Drug Manual	**8-9**	
Client Services Standards Manual (Advanced Directive re. resuscitation of client)	**9**	
Nursing Policy Manual	**9**	
Braden Scale for Predicting Risk	**9**	
Procedure: Insulin Preparation and Administration (from *Health Care Manual)*	**9**	
Procedure: Diabetes Management (from *Health Care Manual)*	**9**	
CLB READING AND WRITING LEVELS ASSIGNED		
Initial Wound Assessment and Treatment	**6-7**	**8**
Disaster Plans Questionnaire	**7**	**6**
Patient Weekly Assessment	**7**	**6**
Transfer Checklist: Patients follow directions consistently	**7**	**6**
Transfer Checklist: Patients who do not follow directions consistently	**7**	**6**
Baby Assessment	**7-8**	**6**
Functional Assessment	**8-9**	**6**
Family Medicine Program Standing Orders	**8-9**	**6**

Functional Assessment	**8-9**	**6**
Acute MI Care Map	**9**	**7-8**
HIV Testing Guidelines: Pre-test Visit	**9**	**7-8**
HIV Testing Guidelines: Post-test Visit	**9**	**7-8**
CLB WRITING LEVELS ASSIGNED		
Care Plan for Activities of Daily Living		**6**
Clinical Chart		**6**
Client Medication Renewal Sheet		**6**
Fluid Balance Record		**6**
Notification of Death Record		**6**
Supply Record for In-home Chart		**6**
Standard Medication Orders		**6**
Medication Administration Record		**6**
Nursing Orientation Skills Checklist		**6**
Prenatal Group Registration Form		**6**
Initial Signatures Form		**6**
Annual Adult Health Assessment		**6-7**
Discharge Planning for Complex Care Needs and *Application/Assessment to Personal Care Home/Chronic Long Term Care*		**6-7**
Electrocardiograph Requisition		**6-7**
Lab Requisition		**6-7**
Footcare Assessment Form		**6-7**
Footcare Flow Sheet		**6-7**
Basic Data Flow Sheet		**6-7**
Neurological Record		**6-7**
PICC Line Care		**6-7**
Patient Care Record		**6-7**
Record of Post Partum Patient Learning		**6-7**
Prenatal Group Preliminary Intake Form		**6-7**
Record of Medications Taken by Individual		**6-7**
Patient Classification Data Chart		**6-7**
Request for Review by Facilities Liason		**6-7**
Requisition for Occupational Therapy		**6-7**
Standard Medication Orders		**6-7**
Well-woman Form		**6-7**
Record Audit Tool		**6-7**
Unusual Occurrence Report Form		**6-7**
Home Care Referral Form		**7**
Intravenous Therapy Form		**7**
Client Admission Form		**7**
Consult to Home Care		**7-8**
Health Questionnaire and Immunization Form (completion required of hospital employees)		**7-8**
Nursing Diagnosis Index		**7-8**
Rehab/Geriatric Rounds		**7-8**

Kardex		**7-8**
Quality Improvement Form		**7-8**
First Aid Report		**7-8**
Accident Report		**7-8**
Incident Report 1		**7-8**
Incident/Accident Report 2		**7-8**
Incident Report 3		**8**
Postpartum Referral Form		**8**
Emergency Nursing Assessment/Notes		**8**
Health Assessment		**8**
Ongoing Wound Assessment and Treatment		**8**
Narrative Progress Notes		**8**
Integrated Progress Notes		**8**
Nursing Care Plan 1		**8**
Nursing Care Plan 2		**8**
Nursing Care Plan 3 (Home Care)		**8**
Resident Care Plan		**8**
Problem/Profile List		**8**
Incident Follow-up		**8-9**

Although the observations were very helpful in helping to determine the English language demands of the nursing profession across Canada, they only represent a very small fraction of nursing practise. Many settings in which nurses practise were not observed.

In addition, nurses were only observed for a short period of time, usually three consecutive hours. Furthermore, none of the observations was carried out in the evening or at night. Therefore, tasks specific to those times were not observed.

It can also be assumed that nurses who were willing to be observed were among the more experienced, competent and confident. As a result, it can be inferred that nurses are probably practising successfully with language skills lower than those observed.

5. Summary of Results

In making the final decision regarding CLB levels for the nursing profession, all of the data, both quantitative and qualitative, have been considered carefully. One factor is the inherent high stakes involved in the profession. CLB levels must be high enough to ensure a high quality of service in the workplace. It is of vital importance that nurses have the ability to communicate well, as their actions and decisions play a critical role in the delivery of health care in Canada. Nurses have a great responsibility in ensuring that clients receive quality health service.

On the other hand, it is also important that internationally-educated nurses with adequate English language skills not be excluded by language requirements that are unrealistically high. The result would be not only an additional unfair barrier for these nurses, but also the loss of valuable human resources that could help to address the critical nursing shortage that Canada is expected to experience in the next ten years.

Another factor that must be considered is that second language nurses will generally improve their English language skills in the workplace. In an article entitled, "Professional Writing and the Role of Incidental Collaboration: Evidence from a Medical Setting" (2000), Parks described research carried out in Quebec with francophone nurses hired to work in an English-medium hospital. Initial oral proficiency in English was in the low to high intermediate range, and these nurses experienced considerable difficulty starting out; however, the study concludes that incidental collaboration on the job was a major factor in enabling these nurses to achieve writing competence in the workplace.

Furthermore, internationally-educated nurses already have a knowledge base in the profession. This factor must also be considered in assigning levels of English language proficiency. The assumption that these nurses already have basic knowledge of the field indicates that they have background knowledge that facilitates comprehension and use of language in the workplace. This is also an advantage in dealing with new information, as they are building on what they already know.

In addition, it must be noted that a CLB level indicates general proficiency, implying that this proficiency has been achieved in the broad range of the four sub-skills. However, this broad range of proficiency in all the sub-skills may not be applicable to the nursing profession. While a general CLB level has been assigned for each skill (speaking, listening, reading and writing), we have also indicated the range of proficiency needed for the sub-skills. In some cases, one sub-skill may require higher proficiency, while other sub-skills may be much lower. As a result, it was decided that it would be unfair to require the high level of general proficiency, when only one sub-skill required it. An appropriate assessment tool would address this issue, as certain sub-skills could be assessed at higher levels.

It was also decided that English language requirements for all the designations addressed by this study (RN/LPN/RNA/RPN) be set at the same CLB levels. This is based on feedback from the focus groups and interviews, and on the observations. There was general agreement that, while the language demands of RN programs were higher than programs for other designations, the language demands of the workplace were similar.

Based on all the data collected, we have established the English language demands of the nursing profession using CLB levels. The outcomes are listed in Table 12.

Table 12.

SKILL		CLB LEVEL ASSIGNED	
GENERAL SKILL	**SUB-SKILL**	**CLB RANGE FOR SUB-SKILLS**	**GENERAL CLB LEVEL**
SPEAKING	1. Social Interaction	7-9	**8**
	2. Instructions	7-9	
	3. Suasion	7-8	
	4. Information	7-8	
	Workplace Tasks	6-9	
LISTENING	1. Social Interaction	7-9	**9**
	2. Instructions	7-9	
	3. Suasion	7-9	
	4. Information	7-8	
	Workplace Tasks	6-9	
READING	1. Social Interaction Texts	6-7	**8**
	2. Instructions	7-9	
	3. Business/Service Texts	7-9	
	4. Informational Texts	7-9	
	Workplace Tasks	5-9	
WRITING	1. Social Interaction	6-7	**7**
	2. Reproducing Information	5-7	
	3. Business/Service Texts	6-9	
	4.Presenting Information and Ideas	5-6	
	Workplace Tasks	5-9	

While speaking and listening skills are in similar ranges, it was noted that clients who are communicating with nurses may have difficulty speaking, or may not be able to speak at all, for a wide range of reasons. Furthermore, they may be under a great deal of stress. For these reasons, it was decided that listening would be benchmarked at a higher level than speaking.

In reading, most texts were in the CLB Levels 7-8 range. The content of the more demanding texts dealt with topics familiar to nurses within the context of their practise. As a result, reading was benchmarked at CLB Level 8 in terms of general proficiency.

Most of the writing required of nurses was in the CLB Levels 5-7 range. The only sub-skill that exceeded that range was *Business/Service Texts*. This category includes forms and charts. Very little extended writing was required, and most writing was in point form. The form and terminology used was within the structured context of the specific work environment. The research referred to earlier suggests that second language nurses become more skilled in writing through incidental collaboration. Interviews with second language nurses confirmed that this type of support is frequently available when requested from co-workers. In addition, second language nurses compensated by looking at other entries to ensure that the form and terminology they were using were appropriate. Based on this information, it was decided that

nurses at CLB Level 7 in writing would have the skills needed to enter the workforce as nurses.

It is important to note that these CLB levels reflect the English language demands of the nursing profession for internationally-educated nurses entering the profession in Canada. These nurses can be expected to improve their language skills as they work in the field. Depending on their background knowledge and experience, and also on the improvement they make in the use of the English language on the job, there is the potential for them to advance to positions which require more advanced language skills.

According to Lumley (1998, pp. 352-353), "the issues of setting standards in language tests is always a political one". He describes it as the tension between "the views of advocates of the immigrant professionals (who generally press for a more lenient standard), and those of the representatives of professional registration boards who typically advocate more stringent criteria)". While he is speaking of his experience in Australia, the same could be said of setting standards for English language proficiency in Canada. In this project, we have endeavoured to find a balanced approach in assigning CLB levels to the profession of nursing.

6. Implications for Stakeholders

6.1. Implications for ESL Programs

In some parts of the country there are gaps in the availability of English language training programs for professionals. As a result, valuable human resources are wasted because professionals who already are qualified have no means of improving their English to the level required to enter refresher programs and/or to pass national exams. This means that many professionals, including internationally-educated nurses, are unable to access the profession, and this potential resource is lost. The data gathered in this project provides a framework of language tasks and cultural issues that should be addressed in ESL programs offered for internationally-educated nurses.

It should be noted that there are already some excellent bridging programs available for nurses in some provinces. One example is the Care for Nurses Project in Toronto. This project was established to help internationally-educated nurses become licenced in Ontario. It is funded by the Ontario Ministry of Training, Colleges and Universities, Access to Professions and Trades Units, and is seen as a model for other professions. The Care for Nurses Project works collaboratively with health care facilities, educational institutions and government agencies. They offer a total of 829 hours of instruction in collaboration with local colleges. The language requirements for the module, English Communication for Nurses (348 hours of instruction), are Canadian Language Benchmark (CLB) scores of Listening and Speaking: 6, Reading: 6, Writing: 5. For other modules, CLB Listening and Speaking: 7, Reading: 7, and Writing: 6 are required. Early results of the program have been very encouraging.

6.2. Implications for Nursing/Nursing Refresher Programs

Most nursing/nursing refresher programs across the country are dealing with second language students. The analysis of language tasks of nurses provided by this project can help to establish appropriate English language requirements for programs, and also to suggest the types of support needed. It is important that fair language requirements be in place for students entering programs, to avoid setting these students up for failure. At the same time, language requirements should not pose an unfair barrier. Programs also need to be aware of the unique challenges facing second language students; with this knowledge, appropriate support can be provided to facilitate success for these students, both in programs and later in the workplace.

It is also important that programs recognise the wealth of experience and knowledge that students from other cultures bring to the classroom, and to the workplace. In Canada, nurses will experience a multicultural workplace, with both co-workers and clients of other races and backgrounds. Building relationships with students of other cultures in a nursing program is a very practical learning experience, which will be of benefit later in the workplace.

The development of an English language assessment tool specific to the occupation also has implications for training programs. Presently the English language assessment tools used for internationally-educated nurses are not specific to the occupation. As a result, students in bridging programs or nursing refresher programs often take separate training to prepare themselves for the language assessment itself. Because a test specific to the nursing occupation would reflect the real-life professional communicative demands of the nursing

profession, the nursing refresher/bridging program itself would provide the best preparation for the language test.

6.3. Implications for Employers/Workplace

Employers in the health industry are in a difficult position at the present time. On one hand, they are faced with government spending constraints. On the other hand, they are responsible to deliver health care to an aging population, with the need for more and more services. At the same time, professionals, including nurses, cannot always be found to fill positions that are available.

It is important that employers recognise that internationally-educated nurses are a resource that can help to meet the current and future needs of the health system. Workplaces need to examine hiring policies, to make sure that unfair barriers are not in place. In some cases, these barriers prevent nurses, who have already proven their English language and nursing ability, from entering the system. Further language tests and/or other tests should not be required by specific workplaces.

Also, systems should be in place to support internationally-educated nurses when they enter the profession in Canada. It must be acknowledged that, while these nurses may need some extra support at the beginning, they will benefit the system in the long term. The support needed should not be added on to the already heavy burden of work borne by existing staff. Rather, time and money should be available for experienced nurses to provide orientation and support to the nurses entering the profession in Canada. While this is a short-term expense, it would have long-term benefit. Mentoring programs would also provide practical support to internationally-educated nurses wishing to enter the profession.

While many workplaces are very accepting of nurses who come from other cultures and speak first languages other than English, it is essential that the workplace foster this acceptance. Many stereotypes and prejudices are unconscious, and it is important that co-workers be aware of these issues and work at becoming more sensitive. Second language nurses should be valued for the important contributions they bring. They come with an awareness of another language and culture, and can contribute this awareness to the health setting. Mutual respect encourages collaboration and teamwork. These qualities will enhance the delivery of health services in any setting.

6.4. Implications for Regulatory Bodies

Regulatory bodies carry the heavy burden of responsibility of ensuring that internationally-educated nurses are qualified, both in terms of language and in terms of knowledge and experience, to practise in Canada. They face pressure from some stakeholders to increase the requirements, and from others to lower them. This project addresses the issue of the language needed for nurses whose first language is not English. An appropriate English language assessment tool for nurses, based on the results of this study, will help to address these issues faced by regulatory bodies. It will give internationally-educated nurses a measure of their English language ability specific to the workplace. For example, if they have practised in English in another health setting, this experience will have direct relevance to skills tested by the assessment tool. At the same time, specific concerns about language in the workplace will be addressed. Such an assessment tool will target specific language skills essential for the nursing profession, such as describing, explaining, asking for information, and filling out

medical forms and charts. By basing access on an appropriate assessment tool, regulatory bodies can more accurately predict English language competence for the workplace.

Another issue raised in the focus groups is the complicated nature of the process internationally-educated nurses face as they attempt to access the nursing profession in Canada. There were recommendations made for a consistent national policy that is clearly articulated in the country of origin. With such a policy, nurses will have more realistic expectations when they make the decision to immigrate to this country.

6.5. Implications for Government Agencies

With the prediction of a critical shortage of nurses within the next ten years, it is important that government agencies at all levels respond with solutions that are both long-term and cost effective. Internationally-educated nurses are, and will continue to be, available to help address the problem. Because they are already educated as nurses, time and money is not needed to support them in full training programs. The challenge is to facilitate their integration into the nursing profession. Government agencies need to provide resources in the following areas:

- Ensure that immigration policies facilitate access into the nursing profession for internationally-educated nurses.
- Work towards making the process of accessing the profession as transparent as possible, both for nurses who are considering immigration to Canada, and for nurses who are already in Canada.
- Provide funding for more high level ESL and English for Nursing Programs; these programs are needed to address the needs of internationally-educated nurses who do not meet the English language requirements of nursing refresher programs.
- Provide funding for more bridging programs for internationally-educated nurses who need both specific language training and cultural orientation for the nursing profession in Canada.
- Provide funding for the benchmarking of the English language demands of nursing refresher and bridging programs for nurses.
- Provide funding for the development of an assessment tool, which appropriately measures the English language proficiency of nurses, based on the language demands of the profession.
- Provide funding to employers for initiatives that provide support to internationally-educated nurses in the workplace (e.g., orientation programs, mentorship programs, cross-cultural awareness programs).

While resources are needed to put these recommendations into effect, all of these initiatives would contribute to a long-term, cost-effective solution to the nursing shortage that is anticipated in Canada.

6.6. Implications for Internationally-Educated Nurses

Internationally-educated nurses are often frustrated in their attempts to access the nursing profession in Canada. Despite shortages already being experienced across the country, many talented nurses are lost to the health system because of the barriers that they face. It is hoped that this project is one step in the direction of facilitating access to the profession for these nurses. The data gathered helps to indicate exactly which language tasks are needed for nursing. With an assessment tool that reflects these tasks, internationally-educated nurses

who have practised their profession in an English-speaking setting in another country will have an advantage in that their experience in the workplace will be more directly related to the content of the test. In the same way, internationally-educated nurses who have been working in Canada in a health-related field will also find that their experience will help to prepare them for the English language assessment.

Furthermore, an occupation-specific assessment tool will help to avoid setting up internationally-educated nurses for failure. It will be more accurate than the present tests in predicting whether or not a candidate has the English language skills for the workplace. For internationally-educated nurses who do not yet have the language skills to practise in the profession, the data gathered in this project helps to direct them in terms of the language skills needed.

6.7. Implications for Language Assessment Developers

This project gives direction to the development of an English language assessment tool in various ways. The findings inform language assessment developers in deciding the level of complexity and the content of an assessment tool. The range of CLB levels needed for each skill (speaking, listening, reading, and writing) is identified. In addition, the data indicates the importance of certain sub-skills and competencies. For example, in terms of speaking and listening, a broad range of sub-skills needs to be represented. In reading and writing, business/service texts are of key importance.

Also, data gathered in the observation of nurses indicates the frequency of various types of interactions. Most interactions are with clients, and most types of interaction involve asking for information, explaining, and describing. This knowledge helps to direct the format of the listening and speaking sections of an assessment tool.

A great deal of information was gathered regarding the challenges faced by internationally-educated nurses. Some examples frequently cited were pronunciation and taking physician's orders over the phone. These challenges need to be analyzed in terms of importance, and decisions need to be made regarding how they can be represented in an assessment tool.

The following suggestions regarding the development of an assessment tool were made in the focus groups: (1) The test should be realistic and reliable; (2) Key indicators for predicting success should be identified and used; (3) The test should determine comprehension and ability to converse with other professionals, clients, and families; (4) The test needs to have occupational validity and conformity; (5) The test should be designed so that some diagnostic feedback is possible; (6) The test needs to be cost-effective; (7) Materials for preparation for the test should be available to candidates; (8) The test should be field-tested with a large control group of both first and second language nurses. Language assessment developers need to take these suggestions into consideration.

6.8. Implications for Related Research

For researchers who carry out similar research in the future, a few suggestions can be made based on lessons learned during this project. If research is being carried out in any health facility, it is wise to allow for plenty of lead time. It is important to make sure enough time is allowed for application for ethics approval. Also, one cannot take for granted that this process is the same in every province, or even within each province.

In addition, if a survey is being conducted, it is important to allow enough time and resources for that process. The field testing of the survey, the number of surveys to be sent out, the system for identifying potential participants, and the importance of sending reminders before the deadline must be taken into consideration. Other methods could also be employed to improve the percentage of survey returns (e.g., enclosing a pencil, offering a small reward such as a gift certificate for returned surveys).

We found that it was very important to have support in the statistical analysis of the project. This support should already be available at the proposal stage of the project, allowing for better projections of the implications, time, and resources needed to carry out the research.

The value of using a mixed methods approach is evident in the results of the project. In many ways, each method helped to validate the other. Also, we were challenged to analyze the limitations of each method, and interpret the results holistically. This process contributed to the reliability of the outcomes.

6.9. Implications for Further Research

This project suggests several directions for further study. It would be helpful address the following questions:

- What are the access issues for internationally-educated nurses, and how can they be addressed?
- What systemic barriers do internationally-educated nurses face, and how can they be addressed?
- What are appropriate levels of English language proficiency for entry into English for Nursing Programs, Nursing Refresher/Bridging Programs and Nursing Programs?
- What supports are presently available for internationally-educated nurses in the workplace?
- What supports would be helpful to internationally-educated nurses in the workplace?
- How can existing staff in the workplace be educated to facilitate better integration of internationally-educated nurses?
- What is the experience of other countries in developing occupation-specific language assessment tools, especially for health-related professions? What can we learn from them?
- How successful are second language nurses in the workplace? How does this relate to their English language competence? What other factors (besides language competence) predict success?
- Is it feasible to assess aspects of language proficiency such as adaptation of register, use of idiomatic language, and/or language proficiency in stressful situations?

References

Centre for Canadian Language Benchmarks. (2001). *Benchmarking the nursing profession and developing an occupational specific assessment instrument: Feasibility study*. Ottawa, ON.

Des Brisay, M. and St. John, J. (2001). *Development and validation of CanTEST versions for Canadian Language Benchmarks*, Report submitted to the Centre for Canadian Language Benchmarks. University of Ottawa, Ottawa, ON.

Epp, L., & Stawychny, M. (1999). *Benchmarking the CanTEST*, Benchmark project report. Red River College. Winnipeg, MB.

Lockhart, J. (1998). *Language at work:* A job analysis guide. Bow Valley College.

Lumley, T. (1998). Perceptions of language-trained raters and occupational experts in a test of occupational English language proficiency. *English for Specific Purposes, 17*, (4): 347-367.

Parks, S. (2000). Professional writing and the role of incidental collaboration: Evidence from a medical setting. *Journal of Second Language Writing, 9*,(2: 101-122).

Pawlikowska-Smith, G., (2000). *Canadian Language Benchmarks 2000*. Centre for Canadian Language Benchmarks. Ottawa, ON.

Pawlikowska-Smith, G., (2001). *Canadian Language Benchmarks 2000*: *Additional Sample Task Ideas.* Centre for Canadian Language Benchmarks. Ottawa, ON.

Registered Nursing Association of Ontario with Registered Practical Nurses Association of Ontario, (2000). *Ensuring the care will be there. Report submitted to the* Ontario Ministry of Health and Long-term Care, Toronto, ON.

APPENDIX A

ADVISORY COMMITTEE FOR NURSING PROJECT PROFILE

Name:_____

Name of Organization/Institution: _____

Position: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

What is the reason for your interest in this project?

_____

_____

_____

How can your organization/institution benefit from this project?

_____

_____

_____

What do you see as the greatest language challenges for nurses who speak English as a second language?

_____

_____

_____

Please mark with an X the nursing designations used in your province.

Registered Nurses (RNs)

Registered Practical Nurses (RPNs)

Registered Nursing Assistants (RNAs)

Licensed Practical Nurses (LPNs)

Please mark with an X the following weeks that would **NOT** be suitable for our visit to your location.

March 18, 2002 to March 22, 2002

March 25, 2002 to March 28, 2002

April 1, 2002 to April 5, 2002

April 8, 2002 to April 12, 2002

April 15, 2002 to April 19, 2002

April 22, 2002 to April 26, 2002

APPENDIX B

ROLE OF MEMBERS OF THE NATIONAL ADVISORY COMMITTEE FOR THE NURSING PROJECT

As a member of the Advisory Committee for the project, you would provide perspective from your province and from your organization/institution in the following ways:

1) Fill out a brief profile form.

2) Provide feedback regarding the:

   a) project plan (initially)
   b) first interim report (after Stage 1: Development of a process)
   c) second interim report (after Stage 2: Data gathering)
   d) draft of the final report (Near the end of Stage 3: Analysis of data)

3) Provide names of other contacts who would be helpful in providing information related to the project.

4) In addition, **Advisory Committee members at locations which would be visited by researchers** would help in the following ways:

   a) Identify appropriate contacts for members of focus groups.
   b) Provide assistance with the arrangement of focus group meetings.
   c) Participate in focus groups.
   d) Provide assistance with the arrangements for on-site observation of nurses by researchers.
   e) Identify appropriate candidates for assessment using the CanTEST.

5) **Advisory Committee members at locations not visited by researchers** would provide feedback through in-depth interviews by phone and/or e-mail.

The time frame for the project is:

STAGE 1: Feb. 18 - March 15, 2002

STAGE 2: March 18 - April 26, 2002

STAGE 3: April 29 - May 31, 2002

APPENDIX C

Dear Survey Participants:

We are undertaking a project in which we are analyzing the language demands of the nursing profession across Canada. This project is funded by the Centre for Canadian Language Benchmarks in Ottawa. Through this study, we will determine language levels needed for foreign trained nurses, based on the actual language used on the job. The results of this project will be reported to the Centre for Canadian Language Benchmarks in the form or a report.

This survey is one way in which we are gathering data for this purpose. It will take about 45 minutes for you to fill it out. The survey results will give us very helpful information. This survey is intended for practicing nurses. Participants' confidentiality will be preserved by storing all data in a locked data storage cabinet. All papers and electronic records will be shredded 2 years after the project is completed. You are not under any obligation to participate, and can decline to answer any questions. By submitting the survey, you will be acknowledging your informed consent to provide this information for the purposes of this research project. The deadline for returning this survey is XXXX.

Lucy Epp

Mary Stawychny

Language Training Centre
Red River College
300-123 Main St.
Winnipeg, Manitoba R3C 1A3

phone: 204-945-6151
fax: 204-948-3214
e-mail: lepp@rrc.mb.ca

Directions:

1. **Indicate your response to each statement on the survey, following the IMPORTANT MARKING INSTRUCTIONS at the top of the answer sheet.**

2. **Return the answer sheet, using the enclosed, addressed stamped envelope.**

SURVEY OF LANGUAGE TASKS FOR THE NURSING PROFESSION IN CANADA

Please indicate how important it is for nurses in your position to perform the following **language tasks** with **(1) being not important** and **(5) being extremely important**.

1. **not important**
2. **somewhat important**
3. **important**
4. **very important**
5. **extremely important**

SPEAKING AND LISTENING

IMPORTANCE	SPEAKING/LISTENING TASKS: SOCIAL INTERACTION
	INTERPERSONAL COMPETENCIES
1 2 3 4 5	1. Express sympathy formally.
1 2 3 4 5	2. Respond to a minor conflict or complaint.
1 2 3 4 5	3. Comfort or reassure a person in distress.
1 2 3 4 5	4. Express and respond to expressions of respect, friendliness, distance and/or indifference.
1 2 3 4 5	5. Respond to perceived hostility, blaming, putdowns, sarcasm, condescension/ patronizing or lies in social interaction.
1 2 3 4 5	6. Express and respond to negative value judgements/criticism.
	CONVERSATION MANAGEMENT
1 2 3 4 5	7. Change the topic.
1 2 3 4 5	8. Manage conversation; make sure that you understand others and that they understand you (e.g., ask for clarification about a doctor's order).
1 2 3 4 5	9. Encourage others to participate.
1 2 3 4 5	10. Contribute to/co-manage a discussion and/or debate (e.g., discussion with other health care professionals regarding a decision related to a patient during rounds).
1 2 3 4 5	11. Contribute to/co-manage a discussion and/or debate in a large formal familiar group (e.g., an interdisciplinary group meeting discussing patient care plans).
1 2 3 4 5	12. Lead/chair a discussion or a debate in a formal group (e.g., at a medical conference).
1 2 3 4 5	13. Recognize and prevent conflict-escalating language behaviour by reframing negative statements (e.g. during a family conference with health professionals).
	SPEAKING/LISTENING TASKS: SOCIAL INTERACTION
	PHONE COMPETENCIES
1 2 3 4 5	14. Ask for information about the availability of services.
1 2 3 4 5	15. Take and pass on a message with specific details for someone else.
1 2 3 4 5	16. Discuss unfamiliar topics by telephone (e.g., coordinating the transfer of a patient).

IMPORTANCE	SPEAKING TASKS: INSTRUCTIONS
1 2 3 4 5	17. Give clear instructions and directions related to a moderately complex familiar task (e.g., how to handle a household emergency).
1 2 3 4 5	18. Give/pass on instructions about an established familiar process or procedure (e.g., instructions on how to change dressing).
1 2 3 4 5	19. Give clear, detailed information to someone to carry out complex multi-step instructions for a familiar technical/non-technical process (e.g., discharge plan).
1 2 3 4 5	20. Give complex multi-step instructions for carrying out very important procedures; situation **may be demanding and stressful**.
1 2 3 4 5	21. Give instructions on complex unfamiliar procedures **in a demanding and stressful** situation (e.g., experimental procedures, research assignments).
	SPEAKING TASKS: SUASION (GETTING THINGS DONE)
1 2 3 4 5	22. Indicate problems and/or solutions in a familiar area (e.g. participate in a discussion with other professionals regarding a care plan).
1 2 3 4 5	23. Formally raise an issue with an individual and/or a group in authority.
1 2 3 4 5	24. Express, ask, appeal for and/or respond to a promise (e.g., for a govt. grant).
1 2 3 4 5	25. Respond to ingratiation (e.g., flattery, compliments, favours).
1 2 3 4 5	26. Respond to threats (overt and covert).
1 2 3 4 5	27. Negotiate a concession and/or solution using persuasive techniques (e.g., evidence, logical argument, ethical and/or emotional appeals).
	SPEAKING TASKS: PRESENTATIONS
1 2 3 4 5	28. Give a summary/report of the main points of a presentation by someone else.
1 2 3 4 5	29. Describe a moderately complex process (e.g., admission to the hospital).
1 2 3 4 5	30. Give a presentation (15 minutes) to describe and/or explain a complex structure, system or process based on research.
1 2 3 4 5	31. Give a presentation (20 minutes) on a research topic in your own field.
1 2 3 4 5	32. Give a demonstration or briefing about a program, product, service and/or issue at your staff meeting or to a familiar small group of clients.
1 2 3 4 5	33. Give seminar-style presentation on a researched topic; explain complex concepts and ideas by using analogy, examples, anecdotes and/or diagrams.
1 2 3 4 5	34. Give a small lecture-style expository and/or argumentative presentation on a researched topic.
	INTERACTION ONE-ON-ONE
1 2 3 4 5	35. Ask for and provide detailed information related to personal needs, varied daily activities and routine work requirements.
1 2 3 4 5	36. Discuss options with a patient or another professional.
1 2 3 4 5	37. Provide, obtain and/or discuss detailed complex information and opinions with an individual in order to coordinate teamwork assignments/tasks.
1 2 3 4 5	38. Provide, obtain and/or discuss detailed complex information and opinions with an individual in a peer or superior relationship in order to coordinate work, delegate, solve a problem or conflict, and/or make a decision.
1 2 3 4 5	39. Exchange/discuss detailed complex information to solve a problem, make a decision, supervise, motivate, and/or discipline or evaluate performance.
	INTERACTION IN A GROUP
1 2 3 4 5	40. Express opinions and/or feelings in a group; qualify opinion, express reservations, approval, disapproval, possibility and/or probability.
1 2 3 4 5	41. Participate in a debate/discussion/meeting on an abstract familiar topic and/or issue.
1 2 3 4 5	42. Contribute to a debate and/or case study discussion with familiar participants in a workplace context.

IMPORTANCE					*INTERACTION IN A GROUP*
1	2	3	4	5	43. Contribute to a seminar and/or debate.
1	2	3	4	5	44. Contribute to a symposium and/or conference with unfamiliar participants.
1	2	3	4	5	45. Facilitate a discussion, seminar/formal meeting; help participants clarify issues and reach set goals.
					LISTENING TASKS: INSTRUCTIONS
1	2	3	4	5	46. Follow simple instructions on phone or left on voice mail and/or audio tape.
1	2	3	4	5	47. Follow an extended set of multistep instruction on technical and non-technical tasks for familiar processes and/or procedures (e.g., first aid).
1	2	3	4	5	48. Integrate several detailed and extensive pieces of oral information to carry out multistep complex instructions for a familiar process and/or procedure.
1	2	3	4	5	49. Follow complex multi-step instructions for carrying out important procedures; **situation may be demanding and stressful** (e.g., mediating and resolving an escalating conflict between others).
1	2	3	4	5	50. Follow instructions on complex unfamiliar procedures **in a demanding and stressful situation** (e.g., various unfamiliar emergency response procedures).
					LISTENING TASKS: SUASION (GETTING THINGS DONE)
1	2	3	4	5	51. Follow extended warnings, threats, suggestions and/or recommendations.
1	2	3	4	5	52. Evaluate extended suggestions for solutions to problems, recommendations and/or proposals.
1	2	3	4	5	53. Identify, analyze and/or evaluate values and assumptions in persuasive presentations.
					LISTENING TASKS: INFORMATION
1	2	3	4	5	54. Follow an extended oral presentation or conversation about abstract and complex ideas on a familiar topic (e.g., information discussed on rounds).
1	2	3	4	5	55. Follow a complex 20 - 30 minute lecture, presentation, and/or panel discussion.
1	2	3	4	5	56. Follow a 20 to 30 minute presentation to obtain detailed information to evaluate the validity of argumentation.
1	2	3	4	5	57. Reconstruct the message, position, bias, assumptions and motives of the speaker from a series of complex oral statements (20 - 40 minute debate and/or discussion).

READING

IMPORTANCE	READING TASKS: SOCIAL INTERACTION
1 2 3 4 5	58. Read authentic notes, e-mail messages and/or letters expressing gratitude and appreciation, complaint, hope, disappointment, satisfaction, and dissatisfaction.
1 2 3 4 5	59. Read authentic notes, e-mail messages and letters (personal and public) containing general opinions, assessments of situations, response to a complaint and/or expressions of sympathy.
1 2 3 4 5	60. Identify and explain point of view, personal attitudes and/or emotions in editorials, letters, personal essays and fictional writing.
1 2 3 4 5	61. Identify and explain values and assumptions in letters and/or memos.
1 2 3 4 5	62. Infer attitudes, emotions, intentions and motivations and/or draw conclusions from letters, memos and/or notes containing disagreements, claims and denials of claims, and/or clarifications and restatements of information.
	READING TASKS: INSTRUCTIONS
1 2 3 4 5	63. Follow instructions on 10 to 13 step everyday procedures related to simple technical and non-technical tasks (e.g., how to apply the Heimlich manoeuvre).
1 2 3 4 5	64. Follow extended multistep instructions for established process (e.g., what to do in case of a serious injury in a car accident).
1 2 3 4 5	65. Follow formal instructions of advisoryinstructional texts, and/or instructions for a familiar process or procedure that require integration of several pieces of information (e.g., read policy and procedure manuals and health and safety advisories).
1 2 3 4 5	66. Summarize complex instructional texts in continuous prose into comprehensive multistep instructions for a familiar process or procedure (e.g., explain instructions from a reputable medical program on how to lose, gain and maintain body weight).
1 2 3 4 5	67. Follow extensive written, specialized instruction for an unfamiliar, complex process and/or procedure (e.g., emergency response procedures).
	READING TASKS: BUSINESS/SERVICE TEXTS
1 2 3 4 5	68. Obtain information from texts containing assessments, evaluations and/or advice (e.g., public health advisories).
1 2 3 4 5	69. Follow written solutions, recommendations and proposals, and/or statements of rules and regulations. (e.g., information on workplace hazardous materials).
1 2 3 4 5	70. Obtain information for key work tasks by locating and integrating several pieces of information in complex prose texts and formatted texts (e.g., forms, public reports).
1 2 3 4 5	71. Obtain information for key work tasks by locating and integrating several pieces of information in complex prose texts **and/or in complex forms and graphic displays.**
1 2 3 4 5	72. Evaluate the validity/logistics of proposed timetables, schedules, and/or programs and itineraries when compared with other variables (needs, requirements, availability, etc.).
1 2 3 4 5	73. Obtain information for complex key work tasks by locating and integrating several pieces of explicit and implied information in **multiple complex prose texts** and/or in **complex forms** and graphics displays (e.g., persuasive service texts).
	READING TASKS: INFORMATION
	UNFORMATTED TEXT (Written language in complete sentences and/or paragraphs)
1 2 3 4 5	74. Comprehend an extended description, report and/or narration when events are reported out of sequence; draw conclusions.
1 2 3 4 5	75. Identify main ideas(s) and/or identify ways in which the supporting details develop the main idea(s) in complex text (5 pages) by reorganizing the text into an outline format.
1 2 3 4 5	76. Trace the development of an argument in a complex text in your field of work in a one-page summary.

IMPORTANCE	READING TASKS: INFORMATION
	UNFORMATTED TEXT (Written language in complete sentences and/or paragraphs)
1 2 3 4 5	77. Reconstruct the message, position, bias, values, assumptions and motives of a writer from fragments of text.
	FORMATTED TEXT (Written language not in complete sentences and/or paragraphs (e.g.,lists, menus, recipes, calendars, maps, graphs, charts, diagrams, directories.)
1 2 3 4 5	78. Interpret verbal ideas and/or graphics contained in charts and/or graphs (e.g., a process flow chart related to patient care).
1 2 3 4 5	79. Comprehend complex process flow charts, graphs, pictographs and/or diagrams.
1 2 3 4 5	80. Interpret and convert survey information from a questionnaire into percentages/ categories as text and graphs.
1 2 3 4 5	81. Demonstrate comprehension of rating scales and evaluation grids (e.g., use a rating scale to interpret group test scores).
	INFORMATION LITERACY/REFERENCE AND STUDY SKILLS COMPETENCIES
1 2 3 4 5	82. Access and locate three or four pieces of information in on-line electronic reference sources (e.g., World Wide Web, library databases).
1 2 3 4 5	83. Access a single piece of information involving a complex search in on-line electronic reference sources.
1 2 3 4 5	84. Access and locate several pieces of information involving a complex search of on-line electronic reference sources (e.g., library databases) or of a variety of reference materials in libraries and/or archives.
1 2 3 4 5	85. Conduct a whole-topic information search of on-line electronic reference sources (e.g., library databases) and traditional sources.

WRITING

IMPORTANCE	WRITING TASKS: SOCIAL INTERACTION
1 2 3 4 5	86. Convey a personal message in a formal short letter or note, and/or through e-mail, expressing or responding to appreciation, complaint, disappointment, satisfaction, dissatisfaction, and hope.
1 2 3 4 5	87. Convey a personal message in a formal short letter or note, and/or through e-mail expressing or responding to sympathy; clarifying a minor conflict; or giving reassurance.
1 2 3 4 5	88. Write a note to express thanks, state acceptance and/or acknowledgement in the workplace.
1 2 3 4 5	89. Write a note to schedule/cancel/reschedule professional appointments and/or meetings.
1 2 3 4 5	90. Write social business letters to express thanks, acceptance, acknowledgement, offer of resignation, congratulations, sympathy, condolence.
1 2 3 4 5	91. Write letters to give personal references and/or recommendations.
1 2 3 4 5	92. Write letters to network and/or exchange ideas with others.
	WRITING TASK: REPRODUCING INFORMATION
1 2 3 4 5	93. Take notes from an oral presentation and/or a page of written information. (e.g., seminar on procedures for frost bite).
1 2 3 4 5	94. Take notes from pre-recorded longer messages with seven to ten details. (e.g., listening to the shift to shift report on an audio cassette and/or through voice mail).
1 2 3 4 5	95. Write instructions about an established process or procedure given in a live demonstration, over the phone and/or from pre-recorded audio or video material.
1 2 3 4 5	96. Write summaries and summary reports of longer texts using data recorded in various formats and from several different sources, including graphs, charts and/or other computer screen displays.
1 2 3 4 5	97. Write minutes or a narrative record of a formal meeting. (e.g. interdisciplinary team meeting).
1 2 3 4 5	98. Write a paragraph to summarize complex information in questionnaires, graphs, charts.
1 2 3 4 5	99. Take detailed notes of text comprised of up to 20 pages of written text, and/or up to 60 minutes of oral discourse.
1 2 3 4 5	100. Reproduce information from several complex visual graphics in one to two paragraphs.
1 2 3 4 5	101. Reduce and synthesize very complex and extensive information from multiple sources into a variety of formats (e.g., point form notes, minutes, outlines, summaries, reports, abstracts, charts, tables, graphs).
	WRITING TASK: BUSINESS/SERVICE MESSAGES
1 2 3 4 5	102. Fill out moderately complex forms. (e.g., short medical history form, one or two page straightforward job application, or application for training).
1 2 3 4 5	103. Convey business messages as written notes to pass on routine information, make requests, and/or respond to recommendations and warnings.
1 2 3 4 5	104. Write a report/memo in paragraph form.
1 2 3 4 5	105. Fill out forms and other materials in pre-set formats with required brief texts. Fill out application for employment forms of any length.
1 2 3 4 5	106. Write letters to request and to respond to requests for information, directions, service/product, clarification, permission.

IMPORTANCE	WRITING TASKS: BUSINESS/SERVICE MESSAGES
1 2 3 4 5	107. Write a report as a one or two paragraph memo or as a pre-set form (e.g., incident/accident report).
1 2 3 4 5	108. Write instructions and instruction letters.
1 2 3 4 5	109. Write semi-formal reports and proposals.
1 2 3 4 5	110. Fill out complex forms and other materials in pre-set formats with one to five paragraphs of text.
1 2 3 4 5	111. Write formal business reports, requests for proposals and formal proposals.
1 2 3 4 5	112. Create forms and other materials in pre-set formats to collect and record complex information in a standard way. Develop a questionnaire for a study or survey.
	WRITING TASKS: PRESENTING INFORMATION AND IDEAS
1 2 3 4 5	113. Write two or three paragraphs to narrate a familiar sequence of events from the past, to tell a story, and/or to provide a detailed description/ comparison. Describe a process.
1 2 3 4 5	114. Write a paragraph to relate/explain information in a table, graph, flow chart or diagram.
1 2 3 4 5	115. Write a paper, essay, or report to describe and compare complex ideas, phenomena or processes.
1 2 3 4 5	116. Write an expository paper, report and/or essay to explain causal and logical relationships between facts, phenomena and events.
1 2 3 4 5	117. Write a report to interpret extensive complex information using conventions for academic writing in nursing.

APPENDIX D

CLB LEVEL/CANTEST BAND SCORE COMPARISONS: UNIVERSITY OF OTTAWA (U of O) AND RED RIVER COLLEGE (RRC)

SECTIONS OF THE CANTEST	CANTEST BAND SCORES	U of O CORRESPONDING CLB LEVELS	RRC CORRESPONDING CLB LEVELS
ORAL	**3.5**	**6**	**N/A**
	4.0	**7**	**7**
	4.5	**8**	**8**
	5.0	**9**	**9**
	5.0+	**10**	**N/A**
	??	**11**	**N/A**
LISTENING	**3.0**	**6**	**N/A**
	3.5	**7**	**N/A**
	4.0	**8**	**7-8**
	4.5	**9**	**8-9**
	5.0	**10**	**9-10**
	5.0+	**11**	**N/A**
READING	**3.0**	**6**	**N/A**
	3.5	**7**	**N/A**
	4.0	**8**	**7-8**
	4.5	**9**	**8-9**
	5.0	**10**	**9-10**
	5.0+	**11**	**N/A**
WRITING	**3.0**	**6**	**N/A**
	3.5	**7**	**N/A**
	4.0	**8**	**8**
	4.5	**9**	**9**
	5.0	**10**	**10**
	5.0+	**10+**	**N/A**

APPENDIX E

Dear CanTEST Participant,

We are undertaking a project in which we are analyzing the language demands of the nursing profession across Canada. This project is funded by the Centre for Canadian Language Benchmarks in Ottawa. Through this study, we will determine language levels needed for foreign trained nurses, based on the actual language used on the job.

One way in which we hope to verify our results is to administer the CanTEST to foreign trained nurses who speak English as a second language, and are currently practising nurses in Canada. It will take about 3 hours. The results will give us very helpful information. Your confidentiality will be preserved by the use of numbers rather than real names in our files. No identifying characteristics of any individuals will be reported, and files will be stored in a locked data cabinet. All paper files will be shredded and all electronic files will be erased within 2 years of completion of the project. You will be paid a $75.00 honorarium for taking the CanTEST. You are not under any obligation to participate, and you may withdraw at any point during the test; however, to receive your honorarium, the test must be completed. The results of this project will be reported to the Centre for Canadian Language Benchmarks in the form of a report.

Please sign the consent form to indicate that you are willing to participate by taking the CanTEST.

Lucy Epp

Mary Stawychny

Red River College
Language Training Centre
Winnipeg, MB

ph 204-954-6151
e-mail: lepp@rrc.mb.ca

CANTEST CONSENT FORM

FIRST LANGUAGE: _____

NURSING ASSIGNMENT: _____

UNIT: _____

HOURS: _____

FACILITY: _____

ADDRESS OF FACILITY: _____

_____

How long have you been a practising nurse in Canada? _____

I understand that any information that I share and any information about my CanTEST score is confidential, and will be used only for research purposes. My name will not be used in any report. I hereby give the researchers permission to use this information in the benchmarking of the nursing profession.

Signature: _____ Date: _____

Researcher's Initials _____

APPENDIX F

BENCHMARKING OF THE NURSING PROFESSION

Focus Group Consent Form

I agree to participate in this focus group which is part of the project, Benchmarking of the Nursing Profession across Canada.

The focus group will last for 2 hours. Notes will be taken by one of the two investigators. I understand that my participation in this focus group is entirely voluntary, and that if I wish to withdraw, I may do so at any time, and that I do not need to give any reasons or explanations for doing so.

I understand that all the information I give will be kept confidential, and I agree to keep all information confidential. Names of groups and/or individuals participating in the focus group will not be identified in any reports.

I have read and understand this information and I agree to take part in the focus group.

_____ _____

Today's Date Your Signature

APPENDIX G

Dear Interview Participants:

We are undertaking a project in which we are analyzing the language demands of the nursing profession across Canada. This project is funded by the Centre for Canadian Language Benchmarks in Ottawa. Through this study, we will determine language levels needed for internationally educated nurses, based on the actual language used on the job.

This interview is one way in which we are gathering data for this purpose. It will take about half an hour. The interview results will give us very helpful information. The interview is intended for practicing nurses, and for others who work closely with nurses. Your confidentiality will be preserved by the use of numbers rather than real names in our files. No identifying characteristics of any individuals will be reported, and files will be stored in a locked data cabinet. All paper files will be shredded and all electronic files will be erased within 2 years of completion of the project. You are not under any obligation to participate, and you may withdraw at any point in the interview or decline to answer any questions. The results of this project will be reported to the Centre for Canadian Language Benchmarks in the form of a report.

Please sign the consent form below to indicate that you are willing to participate in the interview, and contact us by XXX to indicate your willingness to be interviewed.

I, the undersigned, agree to participate in the project described above by participating in the interview. I understand that any personal information (my name and contact information) will be kept fully confidential within your research team.

Name (Print): _____ Date:_____

Signature: _____

Profile Information Interview

Name: _____ Consent Confirmed: _____

Job Title of Interviewee: _____

Name of Health Care Facility: _____

Address: _____Phone Number: _____

Size of Establishment: _____ Number of Employees: _____

Description of Health Care Facility: (type of health care facility, work processes, technology, organization of work, distribution of work):

General Observations on Language Use in the Workplace:

Indicate how important it is for nurses to perform the language tasks based on the following scale:

Not important (1)
Somewhat important (2)
Important (3)
Very important (4)

Task	Examples	Importance
Speaking		
1. Talk to other health care professionals face to face		1 2 3 4
2. Talk to other health care professionals on the phone		1 2 3 4
3. Talk to authority figures face to face		1 2 3 4
4. Talk to authority figures on the phone		1 2 3 4
5. Give instructions		1 2 3 4
6. Use imperatives		1 2 3 4
7. Make requests		1 2 3 4
8. Ask for detailed information		1 2 3 4
9. Analyse or express opinions about the work		1 2 3 4

10. Clarify/ Elaborate		1 2 3 4
11. Explain		1 2 3 4
12. Attract attention		1 2 3 4
13. Provide, obtain and discuss detailed complex information in order to coordinate teamwork assignments/tasks (meeting format)		1 2 3 4
14. Facilitate a discussion, seminar, formal meeting; help participants clarify issues and reach set goals		1 2 3 4
15. Ask for assistance		1 2 3 4
16. Ask for permission		1 2 3 4
17. Indicate solutions to problems		1 2 3 4
18. Give advice/make suggestions		1 2 3 4
19. Use a certain level of formality in the workplace		1 2 3 4

Listening		
20. Listen to other health care professionals on the phone/face to face		1 2 3 4
21. Follow instructions		1 2 3 4
22. Deal with communication problems		1 2 3 4
23. Listen to audio cassette tapes or videos		1 2 3 4
Reading		
24. Scan text quickly to find specific information		1 2 3 4
25. Recall what has been read		1 2 3 4
26. Read and interpret formatted text (e.g., tables, charts, flow charts, graphs)		1 2 3 4
27. Read unformatted texts (e.g., journal articles, textbooks, descriptions)		1 2 3 4
28. Receive assistance from colleagues when reading is required (e.g., charts, reference books)		1 2 3 4
29. Read workplace safety precautions and regulations		1 2 3 4

Writing		
30. Fill out forms		1 2 3 4
31. Keep a record/log book		1 2 3 4
32. Write reports. What is the length of the reports?		1 2 3 4
33. Write down messages		1 2 3 4
34. Assist each other when writing is involved (e.g., charting, report writing)		1 2 3 4
35. Take notes in point form from an oral presentation		1 2 3 4
36. Use a keyboard		1 2 3 4
37. Hand write		1 2 3 4

QUESTIONS

1. Identify what you would consider the three main differences between the tasks carried out by the different nursing designations (e.g., RN/LPN/RNA/RPN) in your province?

   1. _____

   2. _____

   3._____

2. How would these differences be reflected in the language tasks required of nurses in each designation?

   1. _____

   2. _____

   3._____

3. What do you see as the three greatest challenges related to the language demands of the nursing profession in Canada?

   1. _____

   2. _____

   3._____

APPENDIX H (sample letter for participants--nurses)

Date

Dear Participant:

You have been invited to participate in the Benchmarking the Nursing Profession project. In this project, the English language demands of the nursing profession across Canada will be analyzed. The project is sponsored by the Centre for Canadian Language Benchmarks in Ottawa, Ontario. We, Lucy Epp and Mary Stawychny, instructors and researchers at Red River College, in Winnipeg, Manitoba, Canada, are the researchers.

This project will be of benefit to the nursing profession as it will help to establish English language demands of the profession and facilitate access into the profession

The researchers plan to observe participants for about 3 consecutive hours, noting the language that is used to carry out nursing tasks. Previous interviews have indicated that certain language tasks are more predominant. These tasks include listening and speaking interactions with other professionals, patients, and patients' families. In reading, the focus is on reading charts and other informational text. In writing, the focus is on filling out charts and other forms. We would, wherever possible, like to collect samples of reading and writing that is actually done on the job.

All information will be held confidential, except when professional codes of ethics or legislation or the law requires reporting. The information you provide will be kept for at least five years after the study is done. The information will be kept in a locked filing cabinet. Your name or any other identifying information will not be attached to the information you provide. Your name will also never be used in any presentations or publications of the study results. You may withdraw from participation in the observation at any time.

In the case of any concerns, complaints, or consequences, you may contact Audrey Bonham, chair of the Language Training Centre, Red River College, at the address below .

Yours truly,

Lucy Epp, Instructor and Researcher/Mary Stawychny, Instructor and Researcher

Red River College
Language Training Centre
Suite 300-123 Main Street
Winnipeg, MB R3C 1A3
Phone: (204) 945-6151
Fax: (204) 948-3214

APPENDIX I

Consent Form (Nurse)

Part 1: Researcher Information		
Names of Principal Investigators: Lucy Epp/Mary Stawychny Affiliation: Red River College, Language Training Centre Contact Information: 123 Main Street, Winnipeg, MB, R3C 1A3; phone: (204) 495-6151		
Name of Co-Investigator/Supervisor: Affiliation: Contact Information:		
Part 2: Consent of Subject		
	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your work situation.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to the data gathered?		
Part 3: Signatures		
This study was explained to me by: _____ Date: _____		
I agree to take part in this study. Signature of Research Participant: _____ Printed Name: _____		
Witness (if available): _____ Printed Name: _____		
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Researcher: _____ Printed Name: _____		
* A copy of this consent form must be given to the subject.		

APPENDIX J

LANGUAGE SKILL: SPEAKING TIME: 9 am to 12 pm DAY: Tuesday UNIT: Surgery DESIGNATION: RN

INTERACTION WITH:	COMFORTS/ REASSURES	ASKS FOR CLARIFICATION	PARTICIPATES IN DISCUSSION	EXPLAINS	DESCRIBES	INFORMS	ASKS FOR INFORMATION
CLIENT	✓✓✓		✓✓✓✓✓✓✓✓✓✓	✓		✓✓✓✓✓✓✓	✓✓✓✓✓✓✓✓✓✓✓ ✓✓✓✓✓✓✓✓✓✓✓ ✓
PROFES-SIONAL		✓	✓✓✓✓✓✓				
CLIENT'S FAMILY/ FRIEND(S)							

INTERACTION WITH:	ASKS FOR HELP	OFFERS HELP	GIVES INSTRUCTIONS	APOLOGIZES	SUGGESTS/ CONVINCES	SMALL TALK	**PHONE**	
CLIENT			✓✓	✓	✓✓✓	✓✓✓	ASKS FOR INFO	
PROFES-SIONAL			✓✓		✓✓✓	✓✓	TAKES MESSAGE	
CLIENT'S FAMILY/ FRIEND(S)							DISCUSSES	
							REQUEST	

COMMENTS: RN was working with a student nurse; RN sometimes has to call physician after hours. _____

_____

LANGUAGE SKILL: LISTENING

INTERACTION WITH:	DESCRIPTION	EXPLANATION	FOLLOW INSTRUCTIONS	SMALL TALK	RESPONDS TO QUESTIONS	PHONE	
CLIENT					✓	TAKES MESSAGES	✓
PROFES-SIONAL		✓✓✓	✓✓	✓✓	✓✓✓✓✓✓		
CLIENT'S FAMILY							

COMMENTS: _____

LANGUAGE SKILL: READING

SAMPLES: 1. Teaching Instructions 2. Discharge Instructions 3. _____

4. _____ 5. _____ 6. _____

COMMENTS: Samples provided; staff assist each other when reading (especially on charts)

_____

_____

LANGUAGE SKILL: WRITING

SAMPLES: 1. Post-Partum Referral Form 2. Record of Post-Partum Patient Learning 3. Assessment Planning Implementation Evaluation

4. _____ 5. _____ 6. _____

COMMENTS: _____

_____

_____

GENERAL COMMENTS: Unit also included some maternity patients. _____

_____

APPENDIX K: Description of Results of Survey

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
QUES1	154	0	5	3.92	1.08
QUES2	154	2	5	3.97	.92
QUES3	154	1	5	4.51	.86
QUES4	154	0	5	3.99	1.00
QUES5	154	0	5	3.81	1.25
QUES6	154	0	5	3.69	1.20
QUES7	154	0	5	2.97	1.32
QUES8	154	0	5	4.69	.81
QUES9	154	0	5	3.78	1.15
QUES10	154	0	5	4.10	1.17
QUES11	154	0	5	3.57	1.47
QUES12	154	0	5	2.74	1.58
QUES13	154	0	5	4.03	1.19
QUES14	154	0	5	3.88	1.19
QUES15	154	0	5	4.14	1.26
QUES16	154	0	5	3.99	1.22
QUES17	154	0	5	4.16	1.17
QUES18	154	0	5	4.22	1.16
QUES19	154	0	5	4.19	1.20
QUES20	154	0	5	3.94	1.52
QUES21	154	0	5	3.55	1.67
QUES22	154	0	5	4.10	.98
QUES23	154	0	5	3.87	1.06
QUES24	154	0	5	3.27	1.39
QUES25	154	0	5	2.92	1.11
QUES26	154	0	5	3.55	1.30
QUES27	154	0	5	3.62	1.38
QUES28	154	0	5	3.16	1.33
QUES29	154	0	5	3.72	1.26
QUES30	154	0	5	2.98	1.62
QUES31	154	0	5	2.94	1.47
QUES32	154	0	5	3.23	1.38
QUES33	154	0	5	2.86	1.54
QUES34	154	0	5	2.69	1.54
QUES35	154	0	5	3.95	1.12
Valid N (listwise)	154				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
QUES36	154	0	5	4.28	.82
QUES37	154	0	5	4.05	1.08
QUES38	154	0	5	4.23	.97
QUES39	154	0	5	3.95	1.25
QUES40	154	0	5	3.88	1.01
QUES41	154	0	5	3.21	1.19
QUES42	154	0	5	3.42	1.20
QUES43	154	0	5	2.91	1.33
QUES44	154	0	5	2.69	1.40
QUES45	154	0	5	2.94	1.52
QUES46	154	1	5	4.08	.99
QUES47	154	0	5	4.14	1.03
QUES48	154	0	5	4.06	1.05
QUES49	154	0	5	4.08	1.16
QUES50	154	0	5	4.12	1.27
QUES51	154	0	5	3.71	1.28
QUES52	154	0	5	3.79	1.15
QUES53	154	0	5	3.37	1.39
QUES54	154	0	5	3.59	1.28
QUES55	154	0	5	3.44	1.31
QUES56	154	0	5	3.16	1.41
QUES57	154	0	5	2.88	1.42
QUES58	154	0	5	3.44	1.28
QUES59	154	0	5	3.41	1.29
QUES60	154	0	5	2.46	1.38
QUES61	154	0	5	2.81	1.36
QUES62	154	0	5	2.90	1.39
QUES63	154	0	5	3.99	1.22
QUES64	154	0	5	4.05	1.32
QUES65	154	0	5	4.08	1.11
QUES66	154	0	5	3.45	1.25
QUES67	154	0	5	4.09	1.24
QUES68	154	0	5	3.56	1.23
QUES69	154	0	5	3.96	1.26
QUES70	154	0	5	3.21	1.37
Valid N (listwise)	154				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
QUES71	154	0	5	2.89	1.46
QUES72	154	0	5	3.12	1.42
QUES73	154	0	5	2.84	1.42
QUES74	154	0	5	3.33	1.41
QUES75	154	0	5	2.81	1.40
QUES76	154	0	5	2.75	1.39
QUES77	154	0	5	2.71	1.43
QUES78	154	0	5	3.69	1.25
QUES79	154	0	5	3.49	1.25
QUES80	154	0	5	2.49	1.39
QUES81	154	0	5	2.55	1.50
QUES82	154	0	5	2.99	1.50
QUES83	154	0	5	3.00	1.42
QUES84	154	0	5	2.81	1.48
QUES85	154	0	5	2.73	1.46
QUES86	154	0	5	3.36	1.43
QUES87	154	0	5	3.38	1.35
QUES88	154	0	5	3.44	1.23
QUES89	154	0	5	3.52	1.38
QUES90	154	0	5	3.02	1.47
QUES91	154	0	5	3.10	1.48
QUES92	154	0	5	3.03	1.35
QUES93	154	0	5	3.41	1.25
QUES94	154	0	5	3.59	1.50
QUES95	154	0	5	3.25	1.42
QUES96	154	0	5	2.66	1.51
QUES97	154	0	5	3.17	1.45
QUES98	154	0	5	2.75	1.50
QUES99	154	0	5	2.56	1.46
QUES100	154	0	5	2.53	1.48
Valid N (listwise)	154				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
QUES101	154	0	5	2.69	1.49
QUES102	154	0	5	3.95	1.20
QUES103	154	0	5	3.63	1.24
QUES104	154	0	5	3.58	1.25
QUES105	154	0	5	3.64	1.27
QUES106	154	0	5	3.35	1.38
QUES107	154	0	5	3.95	1.14
QUES108	154	0	5	3.41	1.43
QUES109	154	0	5	2.95	1.47
QUES110	154	0	5	3.03	1.48
QUES111	154	0	5	2.55	1.59
QUES112	154	0	5	2.60	1.59
QUES113	154	0	5	3.19	1.41
QUES114	154	0	5	2.75	1.43
QUES115	154	0	5	2.72	1.48
QUES116	154	0	5	2.53	1.45
QUES117	154	0	5	2.49	1.53
Valid N (listwise)	154				